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Individualized Senior Support Program at Pears and Leonard Ave

Alzheimer Knowledge Exchange
Behavioural Support System Series
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Goals of Today's Presentation

1. Introduce participants to an individualized funding model
2. Provide an overview of the program
3. Provide a profile of clients
4. Review indicator data
5. Provide an overview of successes and challenges to date
6. Discuss possibility for replication



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History

- FST work with people with developmental challenges
- Application to TC LHIN as innovative program
- Expanding/adapting Supportive Housing for seniors



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Vision of Program

Support unique capabilities, interests and needs of participants through the use of person-centered planning and individualized funding.



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Guiding Principles

- Person-centered, person-directed planning and supports
- Program contributes to overall health and well-being of tenant community
- Capacity building within partnership and with external partners
- Flexible, equitable, effective, transparent and accountable processes in place
- An equity and inclusion framework informs and underpins all facets



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Service Description

- Individuals are supported to remain in their own home with the availability of an individualized funding package
- Participants direct the work of a support worker who they engage to assist them with specific issues they have identified
- Participants are deemed eligible due to needs in a variety of areas
- Support plans developed
- Outreach support to people who are reluctant to engage



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Service Providers

- Partnership of four agencies
 - Family Service Toronto
 - Margaret Frazer House
 - City of Toronto
 - St. Clare's Housing Society



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Eligibility Criteria

- Live at 138 Pears Ave or 25 Leonard Ave
- 60 years of age or older or 50 years of age or older and experiencing one or more health related challenges
- At risk of not being able to live independently because community supports are not of sufficient quantity and/or flexibility to meet the needs of the applicant in a safe way
- Interested in directing their own care and/or have the necessary supports to do this.



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Eligibility Criteria cont'd

- Have an assessed need for supports in at least three or more of the following areas:
 - Homemaking assistance
 - Shopping assistance
 - Personal care assistance
 - Medication monitoring
 - Activation/socialization
 - Meal support/preparation
 - 24/7 Emergency Response



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Demographics of Participants

- Chronological age range from mid 50s to over 80
- Prolonged history of marginal housing or life on the street or in shelters has precipitated advanced functional age and/or mental health issues
- Admitted to program from own home, from shelter, after hospitalization
- Living at sites 1 to 5 years
- Income from ODSP or CPP/OAS
- Most have no family support
- Range of ethno-cultural backgrounds
- Sexual orientation varies amongst participants



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General Profile of Presenting Issues

- 100% mental health issues (e.g. schizophrenia, bi-polar, functionally psychotic, sociopathic, dementia)
 - 80-90% substance use issues (e.g. alcohol, crack, cocaine, oxycotin)
 - Range of physical health issues (e.g. diabetes, COPD, HIV+)
 - Developmental disabilities
- Many concurrent issues



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Direct Service Care Team

- Community Resource Facilitator
 - Mental health counsellor
 - Support Workers
 - On-site consulting psychiatrist
- Supported by
- Access to mental health crisis bed (off site)
 - Tenant Support Coordinator
 - Crisis support worker
 - Partner agencies



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“Back Office” Supports

- Senior Director
- Developmental services program
 - Purchase of service clerk
 - Database support



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Desired Outcomes for Participants

- Health and well-being is maintained and/or enhanced
- Inclusion in the community as much as desire and are able
- Appropriate usage of health care resources
- Empowered to manage own care
- Housing is safe and secure
- Fair and equitable flexible funding reflects day to day needs
- Direct required supports



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Tracking Indicators

- Number of unscheduled ED visits
- Number of ED visits resulting in hospitalization
- Number of falls
- Number of falls resulting in ED visits
- Number of participants linked with primary care provider
- Number of visits to physician
- Client satisfaction



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Trends in Indicator Data

- Small number of people experiencing falls
- Very few ED visits – none “unscheduled”
- Hospitalizations related to need to address acute physical health issues, involuntary admissions, palliative care
- Doctor visits as proxy for appropriate use of health care system



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Connecting Indicator Data to Model of Care

- Number of falls decreased when hoarding issues addressed
- People contracting for IADLs
- Utilization varies within participant group in any one month and correlates to presenting health issues
- Saving for a rainy day mentality contributing to lower utilization
- Indicators not allowing us to record mental health and substance use issues



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Individualized Budgets

- Funding Review Committee
 - Plan review
 - Proposed budget
 - Statement of mutual agreement
 - Funding agreement form
- Range from \$2,600 to \$11,000 per year



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Uptake on Individualized Budgets

- Ebb and flow of units of service from month to month influenced by:
 - Mental health of participants
 - Support worker availability
 - Resistance
 - Need vs. willingness to utilize
 - Saving for rainy day
- Staffing changes



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Potential Replication of Model

- Individualized service packages not dependent on location which can be largest barrier to accessing supportive housing/assisted living
- Self directed and self managed by participant and/or caregivers
- Tailored package of services can focus directly on what precipitates ER/ALC usage
- Contributes to diversion by meeting needs as participant's define them and allows "out of the box" thinking on how to respond and what to contract for
- Proven model used in developmental disability sector
- Huge appetite for this type of model amongst seniors, people living with disabilities



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Challenges and Successes

Successes

- Support workers
- High degree of client satisfaction
- High demand for program
- Self directed care and control

Challenges

- Supporting support workers
- Trust issues by participants
- Complexity of intersecting health and social issues
- Administrative issues related to reporting



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Client Satisfaction

Key messages:

- CRF critical to success of program
- Program design provides a sense of empowerment and dignity
- Strong message to replicate in other buildings/communities
- Strong support for selecting own support workers
- Ongoing need for support to direct support workers
- Ongoing need for information and clarification about program processes



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Comments from Clients

“Knowing I have support makes life so much easier”

“(The program) helps with my pain level because I don’t have to do everything myself. It keeps me healthy”

“Dignity. Being comfortable. Knowing I have dependable help”

“I would really like to see the program expanded. This program should be used locally, regionally and nationally. If the higher ups could do a pilot project on a larger basis to expand”



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