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News Release

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North West LHIN Expands Aging at Home Programs

Helping More Seniors Get Health Care at Home

The North West LHIN is expanding its successful Aging at Home Strategy. Ontario has provided the North West Local Health Integration Network with \$3-million to ensure more seniors get health care at home or in the community.

As part of the successful Aging at Home strategy, the North West LHIN is using the funding for local programs that provide health services to seniors in the comfort and dignity of their own home. This permits our seniors to lead healthy and independent lives while avoiding unnecessary visits to hospitals, which can ultimately reduce emergency room (ER) wait times.

The Aging at Home program allows LHINs to provide health care services that are tailor-made to meet local seniors' needs. This year, the North West LHIN Aging at Home program is expanding to include new community-based services such as:

- Respite services for seniors and their caregivers in the Kenora and Rainy River Districts
- Transitional supportive housing in Thunder Bay
- Support for activities of daily living for seniors in Red Lake

Investing in better local community supports will help improve Ontario's Alternate Level of Care (ALC) rate. ALC patients are individuals in hospital beds who would be better cared for in an alternate setting, such as long-term care, rehabilitation centres, or home. By giving seniors the support they need to avoid hospitalization in the first place and helping those who do get admitted to return home faster, access to health care will be improved for residents of Northwestern Ontario.

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

QUOTES

"With this funding, we are reducing the time people spend in hospital emergency rooms by ensuring more services are available to support seniors at home and in their community. As our population ages, the North West LHIN is providing innovative solutions that are responsive to their needs and allow seniors to live in their own homes."

- Janice Beazley, Chair, Board of Directors, North West LHIN

"I am pleased that our government continues to make health care our number one priority. Home care services are part of the continuum of care and represent a very wise investment in the health of our senior population."

- Bill Mauro, MPP Thunder Bay - Atikokan

"I'm proud our government is providing the tools and support for seniors to receive health care and services while remaining in their own homes. This personalized home care and community support prevents the unnecessary loss of independence for seniors and relieves pressure on hospitals and long-term care facilities."

- Michael Gravelle, MPP Thunder Bay - Superior North

QUICK FACTS

- Assisting seniors to live independently at home helps to shorten wait times at hospitals and improve patient flow in emergency rooms.
- Ontario is investing \$382.4 million for Aging at Home programs this year.
- Ontario's senior population will double within 20 years.

LEARN MORE

Read more about [Ontario's Aging at Home Strategy](#).

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 \$560 million of health care services delivered in Northwestern Ontario.

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*Healthier people, a strong
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Backgrounder

North West LHIN Expands Aging at Home Programs

Ontario is investing \$1.1 billion over four years in the Aging at Home Strategy in sectors such as community support services; hospitals; Community Care Access Centre; long-term care homes and other sectors. Aging at Home (AAH), as initially announced in 2007, is a program that provides a continuum of community-based services for seniors and their caregivers to allow them to stay healthy and live independently and with dignity in their homes.

The strategy also aims to decrease the number of alternate level of care (ALC) patients in Ontario hospitals. ALC patients are individuals who are occupying acute care beds in hospitals, but would be better cared for in another setting — whether it be their own homes or long-term care homes.

This year, the North West LHIN has received \$3-million to fund local programs that provide health services to seniors in the comfort and dignity of their own home, allowing them to lead healthy and independent lives while avoiding unnecessary visits to hospitals. These include:

Name of the Project	Service Provider	Project Description	2010/2011 Funding
Aging at Home Projects Continuing from 2008/09			
First Link	Alzheimer Society of Thunder Bay	<p>First Link is an early referral and intervention program that links seniors and their family members and 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.</p> <p>Results: First Link provided coordinated access to information, education and support to over 75 clients in the first year of the program.</p>	\$125,000

Name of the Project	Service Provider	Project Description	2010/2011 Funding
Programs for Community Living - Marathon	Wilson Memorial General Hospital	<p>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 is supported through a strong partnership with the local seniors' association and the local municipality.</p> <p>Results: In its first year, Programs for Community Living provided services to over 200 clients in Marathon.</p>	\$47,650
Programs for Community Living – Terrace Bay/Schreiber	The McCausland Hospital	<p>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 is supported through a strong partnership with the local seniors' organization, Townships of Terrace Bay and Schreiber and the Family Health Team.</p> <p>Results: In its first year, Programs for Community Living provided services to over 250 clients in Terrace Bay.</p>	\$47,650

Name of the Project	Service Provider	Project Description	2010/2011 Funding
Rural Geriatric Primary Care Outreach Program	Mary Berglund Community Health Centre, Ignace	<p>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.</p> <p>Results: Over 300 in-home visits were made to over 37 individuals in the first year of the program, providing vaccinations, wellness exams, education on proper use of medications, and chronic disease management.</p>	\$19,300
Family Directed Respite Services for Seniors in the District of Thunder Bay: A Pilot Project	Wesway Inc., Thunder Bay	<p>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.</p> <p>Results: The program has provided 11,800 hours of respite services to 62 families in 15 communities in the north shore and Greenstone areas. Respite services didn't previously exist in these areas.</p>	\$300,000
Smooth Transitions: A Home Discharge Program	Saint Elizabeth Health Care, Thunder Bay	<p>This program is designed to help seniors in Thunder Bay, who are without adequate caregiver support and ineligible for Community Care Access Centre services, to return home and settle safely after an emergency department visit or hospital stay. Smooth Transitions</p>	\$256,116

Name of the Project	Service Provider	Project Description	2010/2011 Funding
		<p>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. 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.</p> <p>Results: The program assisted with 614 safe discharges from hospital in 2009/10.</p>	
North West LHIN-Wide Falls Prevention Program	St. Joseph's Care Group, Thunder Bay	<p>The aim of this innovative program is to reduce the number of falls amongst seniors, resulting in harm. It includes prevention, improved management and evaluation of falls in the elderly. It is anticipated this program will reduce the incidence of falls and when falls do occur, management will be improved.</p> <p>Results: The Program provided education to over 120 health care providers from across the LHIN.</p>	\$200,000
Aging at Home Projects Continuing from 2009/10			
Programs for Community Living – Dryden and area	Patricia Region Senior Services Inc.	This initiative provides service coordination, homemaking and maintenance services for seniors in the Dryden area. A flexible basket of services is provided based on the unique needs of each senior, through collaborative community efforts and resource sharing.	\$65,000

Name of the Project	Service Provider	Project Description	2010/2011 Funding
Supportive Housing	Board of Management for the District of Kenora Home for the Aged	Enhanced services are being provided for six supportive housing units in Sioux Lookout.	\$74,835
Expansion of First Link	Alzheimer Society of Kenora and Rainy River Districts	The First Link program (see above) was expanded to the Kenora and Rainy River Districts.	\$82,700
Enhanced Interim Long-Term Care Capacity in Thunder Bay	Revera Inc. (Thunder Bay Interim Long-Term Care Centre)	<p>Addition of 5 interim long-term care beds to the existing interim long-term care complement in Thunder Bay.</p> <p>Results: The 5 beds diverted 1825 annualized ALC days.</p>	\$345,000
Aging at Home Projects Approved for 2010/11			
Expansion of Wesway Respite Services to the Districts of Kenora and Rainy River	Wesway Inc. Thunder Bay	Wesway is expanding its pilot project, providing respite to caregivers of frail seniors in the Districts of Kenora and Rainy River.	\$152,891
Community Living	Board of Management for the District of Kenora Home for the Aged	This initiative will provide service coordination as well as other Independent Activities of daily Living for Red Lake community seniors who are frail and at risk of hospitalization. A flexible basket of services will be provided based on the unique needs of each senior.	\$55,000
Enhanced Supportive Housing in the City of Thunder Bay	St. Joseph's Care Group	This investment will provide 75 transitional supportive housing units in Thunder Bay which will be in place until the 132 new units in the Centre of Excellence for Integrated Seniors' Services are operational in 2012.	\$850,380
Intensive Case Management	North West Community Care Access Centre (CCAC)	This program utilizes various strategies including more frequent assessments by the case	\$96,300

Name of the Project	Service Provider	Project Description	2010/2011 Funding
		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.	
Seniors Outreach Service; System Navigation in Thunder Bay District Housing Senior's Apartment Buildings	North West CCAC	This initiative involves a "System Navigator" working with the 1241 senior apartments in Thunder Bay and targets the largest "senior designated" apartment buildings within the housing portfolio. The System Navigator identifies and guides "at risk seniors" who live in these apartments to the most appropriate health and social service agency, or another community service and plays 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.	\$96,300
<ul style="list-style-type: none"> ▪ Total: Aging at Home initiatives approved for 2010/11 funding to date 			\$2,814,122
<ul style="list-style-type: none"> ▪ Total: Aging at Home initiatives yet to be approved for 2010/11 funding 			\$216,943
Total: Aging at Home initiatives funding for 2010/11			\$3,031,065

What is an Alternate Level of Care (ALC) patient and how do ALC patients impact ER wait times?

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

How does the Aging at Home strategy help reduce ER wait times?

The ER wait times strategy committed to reducing the time that patients wait from the moment they arrive at the ER to when they leave.