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News Release

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North West LHIN Investing in More Care for Seniors and Community Services

Seniors in the North West Local Health Integration Network will benefit from \$5,295,484 of investments planned in 2009/10 to ensure more seniors can continue to live independently and to allow hospital patients to receive appropriate care in the right setting.

The North West LHIN is investing \$1,924,956 in Aging at Home initiatives to help seniors receive needed health services in the comfort and dignity of their own homes and communities, instead of in a hospital. The Aging at Home program combines traditional health services – such as home care and supportive housing – with new, locally-driven, innovative approaches to caring for seniors.

The North West LHIN is also investing:

- \$1,255,200 for increased home care, personal support and homemaking services provided by the North West Community Care Access Centre
- \$1,865,328 to invest in local solutions that will address alternate level of care (ALC) pressures
- \$250,000 to create a nurse-led outreach team to provide more care to patients in long-term care homes and help them avoid transfers to a hospital emergency room.

ALC patients are individuals in hospital beds who would be better cared for in alternate setting, such as long-term care, rehab, or at home. Having more home care and community services enables ALC patients to leave hospital sooner, making more beds available to emergency room patients.

*Healthier people, a strong
health system – our future*

QUOTES

“These investments build on the successes of our Aging at Home programs for seniors and initiatives to reduce ALC in the Northwest,” says Janice Beazley, Chair of the North West LHIN Board of Directors. “Our health service providers will be able to continue the good work they are doing helping prevent seniors from emergency room visits and admissions to hospital, supporting seniors’ return home from the hospital or to another care setting, and providing services to support seniors who want to live at home”

"Our government recognizes the importance of maintaining independence and dignity for our seniors," said Bill Mauro, M.P.P for Thunder Bay-Atikokan. "This increased funding for the Aging at Home program will ensure that more seniors in our region will be able to access the services they need to enable them to stay where they are most comfortable, in their own homes."

“Our government is reducing the time people spend in hospital emergency rooms by ensuring more services are available to seniors at home and in their community,” said Michael Gravelle, M.P.P. for Thunder Bay-Superior North. “These community-based services will ensure seniors have the quality of life they deserve at home.”

QUICK FACTS

- The Ontario government is investing \$1.1 billion over four years in the Aging at Home Strategy.
- It is estimated that Ontario’s senior population will double over the next 16 years.
- The Ontario Hospital Association indicates that hospital patients who are awaiting access to appropriate care elsewhere occupy almost 19 per cent of hospital beds in the province.

LEARN MORE

To read more about the North West LHIN, visit our website at www.northwestthin.on.ca

The North West LHIN is responsible for planning, integrating and funding local health services – hospitals, long term care facilities, the community care access centre, community health centres, community support services and mental health and addictions agencies. The North West LHIN and its Board of Directors are responsible for over \$535 million of health care services delivered in Northwestern Ontario.

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Backgrounder

North West LHIN Investing in More Care for Seniors and Community Services

The North West Local Health Integration Network (LHIN) is investing \$5,295,484 in 2009/10 for a number of initiatives to help seniors live healthy, independent lives in their own homes and to decrease the number of alternate level of care (ALC) patients in hospitals.

Having more home care and community services enables an ALC patient to leave a hospital sooner, making more beds available to emergency room patients. These services also provide ongoing health supports to seniors which reduces their need to go to their local hospital emergency room.

Aging at Home Strategy

The North West LHIN will be investing \$1,924,956 in 2009/10 to increase the range and quantity of services available to seniors, and to help relieve pressure in hospitals and long-term care homes.

This year's investment is an increase of \$878,283 from 2008/09.

The Aging at Home program expands traditional services that help seniors stay healthy and live at home. These services include home care, assistive devices, assisted living/supportive housing and end-of-life care.

It also encourages innovation at a local level, by giving LHINs the flexibility to start some creative projects that are tailor-made for seniors living in communities with specific needs.

To date, the following initiatives have been approved for funding by the North West LHIN Board of Directors in 09/10. The remainder of the funding for this year will be allocated at a later date.

(see chart below)

Name of the Project	Service Provider	Project Description	2009/2010 Funding
Aging at Home Projects Continuing from 2008/09			
Principles of Physical Rehabilitation: A Training Workshop for Personal Support Workers in Remote First Nation Communities	Thunder Bay Regional Health Sciences Centre	This initiative is a new way of offering training and support services closer to the homes of First Nations elders and seniors and their care providers. The use of videoconferencing to deliver telerehab consultations in fifteen remote First Nations communities is innovative, enables service in seniors' home communities and supports improvements in quality of care. This initiative is supported through a partnership with KO Telemedicine.	\$10,000
First Link	Alzheimer Society of Thunder Bay	First Link is an early referral and intervention program that links seniors and family members/caregivers in the Thunder Bay District to coordinated learning, services and support from the point of diagnosis and throughout the continuum of the disease. This program provides access for seniors with Alzheimer's disease or a related dementia and their caregivers to comprehensive and coordinated services early in the disease process.	\$67,500
Programs for Community Living - Marathon	Wilson Memorial General Hospital	This initiative provides a functional support program for Marathon community seniors who are frail and at most risk of hospitalization. Support for daily living activities such as seasonal chores, meals, housekeeping, home repairs and grocery shopping is provided through traditional and non-traditional care partnerships. The initiative is designed to provide a flexible basket of services based on the unique needs of each senior. This initiative will be supported through a strong partnership	\$55,150

Name of the Project	Service Provider	Project Description	2009/2010 Funding
		with the local seniors' association and the local municipality.	
Seniors Maintaining Active Roles Together (SMART) Program	Victorian Order of Nurses – Thunder Bay	This initiative provides physical activity to isolated, homebound, sedentary seniors as a positive health intervention. This program brings services to seniors with the goal of improving mobility, flexibility and strength. Services will be offered throughout the North West LHIN.	\$21,904
Programs for Community Living – Terrace Bay/Schreiber	The McCausland Hospital	This initiative provides a functional support program for Terrace Bay/Schreiber community seniors who are frail and at most risk of hospitalization. Support for daily living activities like seasonal chores, meals, housekeeping, home repairs and grocery shopping is provided through both traditional and non-traditional care partnerships. The initiative is designed to provide a flexible basket of services based on the unique needs of each senior. This initiative will be supported through a strong partnership with the local seniors' organization, Townships of Terrace Bay and Schreiber and the Family Health Team.	\$55,150
North Shore MedExpress Services	Manitouwadge General Hospital	A medical transit bus is providing transportation from Manitouwadge to Thunder Bay for medical appointments three times weekly. This safe, economical service will link seniors with specialist health services in Thunder Bay. The bus is accessible and can accommodate one stretcher per trip. This initiative will link communities along the highway 17 corridor and will be managed through a centralized and	\$23,142

Name of the Project	Service Provider	Project Description	2009/2010 Funding
		coordinated approach.	
Rural Geriatric Primary Care Outreach Program	Mary Berglund Community Health Centre, Ignace	A multidisciplinary health team on board a Rural Geriatric Health Mobile Unit provides comprehensive health care services for homebound elderly in Ignace and the outlying rural areas of Dinorvic and Savant. Services include primary care, chronic disease management and prevention, health promotion and health screening.	\$19,300
Family Directed Respite Services for Seniors in the District of Thunder Bay: A Pilot Project	Wesway Inc., Thunder Bay	This innovative pilot program provides respite services for frail seniors and their caregivers living in small communities throughout the District of Thunder Bay. Respite care is essential for dedicated family caregivers who require temporary breaks. The program is designed to be flexible, accommodating the strengths and needs of each family.	\$293,100
Smooth Transitions: A Home Discharge Program	Saint Elizabeth Health Care, Thunder Bay	This program is designed to help seniors in Thunder Bay who are without adequate caregiver support and ineligible for CCAC services, to return home and settle safely after an emergency department visit or hospital stay. Smooth Transitions helps to facilitate timely discharge from Thunder Bay Regional Health Services Centre. Services include transportation from hospital to home, settlement and follow-up. Settlement services include ensuring adequate supplies and current prescriptions in the home, safety check and assessment and referral, if required, for ongoing community support services.	\$459,552

Name of the Project	Service Provider	Project Description	2009/2010 Funding
		This program has the potential to provide short-term enhanced services to assist seniors in successfully transitioning from hospital to home. The overall objectives of Smooth Transitions are to reduce the length and numbers of hospital stays, address seniors' safety needs and to provide and facilitate community supports to help seniors maintain independence.	
North West LHIN-Wide Falls Prevention Program	St. Joseph's Care Group, Thunder Bay	The North West LHIN-Wide Falls Prevention Coalition has been formed and during Year 1 the program focus is on communities with high ALC and ED pressures related to falls, with expansion throughout the region in the subsequent two years. This innovative program will include prevention, improved management and evaluation of falls in the elderly. It is anticipated that this program will reduce the incidence of falls and when falls do occur, management will be improved.	\$200,000
Total: Aging at Home initiatives approved for 09/10 funding to date			\$1,204,798

Aging at Home Initiative Success Story

In December 2008, Saint Elizabeth Health Care launched an innovative new home discharge program for seniors, called Smooth Transitions, in partnership with Thunder Bay Regional Health Sciences Centre and the North West Local Health Integration Network (LHIN).

When leaving the hospital there are a lot of things to consider, like making arrangements for transportation, picking up groceries and medications, as well as everyday things like tidying the house. These are all things that the Smooth Transitions program helps with, to make the move an easier one.

An 88-year old patient was discharged home from hospital requiring many additional supports. The patient's spouse was providing care at home and was becoming stressed and burnt out. Transportation had become an issue as the patient was the only driver. These life changes were taking a toll on their relationship as they no longer had leisure time to spend on their own. Through the Smooth Transitions Program, support was arranged for both the patient and spouse. Transportation arrangements were

made, information they required was provided and things became easier for both of them. The spouse was relieved to have this help and not have to deal with their situation alone.

Many people who have been helped by this program would have had a difficult time without it. The program has helped over 100 people over age 65 have a smooth transition from the hospital to their homes and be able to remain independent.

Urgent Priorities Fund - Addressing ALC Pressures

The North West LHIN is investing \$1,865,328 to help provide community alternatives to hospital care.

Last year, this fund helped to:

- Reduce ER visits by providing additional community supports through supportive housing or by placing more nurses in long-term care homes
- Move ALC patients to a more appropriate health care setting as quickly as possible by improving the electronic flow of information from hospitals to long-term care homes.

To date, the following initiatives have been approved by the North West LHIN Board for funding in 09/10. The remainder of the funding for this year will be allocated at a later date.

Name of Project	Service Provider	Project Description	2009/2010 Funding
Urgent Priority Funding Projects continuing from 2008/09			
Bridging the Gaps in Care for People with Complex Mental Illness, Addictions and Social Illnesses	St. Joseph's Care Group in partnership with Canadian Mental Health Association and Alpha Court	This initiative will serve a population of vulnerable people (adults over 15 years of age) with very serious, unstable and complex mental illness and addiction needs. This group tends to have a very high no show rate for services and are known to be frequent users of the health care system i.e. emergency department, inpatient care, withdrawal management programs and walk-in clinics. This initiative establishes a joint, fully integrated program that will provide outreach and engagement with the target group in non-traditional settings.	\$417,266
Supportive Housing	HAGI Community Services for Independence	The proposed initiative will offer supportive housing services for long stay younger patients who are designated as ALC and are	\$130,351

		waiting in hospital in Thunder Bay. Will reduce ALC days by 730 in 2009/10.	
Intensive Case Management	North West CCAC	This program will utilize various strategies including more frequent assessments by the case management and will connect high risk seniors and their caregivers to supports and services in the community to help them remain safely at home. 90 clients will be closely monitored by 2 Case Managers, in Thunder Bay. The goal is to prevent unnecessary visits to the ED and prevent hospitalization where possible.	\$94,500
Seniors Outreach Service; System Navigation in Thunder Bay District Housing Senior's Apartment Buildings	North West CCAC	This initiative will involve a "System Navigator" working with the 1241 senior apartments in Thunder Bay and will target the largest "senior designated" apartment buildings within the housing portfolio. The System Navigator will identify and guide "at risk seniors" who live in these apartments to the most appropriate health and social service agency, or another community service and will play an active role in management of Chronic Disease. The goal is to reduce unnecessary visits to the ED; prevent hospitalization and prevent premature admission to long-term care.	\$94,500
Transitional Care in a Retirement Home Setting	Thunder Bay Regional Health Sciences Centre	This initiative will establish transitional care (10 – 20 units) in a retirement home setting in Thunder Bay for ALC patients who are waiting in hospital. Patients who require some additional strengthening and rehab prior to discharge to home will be cared for in this setting. The goal is to improve access to acute care beds and reduce the pressure experienced by admitted patients waiting in the	\$349,988

		Emergency Department at Thunder Bay Regional Health Sciences Centre.	
Supportive Housing – Benidickson Court	Community Support Services – District of Kenora Home for the Aged	This initiative will provide a Supportive Housing Program for 20 frail elderly clients who currently reside at Benidickson Court. The goal is to reduce unnecessary ED visits and prevent admission to hospital where able by increasing the support services available to clients in the community.	\$225,000
NW LHIN-Wide Wound Management Initiative	North West CCAC	This program will support efforts currently underway in the NW LHIN to improve: patient satisfaction, wound management across sectors; reduce overall costs to the system (reduced length of stay and reduced visits to the ED) and ultimately reduce time to healing. Using evidence-based approaches, the program will be implemented with health care providers throughout the NW LHIN. This initiative will standardize practice and product use and provide more effective ongoing management in the treatment of wounds.	\$200,000
5 Interim Long-term care beds	Thunder Bay Interim Long Term Care Centre operated by Revera	Addition of 5 interim long-term care beds to the existing interim long-term care complement in Thunder Bay.	\$38,940
TOTAL – Urgent Priority Fund initiatives approved for 09/10 funding to date			\$1,550,545

Increasing Home Care Services – CCAC Service Maximums

The North West LHIN is receiving \$1,255,200 in 2009/10 for changes made last year to increase the availability and integration of home care services. This included increasing the limits on hours of person support/homemaking services by 50 per cent, and removing limits entirely for patients waiting for a long-term care bed or receiving end-of-life services at home.

Nurse-Led Outreach Team

The North West LHIN is receiving \$250,000 for a nurse-led outreach team that is being created to provide long-term care home residents with timely and appropriate care, and stabilize residents who need more urgent attention. This team of nurse practitioners and registered nurses will travel to LTC homes to assess urgent problems, determine the need for hospital care, and provide interventions (such as intravenous therapy, antibiotic management and administering oxygen) in cases where unnecessary visits to the hospital and the ER can be avoided.