Toronto Central **LHIN REPORT** | JULY/AUGUST 2008 EDITION

Seniors get a lift from Toronto Central LHIN announcement

"Maintaining our independence is a priority," said seniors, "and, with a little help, we can stay that way." And so the dozens of seniors gathered at Mid-Toronto Community Services on June 19 cheered and applauded when former Health Minister George Smitherman announced that Toronto Central LHIN had heard them, and was receiving a little extra help from the provincial coffers.

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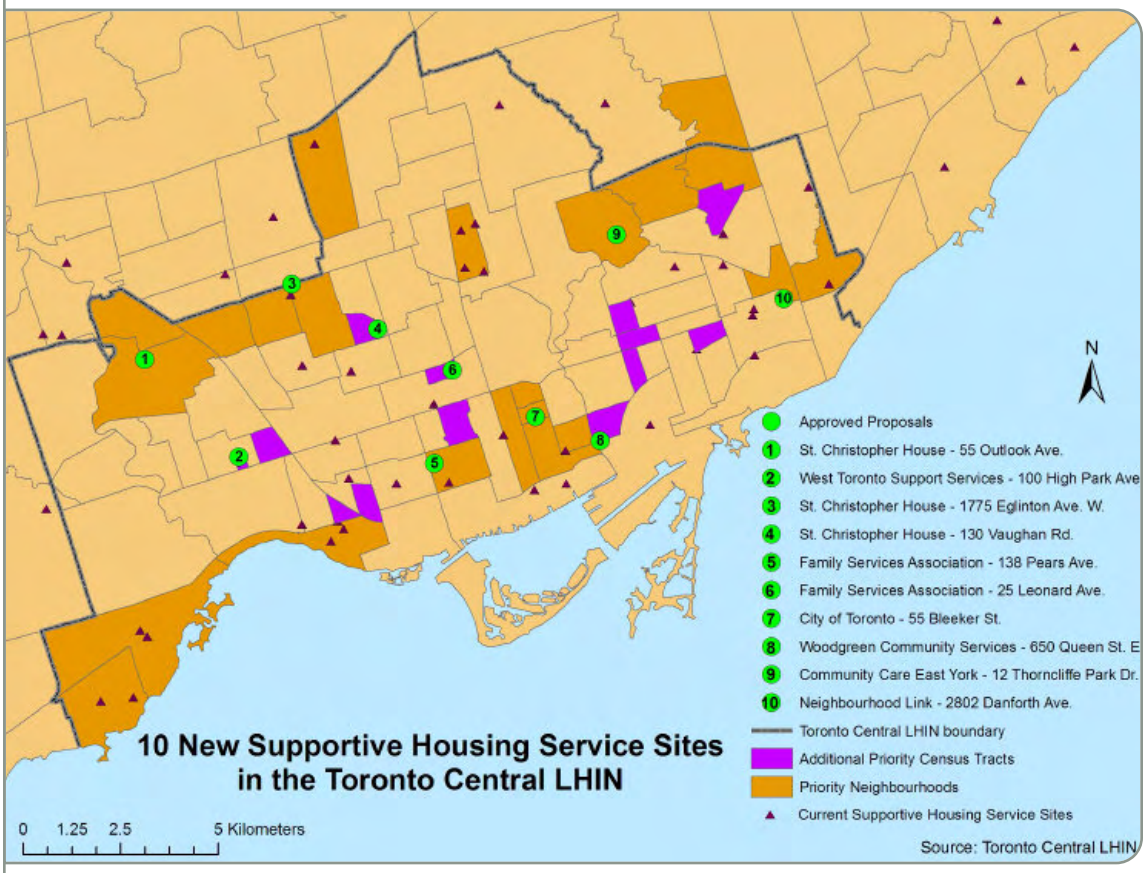
Ontario
Local Health Integration Network

Seniors get a lift from Toronto Central LHIN announcement continued from page 1



As part of the Ontario government's four-year $1.1 billion provincial Aging at Home Strategy, Smitherman announced that the Toronto Central Local Health Integration Network (LHIN) has funded $4.9 million in projects this year designed to better co-ordinate health and community services and help more seniors achieve their goal of staying well and living independently. Included were:

- $2.1 million for more supportive services in buildings located in under-serviced Toronto neighbourhoods where large numbers of frail, marginalized seniors live. (see map for locations) These seniors often make use of Emergency Department services and supportive housing services will help to keep them well and out of the Emergency Departments. Supportive services will vary by location and include such help as wellness programs, security checks, laundry, cleaning, medication reminders and mental health and addictions counseling. Funding for two agencies will enable 50 older men, including some with mental health or addictions problems, to make a new start in supported permanent independent living.
- $1 million for the Seniors Independence Program that will bring community agencies and volunteer resources together to provide services to 400 seniors that help them stay out of long-term care homes.
- $683,750 for Toronto Ride's new ride management system. Toronto Ride, a partnership of 12 community service providers, provides reliable escorted transportation to get seniors to medical appointments, wellness and recreation programs and grocery stores. This is assisted by six new vans provided separately by the Ministry of Health and Long-Term Care, adding more than 8,328 new rides each year
- $475,000 for the Home at Last program to help seniors after they leave hospital to prevent their re-admission to emergency departments. Making sure that seniors are safely set up at home in their first few days after a hospital stay with medications, groceries and care supports will help more than 1,000 seniors.

"We have worked diligently with our community partners to develop innovative health care services for seniors," added Mohamed Dhanani, Chair of Toronto Central LHIN's Board of Directors. "A lack of adequate transportation services presents a serious challenge to the delivery of health care for many people. The new van fleet will provide reliable and vital transportation for Ontario seniors and allow our residents to receive the care they need where and when they want it."

Innovative solution to caring for young adults with disabilities

Crystal Chin has faced more challenges in her childhood and teenage years than most people face in a lifetime.

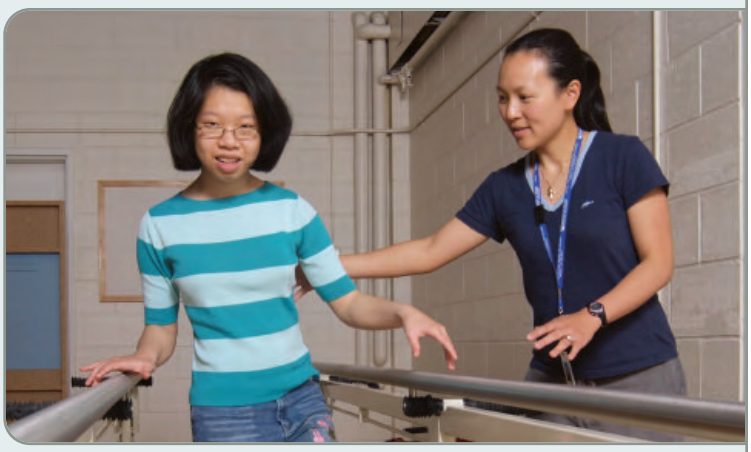
At 19, Crystal is among the first group of young adults to join the LIFEspan (Living Independently and Fully Engaged) Service—a joint initiative of Toronto Rehab and Bloorview Kids Rehab. LIFEspan is designed to help people with childhood-onset disabilities make the transition from pediatric care to adult health services. Believed to be the first of its kind in Ontario, the program also hopes to improve coordination of rehabilitation services throughout adulthood. Toronto Central LHIN provided just over $315,000 to the project earlier this year as part of its Integrated Health Service Plan commitment to smooth out rehabilitation transitions.

"I think it's crucial that they're attempting to do something about adult services because our disabilities don't stop at 18," says Crystal, who was born with cerebral palsy, a neurological disorder that causes physical disability in human development. Since arriving in Canada from Taiwan at the age of 10, Crystal has been an outpatient at Bloorview Kids Rehab, where she has received holistic care from a team of health professionals. "LIFEspan will be helpful because I'll have somewhere to continue my health services," adds Chrystal.

While pediatric services for children with disabilities have been well coordinated for years, adult services for those with childhood-onset disabilities have been slow to develop—leaving many people to fall between the cracks as they grow older.

"The void in services after pediatric care is downright frightening to youth and their families," says Dolly Menna-Dack, who grew up with juvenile rheumatoid arthritis. Now 27 and a youth facilitator at Bloorview, she says the lack of coordinated and centralized adult services caused her health to "deteriorate well past the point I was at upon discharge from Bloorview."

"The problem is that many of these young adults do not meet the admission criteria of traditional adult rehabilitation or complex continuing care programs," explains Joanne Maxwell, Transition Service Project Coordinator. "Thanks to this joint initiative, we are playing a lead role in helping to ensure that they are adequately supported during this transition and throughout adulthood."



Crystal Chin's walking is assessed by a physiotherapist.

The LIFEspan Service will increase the quality of primary care and the health of young adults with childhood onset disabilities, including the prevention of secondary conditions, by ensuring that patients receive the right care from the right source. Although it is difficult to calculate the future health care savings of a new model of care, LIFEspan expects the investment to result in decreased costs in other areas of health service such as acute care. Savings are estimated at $3.7 million annually five years into the program, which more than cover the cost of this new service.

The LIFEspan Service began in December 2006 as a demonstration project for individuals with cerebral palsy and acquired brain injury. The service mirrors the pediatric interdisciplinary team approach to care and features a nurse practitioner, jointly appointed in both rehab centres; a physiatrist (doctor who specializes in rehab medicine); an occupational therapist; physiotherapist; speech language pathologist; and social worker.

Feedback from patients and families during the early months of the project will be used to support a proposal to the Ministry of Health and Long-Term Care for more comprehensive adult services for those with a broader range of disabilities. The LIFEspan Service is located in Toronto Rehab's Rumsey Centre in north Toronto—just across the parking lot from the new Bloorview Kids Rehab.

Standardized rehabilitation referral form

increases access, improves and speeds decision-making

Your patient is a 73-year-old male with a non-surgical leg fracture. He has some cognitive impairment. Should he be referred first to a geriatric program to deal with his forgetfulness or to the musculoskeletal rehab? Which rehabilitation facility and program will be best for him? And how do you move him in a timely way from your acute care hospital to make way for the next patient waiting downstairs in the Emergency Department for an in-patient bed?

That is the daily challenge faced by discharge planners in hospitals across the city. Their task has been simplified as a result of work, funded in part by the Toronto Central LHIN, that was done by the GTA Rehab Network to create a standardized single in-patient rehabilitation/ complex continuing care referral form and transfer checklist for 13 different types of rehabilitation (for list, see What's covered, what's not on next page).

The goals

The form was launched in November 2007 as a way to improve transitions from hospitals and institutional care for those who need rehabilitation

services. The document is helping to resolve inefficiencies in the health care system, reducing the workload for staff and laying the groundwork for an electronic referral system. The form will also increase capacity to monitor system access indicators consistently across programs.

The change is a critical part of improving patient flow within Toronto Central LHIN. Timely access to specialized rehabilitation and complex continuing care services has been identified as key to reducing the stay of patients needing an alternate level of care, who occupy hospital beds needed by people waiting in Emergency Departments.

"In the past there was a different referral form for each program at a rehab facility and there were many different facility forms," says Nancy Boaro, Advanced Practice Leader in the Neurological Rehabilitation Program at Toronto Rehab. "There was often a lack of clarity about what would really meet the patient's needs, incomplete information and that resulted in repeated phone calls and inappropriate admissions. For patients like the gentleman above, who might benefit from more than one program, there was a lot of paperwork flying back and forth, resulting in delays in making admission decisions."

The benefits

Jacqueline Houston, a Case Manager at St. Michael's Hospital on the trauma/ neurosurgery unit, where about 60% of patients require specialized rehabilitation after they have been stabilized, agrees that the development of the new referral form has been very beneficial.

"There is a huge pressure to place these patients and the key has been the time saved," she says. "It has been easier for me to communicate with my team, to get them to complete the form, which you can download from the GTA Rehab Network website. The tick boxes to identify care needs, medical/ functional status and rehab goals help you to get through the form quickly and the fact that you can put in the personalized information required using a computer means we don't have to decipher handwriting."

Heather Reid, Program Director at Rouge Valley adds that the form is used across LHIN boundaries in her own facility and has been "a positive experience that has had lots of acceptance. It is the first step toward an electronic solution and the vision of what we're trying to create. It helps us make better decisions, faster."

What's covered

The In-patient Rehabilitation/ Complex Continuing Care Referral Form covers 13 specific rehabilitation groups:

- Acquired Brain Injury/ Neurological
- Amputee
- Burns
- Cardiac
- General/Medical
- Geriatric
- Musculoskeletal
- Oncology
- Trauma
- Transplant
- Respiratory/Chronic Ventilation
- Spinal Chord
- Complex Continuing Care

What's not

- Palliative Care (plans for integration are underway)
- E-Stroke (integration will be pursued in future once the paper-based form is replaced with an electronic format)
- Toronto Rehab's Geriatric Psychiatry Program

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Standardized rehabilitation referral form increases access, improves and speeds decision-making continued from page 5

The process

The key to achieving results was getting all the players to agree to the essential information needed to make admission decisions and then to consult both within and across facilities to be sure that the needs of users were being met.

A Patient Access and Flow Committee was struck in November 2006 with representatives from 12 Toronto-area acute care and freestanding rehab hospitals (see sidebar for membership). Members acted as leads to oversee the process and communicate within their respective organizations.

The group looked at all the forms in use and consulted within each hospital. They decided to build on the existing e-Stroke Rehab Referral form as a template, to ensure that the standardized rehabilitation referral form could be converted to an electronic format in future. They also consulted with privacy commissioners to ensure that the form conformed to regulations. Funds provided by Toronto Central LHIN enabled the network to translate the patient consent portion of the form into 14 languages, greatly broadening the population base that it can be used with.

"The referral form was evaluated in December 2007," says Sue Balogh, Project Co-ordinator and Planner for the GTA Rehab Network. "At that time 85% of the respondents rated the form as a three or higher on a five point scale for clarity, ease of use, relevance and usefulness to describe patient needs." A second evaluation measuring information flow and how the form is affecting workload is planned.

The next steps

An electronic version of the form is now being implemented through the Toronto Central LHIN's Resource Matching and Referral Project. The GTA Rehab Network is initiating work to use a similar process to address community support rehabilitation services.

The following members of the GTA Rehab Network Patient Access and Flow Committee led the development of the stream-lined, paper-based in-patient rehabilitation and referral process and form:

Baycrest

Bridgepoint Health

Mount Sinai Hospital

North York General Hospital

Providence Healthcare

St. John's Rehab Hospital

St. Joseph's Health Centre

St. Michael's Hospital

Sunnybrook Health Sciences Centre

Toronto East General Hospital

Toronto Grace Health Centre

Toronto Rehab

University Health Network

West Park Healthcare Centre

One of the greatest aspects of the work to date has been the relationships established. "There was a lot of frustration about the referral process," says Heather Garnett, who served as past Chair of the committee and is now a member of the LHIN's Project Co-ordination Office. "Getting everyone around the table to hear about the others' issues provided greater understanding of the patient flow and shaped the vision of the opportunities for improvement."

"The emphasis on partnerships is key," agrees Nancy Boaro. "We have to stop being so siloed –both internally and across organizations."

Creating healthier places to live

for seniors with serious mental illness

Community Psychogeriatric Framework. It's a phrase that doesn't mean much to most people. But it is a term that's vitally important to improving our local health care system.

The phrase describes a system of care (or framework) to ensure appropriate assessment and treatment standards, funding and accountability in community facilities like long-term care homes (LTCH) where care is provided for older people who have serious mental illness that results in behaviours that put themselves or others at risk.

In other words, it's a formal way a way to ensure that if an older person dear to you has a serious mental illness that affects their judgement or behaviour (e.g. depression, dementia, mood disorder), that this fact is identified early.

Equally important is that appropriate supports are accessible to prevent them from hurting themselves or others and to prevent unnecessary transfers to Emergency Departments. It's what we all want and what many have been advocating for more than 20 years. By dealing with the needs of this population sub-group, another aspect of the challenge of bringing down Emergency Department wait times is being addressed.

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Toronto Central LHIN is building on excellent work that has been undertaken by health service providers interacting with the long-term care home sector in this area and is expanding it so that more seniors can benefit.

Background

In 2005, a Long Term Care/Mental Health Steering Committee was started by the Ministry of Health and Long-Term Care to provide advice on how to bring together all the components of the local mental health system for those with serious mental illness who

- Resided in a long-term care home
- Were being assessed by Community Care Access Centres (CCACs) for admission to a long-term care home
- And/or who lived in the community and were provided services by community agencies.

The first two phases of the committee's work took place between 2005 and 2007, under co-chairs Sandra Pitters, General Manager of the City of Toronto Homes for the Aged, and Dr. Carole Cohen, Clinical Director of the Community Psychiatric Services for the Elderly at Sunnybrook Health Sciences Centre. (See box for other Work Group Chairs.)

The committee's vision was to provide appropriate, ethno-culturally sensitive and timely care to avert crises, prevent unnecessary transfers to acute care hospitals and effective and safe transfers where those were necessary. Included were the design of a LTCH-MH strategy framework and an implementation plan to support it that focused on long-term care homes. The goal was to create healthy and safe places to live and work.

Roles and responsibilities of the system partners were clarified and communicated. In 2006 Federal Mental Health Accord funding of $1.7 million helped to align all 85 long-term care homes in the Toronto region with Geriatric Mental Health Outreach Teams (G-MHOTs). Homes were provided with training and information on how staff could tap into expertise available through

- G-MHOTs

- Hospital emergency rooms, specialized assessment, treatment and behaviour management programs in places like the Centre for Addiction and Mental Health, Whitby Mental Health Centre, Baycrest's Behavioural Neurology unit and the Toronto Rehabilitation Institute
- Community Care Access Centres (CCACs)
- Psychogeriatric Resource Consultant (PRC) Program
- Psychiatrists and other specialists providing consultation services
- Physicians providing care with long-term care homes
- A centralized information hotline linked to hospitals with specialized mental health and/or behavioural management programs.

"The project brought together the resources of LTCHs, g-MHOTs and PRCs to support the person and his/her caregivers, thus improving safety and reducing unnecessary transfer to hospital," says Sandra Pitters. "We also generated awareness and willingness of the CCAC and hospital sectors to redesign the process with long-term care homes, to more effectively manage transition of care."

Benefits

In the committee's first evaluation survey, to which 65% of long-term care homes responded, more than 90% expressed the usefulness of the framework and the how-to guide. Equally important, more than 50% of patients transferred to emergency departments since the training were admitted to an in-patient or specialty unit, indicating that transfers are being made more appropriately.

"The impact on CCACs was huge in terms of reducing the need for our services," says Jennifer Scott, Senior Manager, Client Care Services, Central CCAC, who chaired the CCAC Working Group. "As a result, we are able to redirect resources elsewhere."

"Long-term care homes now know the roles of the players in the system, who is working with their home and who to call when a resident needs to be assessed," says Dr. Carole Cohen. "For 20 years some have been advocating this and we've finally achieved it. It's a real accomplishment."

Long-Term Care Home Mental Health Framework

The following health service leaders have successfully lead the first phases of a four phase project to co-ordinate mental health services for seniors in our LHIN:

Sandra Pitters, Co-Chair, Steering Committee; Chair, Implementation Committee

Dr. Carole Cohen, Co-Chair, Steering Committee, Member, Implementation Committee

Dr. Joel Sadavoy, Chair Hospital Work Group

Dr. James Edney, Chair, LTCH Physician Work Group

Mary Nestor, Chair, LTCH Work Group

Jennifer Scott, Chair, CCAC Work Group

Angelina Yau, Project Manager

Building for the future

Toronto Central LHIN's Mental Health and Addictions Council agreed that it was essential to build on this important work. The council recommended that the LHIN fund the adaptation of the existing LTCH-MH Framework to develop a Community Mental Health Framework and implementation plan so that seniors and their caregivers (including neighbours, family doctors and community centres) who live in private homes, retirement homes and supportive housing could know who should be involved with care and could benefit as well. The Toronto Central LHIN Board of Directors agreed.

With $37,500 from the Toronto Central LHIN in early 2008, the committee started by generating an inventory of community-based mental health resources for seniors. The inventory has been added to the Community Care Resources website

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Creating healthier places to live for seniors with serious mental illness continued from page 9

(www.toronto.communitycareresources.ca), launched in April, 2008. (The site can be used by both health service providers and the public.)

"Mapping the existing community resources was an important first step," says Sunnybrook's Dr. Cohen, who will be leading the next phase of the community-based project. "Services have been built in a haphazard fashion over many years. People have been very excited about the opportunity to collaborate to create a more co-ordinated system and have donated countless hours of time and energy.

"We now have a group of about 20 people working with us representing a full range of organizations and sectors, including such groups as addictions, crisis teams, ethno-cultural communities and marginalized seniors ready to start work on the next steps. These will include identifying what the mental health resources should be, what the gaps are, and what the role of each player in the community system should be. By creating a community mental health framework for seniors, we really will be benefiting everyone with mental health and addictions issues."

Tying together the accomplishments in long-term care and work that has yet to be completed in community sector will be another phase of this project expected to move forward in the later part of this fiscal year. It will focus on individuals who use Emergency Department services and on finding ways to improve both culturally sensitive capacity and access to specialty mental health and addiction programs for seniors.

Toronto Central LHIN funding for the Mental Health and Addictions sector will have an impact on co-ordinating the system and reducing Emergency Department wait times.

Agencies listed are the lead partners in coalitions of health service providers working on these projects

Coordinated access to Mental Health and Addictions housing and supports – through LOFT	Development of a model and implementation plan for an electronic centralized access system. **Benefit:** Streamlined referrals and improved access to 3800+ mental health and addiction housing units through a standardized application and assessment process.
Better information for providers and consumers. – through the Centre for Addiction and Mental Health – through Community Mental Health Program, Sunnybrook Health Sciences Centre	a) Development of an inventory of – health promotion and prevention resources, – psychogeriatric resources – integration initiatives related to mental health and addictions; b) Development of a map to illustrate the flow of mental health and addictions patients through local Emergency Departments, and to identify challenges and opportunities to make improvements. **Benefit:** Better access to information for consumers and health service providers targeted to help consumers remain in the community

Supportive Housing – 2802 Danforth. – through Neighbourhood Link Support Services	Provision of supportive housing services to 28 formerly homeless seniors including assistance with activities of daily living and services of a geriatric mental health case worker **Benefit:** Helps high risk seniors age in a safe and supported environment
Supportive Housing – on Leonard and Pear Ave. – through Family Services Toronto	Provision of supportive housing services to 20 seniors who were previously homeless or at risk of being homeless. Each senior will have a budget to allocate and design individualized services **Benefit:** Helps high risk seniors age in a safe and supported environment
First Steps to Home Supportive Housing Model at 650 Queen Street. – through Woodgreen Community Services	Unique form of supportive housing to 28 high risk, repeat shelter users who are seniors. Services include traditional supportive housing services plus an individualized approach to reduction of drug and alcohol use, housing stability and community integration skills **Benefit:** Helps high-risk seniors age in a safe and supported environment
Community Mental Health and Addictions Services Project – Psychogeriatric Framework for Seniors – through Sunnybrook Health Sciences Centre Mental Health Program	Creation of a framework and implementation plan for seniors 55+ to help providers, caregivers and seniors access the resources they need to help those with serious mental illness **Benefit:** helps consumers remain in the community through greater access to information
Seniors Mental Health and Addictions Services Project – Psychogeriatric Framework implementation in Hospital	Piloting of tools and processes to benefit seniors with severe mental illness who visit emergency departments and require specialized services **Benefit:** Increased access to relevant services, and increased consumer and service provider satisfaction
Total funding announced to date:	**$1.78 million**

New Toronto Central LHIN board member appointed

Ms Anju Virmani (Kumar) has been an adviser and consultant in information technology (IT) for more than 20 years in Canada and USA. She is currently Chief Information Officer for Cargojet Income Fund. Prior to this she was the founder and CEO of Bizness Matters Inc., based in California. She was also the founder and CEO of The SAPlementation Group, an SAP consulting company.

Virmani serves on the Advisory Council for National Security, a body that advises the Prime Minister on all issues related to National Security. She is also a member of the Cross Cultural Roundtable on Security.

Among other community involvements, Virmani serves on the board of TiE, The Indus Entrepreneurs, a global, non-profit organization that nurtures entrepreneurship through networking, mentoring and knowledge sharing. She has served on the Trade Committee of the Indo Canada Chamber of Commerce and as a member of the board of Panorama India.

Virmani holds a B.Sc and a B.Ed from the University of Delhi, India and an MBA from Baruch College, City University of New York. She has a keen interest in corporate governance and holds the designation of Charter Director, McMaster University.

Coming soon…
A fresh new look for the LHINs

Ontario's 14 Local Health Integration Networks (LHINs) s are getting a makeover. Over the coming months, we are introducing a visual identity refresh that will introduce distinctive colours for each LHIN and provide a LHIN-specific logo that incorporates the new Ontario trillium.

The new look is being introduced on a "no waste" basis, which means that we will use up supplies of our current print materials before the new look is applied.

Toronto Central LHIN has chosen "Haliburton Green" as its colour to reflect the LHIN's commitment to creating a non-partisan, healthy environment for all. The first aspect of our visual identity to change has been our web site. Stay tuned for the greening of the LHIN!

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