Central East **LHIN**

Keeping Ontarians Healthier at Home in Central East LHIN

McGuinty Government Providing More Access to Community Services

November 14, 2012

NEWS

Local residents in the Central East Local Health Integration Network (LHIN) now have more options for care and to live independently in their homes.

This year, the Ontario government is increasing support for community services in the Central East LHIN and increasing access to treatment for people addicted to opioids by:

- Increasing the number of clients, from across the LHIN, who receive services from the Central East Community Care Access Centre;
- Providing more assistive living services to Chinese and South Asian seniors in the Scarborough cluster;
- Supporting an innovative partnership between Lakeridge Health's Pinewood Centre which specializes in addiction services, Rouge Valley Health System, The Scarborough Hospital and community agencies in the Scarborough Addiction Services Partnership;
- Providing new assisted living services to seniors living in Ajax;
- Initiating a new Adult Day Program for seniors living in Whitby;
- Improving access to primary care in Durham Region by supporting more seniors to get to their appointments and safely home;
- Providing more Adult Day Program services for seniors living in Lakefield, Haliburton, Lindsay and Havelock;
- Streamlining and providing more access to Acquired Brain Injury services in Peterborough and Scarborough;
- Increasing the number of hours that primary care Nurse Practitioner services are available to care for clients at the Port Hope Community Health Centre; and,
- Supporting an innovative community-based multidisciplinary primary care team at the Port Hope Community Health Centre to meet the needs of those at risk for rapid readmission to hospital

These investments will help local residents return home sooner following a hospital stay as hospitals, community based agencies and other partners work together to meet the healthcare needs of local

residents. It also will help free up hospital and long-term care beds, shorten emergency room wait times and reduce the number of readmitted patients.

Across the province, 90,000 more seniors will receive care at home thanks to an additional three million personal support worker hours over the next three years.

Increased support for home care and community services helps provide the right care, at the right time, in the right place and is part of Ontario's Action Plan for Health Care.

QUOTES

"We know that residents in the Central East LHIN want to be able to receive care in their community and in their homes. That's why the Central East LHIN is working with health service providers on developing a three year *Community First* Integrated Health Service Plan. With this investment we'll be able to provide the type of care our patients, particularly seniors, want and need."
— Deborah Hammons, Central East LHIN CEO

"The Central East LHIN has approved $9 million to the Central East Community Care Access Centre (CCAC) for 2012/2013 base funding to support seniors and other individuals to receive services closer to home, reduce emergency department visits, reduce avoidable hospital re-admissions and improve system flow. The funding will enable the CCAC to provide up to 250,000 personal support hours, nursing and therapy visits, meeting the needs of approximately 1,200 complex care clients, allowing them to remain in their homes and the community."
- Donald M. Ford, CEO, Central East CCAC

"We've made the right choice to invest our precious health care dollars where they are most needed. This will allow more Ontarians to live independently at home, and reduce pressure on hospitals and long-term care homes."
— Deb Matthews, Minister of Health and Long-Term Care

QUICK FACTS

- Assisting seniors to live independently at home helps improve hospital patient flow and shorten wait times in emergency rooms as over the next 20 years, the number of seniors living in Ontario will double.

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- With these new investments, the Central East LHIN is building on an expanding system of services for seniors that includes the Geriatric Assessment and Intervention Network (GAIN) clinics, Home at Last, Home First and NPSTAT.
- Following the removal of OxyContin from the Canadian market in March 2012, the Expert Working Group on Narcotic Addiction was formed by the Minister of Health and Long-term Care to advise on how to lessen the effects of opioid addiction and strengthen the existing addictions treatment system in Ontario.
- These investments are part of the 2012 Ontario Budget commitment to increase funding for community and home care services and keep Ontarians healthy.

LEARN MORE
Learn about alternatives to a hospital ER.

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Central East **LHIN**

More Support for Central East LHIN

Ontario is helping the Central East Local Integration Health Network (LHIN) and LHINs across the province provide more seniors and other community residents with care at home, reduce unnecessary emergency room visits and readmissions, decrease the number of patients waiting for alternate levels of care, and increase local addiction services.

This investment is helping deliver on Ontario's Action Plan for Health Care by providing care the right care at the right time and in the right place.

The Central East LHIN is receiving an increase of $12.8 million to fund local programs this year. These include:

Service Provider	Project Description	2012/2013 Funding
Central East Community Care Access Centre	Continue to reduce Emergency Department wait times and Alternate Level of Care days by meeting the needs of approximately 1,200 complex care clients across the Central East LHIN who receive services through an additional 250,000 personal support hours, nursing and therapy visits	$9,000,000
Lakeridge Health Pinewood Centre	"Advancing Addiction and Concurrent Disorders Treatment Capacity in Scarborough" is an innovative partnership that includes Pinewood, the Rouge Valley Health System, The Scarborough Hospital and the Scarborough Addiction Services Partnership to improve the process and enhance resources to advance the addiction system within Scarborough and to reduce avoidable Emergency Room visits.	$560,000

Central East **LHIN**

Service Provider	Project Description	2012/2013 Funding
Yee Hong Centre for Geriatric Care	Supporting 35 more high risk Chinese seniors in the Villa Elegance neighbourhood in Scarborough with Assisted Living Services	$419,572
Carefirst Seniors Community Services Association	Supporting 45 more high risk seniors in the Steeles, L'Amoreaux and Agincourt areas in Scarborough with Assisted Living Services with a specific focus on Asian individuals	$384,303
Community Care Durham	To provide 40 seniors a year, living at 655 Harwood Avenue, with assisted living services including support from personal support workers so that they can live safely in their own homes. This new investment builds on successful programs currently being delivered by Community Care Durham in Oshawa and Whitby	$450,000
Community Care Durham	To open a new Adult Day Program at 20 Sunray Street in Whitby to support seniors and their caregivers. Approximately 13 clients a day will have access to programming, meals and services that will provide a social and recreational outlet for clients and respite services to family caregivers.	$180,000
Community Care Durham	To enhance the current Home at Last (HAL) service by supporting seniors with Personal Support Workers (PSWs) who will accompany them to critical primary care appointments	$80,000

Central East **LHIN**

Service Provider	Project Description	2012/2013 Funding
Victorian Order of Nurses – Peterborough Branch	Increasing the number of days that Adult Day Programming is offered in four VON locations – Lakefield, Haliburton, Lindsay and Havelock. Approximately 10 more clients a day will have access to programming, meals and services that will provide a social and recreational outlet for clients and respite services to family caregivers	$115,088
Four Counties Brain Injury Association	Working in partnership with Community Head Injury Resource Services (CHIRS) in Scarborough, FCBIA and CHIRS will streamline access and provide more services for individuals living with acquired brain injury in the Scarborough and Peterborough communities	$60,000
Port Hope Community Health Centre	Increasing hours of operation through additional primary care Nurse Practitioner services (early morning, evening, and Saturday hours) so that 650 clients have access to care. Supporting an innovative multidisciplinary team to meet the needs of those at risk for rapid readmission to hospital (e.g. seniors with complex health problems and individuals with mental health and addictions concerns). This multidisciplinary team, made up of a nurse practitioner, social worker, and case manager, will respond within 24-48 hours after discharge to stabilize and address specific physical, emotional, mental health and addiction issues and will serve between 75-100 high risk clients each month	$532,877
TOTAL allocated in the LHIN's three Clusters		**$11,682,114**
Amount still to be allocated pending project approvals		**$1,084,500**

Central East **LHIN**

BACKGROUNDERS

Pinewood Centre
Withdrawal Management Program – Scarborough

Pinewood Centre's Withdrawal Management Program will expand its renowned services to the Scarborough community with funding from the Central East Local Health Integration Network (CE LHIN). The program will be open to the public in late November 2012 and will help 150 people get the treatment they need, closer to home.

The outpatient program treats those struggling with drug and alcohol addiction. Referrals are accepted from any source, including self-referral from a person seeking treatment. Clients represent a cross-section of the population, men and women of various ages and socioeconomic backgrounds, and are in treatment for a wide range of substance addictions, including opiate dependence.

The CE LHIN has determined Scarborough is currently under-serviced for addiction treatment services. Pinewood Centre was chosen after gaining a reputation as leaders in withdrawal management, addiction treatment and concurrent disorders across Ontario, and will leverage existing relationships with community partners in East Toronto to provide treatment for those struggling with addiction in this under-serviced area.

The Withdrawal Management Program will initially operate from an outpatient site of The Scarborough Hospital. Pinewood staff will also work with health care professionals at The Scarborough Hospital and Rouge Valley Centenary to better respond to the needs to clients with addictions. A focus of their efforts will be on reducing the number of repeat visitors to the Emergency Department who come seeking treatment for addictions issues.

In addition to providing withdrawal management, Pinewood's inter-professional team works with clients to connect them to the services they need, ranging from inpatient addictions treatment to various social services.

Quotes from Paul McGary, Director, Mental Health & Pinewood Program:

"This is a win-win investment for the Scarborough community because it helps people access the services they need in their own community and it helps relieve pressure in Emergency Rooms. We're thankful for this investment because expanding these services into the community will help us reach more people right where they live."

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Yee Hong Centre for Geriatric Care

Yee Hong Centre is a non-profit organization serving seniors in the Greater Toronto Area. As the service arm of the Yee Hong community, it carries the responsibilities of planning and delivering high quality and culturally appropriate services to enable seniors to live their lives to the fullest - in the healthiest, most independent and dignified ways.

Yee Hong Assisted Living Program

The Yee Hong Assisted Living (Program), newly funded through the Central East Local Health Integration Network, provides 24/7 ethno-cultural specific support services to frail Chinese seniors with complex care needs. It enables them to live in their own homes for as long as possible. The Program focuses on diverting seniors at high risk for episodic health failure and injury from avoidable visits to hospital emergency departments (ED) and reducing premature admissions into long-term care homes by supporting such seniors in their own homes.

The Program will provide the full range of services mandated in the Assisted Living Services for High Risk Seniors Policy 2011 (ALS-HRS) on both scheduled and unscheduled bases. These include personal support, homemaking, care-coordination and security checks/reassurance services.

Accepting referrals from hospital for elderly patients in ED, acute care and alternate level of care (ALC) beds who require 24/7 supportive care the Program expedites their return home. Doing so relieves utilization pressure on hospitals and long-term care homes. It will contribute to the effort to alleviate ED and ALC bed backlogs with a lower cost service. By returning otherwise at risk seniors to independent living with assistance in the community, it enhances their health, wellness and quality of life.

With its culturally sensitive care coordination model the Program also helps frail Chinese seniors in Scarborough navigate through the complex health services system. It ensures equitable access to health services for those to whom differences in cultural health practice and linguistic barrier impede their ability to access necessary supports in a timely manner.

Central East **LHIN**

For Mrs. Chan, a 78-year-old widow who lives alone, falls, fainting and ER visits were frequent. Her rheumatoid arthritis and deformed and dysfunctional fingers impede much of her activities in daily living. With a mild cognitive impairment, it was also common for her to miss meals and medication.

Her daughter tried her best to visit and assist. Yet, the heavy care need and her lack of knowledge about her mother's maladies and how to provide care made the task more daunting everyday. When the daughter's own health started to suffer from the stress and strain she made the wise move of looking to assisted living services for help.

Having had her needs assessed services the Yee Hong Centre Assisting Living Program started providing Mrs. Chan with scheduled services including daily assistance with getting up from bed, toileting and personal hygiene, medication reminder, meal preparation and feeding. She is also entitled to unscheduled help just a phone call away whenever necessary.

Having enjoyed these assistive services for a year, Mrs. Chan's health has improved greatly. Her ER visits are greatly reduced. Her weight and health are more stable due to regular meal and medication intake. With improved physical health, her mental health also improved. She is now more energetic and willing to join the social activities in her apartment building.

Her daughter has also benefitted immensely from the program. Her health improved from the relief from care giving stress. The time she spends with her mom is now of a much higher quality. She is highly appreciative of the program and recommends it to other struggling caregivers in the community.

"For high-risk seniors in the community, culturally appropriate care is essential for those like Mrs. Chan who struggles with cognitive impairment and does not speak either official language. Organizations like Yee Hong have a mandate to serve this vulnerable population. Government support is critical for sustaining such services. Families depend on us to provide the care. We depend on LHIN support for our services. The 4% community funding provided by the government and the Central East LHIN is a wise investment that effectively helps reduce ER wait times and improve the quality of life for those aging at home."

Kaiyan Fu, CEO
Yee Hong Centre for Geriatric Care

Central East **LHIN**

Carefirst Seniors and Community Services Association

Cluster Community Assisted Living to High Risk Asian Seniors Program

The need for assisted living services for high risk Asian seniors in the Scarborough region is evident with the rapid rise in the aging population and great influx of immigrants whom have difficulties in accessing services due to their cultural and language differences. As an innovative and proactive response to the community needs, Carefirst Seniors & Community Support Services, with the funding support from CE LHIN, will be establishing a community hub for the operation of the **Cluster Community Assisted Living to High Risk Asian Seniors Program**.

The program, in collaboration with local hospitals and primary care and community services organizations, will provide **"wrap around care"** to high risk Asian seniors of the Scarborough region particularly in the Steeles, L'Amoreaux and Agincourt areas. The provision of "wrap around care" will include the following basket of services:

- intensive case management
- care coordination and service navigation
- assisted living core services
- adult day program
- in-home caregiver respite services
- comprehensive primary health care
- community support services
- chronic disease self-management program
- other professional services

The program will be provided under the framework, adapted from the USA On-Lok – Program of All Inclusive Care for the Elderly (PACE) Model of Care, of an Integrated Care Delivery Model which will be delivered from a multi and inter-disciplinary team-based approach.

The provision of the **Cluster Community Assisted Living to High Risk Asian Seniors Program** will fulfill the social, health care, and supportive needs of high risk Asian seniors in the Scarborough region, **in a culturally and linguistically appropriate way**. It is expected that the health statuses of high risk seniors will improve with the delivery of coordinated and seamless care services. Their experience of living at home will be enhanced as they will have easier access to health and supportive services, and family relationships will strengthen as caregivers will be fully supported with their caregiving duties.

Furthermore, with the provision of this program, the Scarborough community can expect:

- reduce / avoidable ER visits
- reduce/avoidable long-term care home admissions
- increase in the length of time high risk seniors can remain living safely at home

Central East **LHIN**

All in all, Carefirst's **Cluster Community Assisted Living to High Risk Asian Seniors Program** is a **win, win, win program** for high risk seniors, their caregivers, and the community at large.

Families inquiring about Carefirst's services often share the same stories of hardships. Sons and daughters, working full-time to provide for their families are exhausted with the stressful caregiving duties of their frail, aging parents. Not only are resources and services fragmented and inadequate, they are also not culturally and linguistically appropriate, making it ever more so difficult for families to access the support they need. Clients utilizing Carefirst's services often share that the burden of care is alleviated allowing them to have time to maintain their household, grocery shop, and rest. A variety of services and programs are readily available for high risk seniors to take part in, in order to maintain their health and enhance their independence. To the families, Carefirst Seniors & Community Services Association is much like a one-stop access centre where all of their needs will be met.

"There's no place like home", says Helen Leung, CEO of Carefirst Seniors & Community Services Association. "We all want to live comfortably in our own homes, especially when dealing with illness, injury, recent disability or chronic health conditions. With the Community Assisted Living Program, seniors will be able to enjoy independent, enriched and quality living in the community, and at the same time family members will also get relief from the stress of caregiving."

Carefirst Seniors & Community Services Association is a charitable, non-profit social services organization with 36 years of history in providing quality community support services for the Chinese community in the Greater Toronto Area. Carefirst's mission is to ensure their clients enjoy independent, enriched and quality living in the community, through their social, health care and supportive services, planned and delivered on a holistic basis.

Central East **LHIN**

Community Care Durham

"These new Community Care Durham investments by the Central East LHIN will have a direct and meaningful impact on the wellness of clients living at home in their local communities. The resulting increased independence and capacity to self-manage their health care needs at home, will help provide health care consumers and their families with the choices they require, with a more cost effective and sustainable impact on the health care system."

- **Brent W. Farr, Executive Director, Community Care Durham**

Assisted Living Services for High Risk Seniors

Community Care Durham (CCD) in partnership with the Central East Community Care Access Centre (CECCAC) and the Regional Municipality of Durham received funding approval from the Central East LHIN to expand our current assisted living services to serve 40 new ongoing clients living in Ajax. The target date for service implementation is early January 2013.

Community Care Durham (CCD) has been operating a successful Assisted Living Services for High Risk Seniors program since December 2011 in Oshawa and Whitby. We currently serve over 75 high risk clients within the two designated locations; supporting seniors to live and age at home with dignity.

The CECCAC and CCD have worked collaboratively to develop and implement a model of service that provides personal care, homemaking, security/reassurance checks and care coordination to high risk seniors, on a scheduled and unscheduled 24 hour/7 day a week basis; keeping clients safe at home**,** improving the client's overall health status, reducing social isolation, reducing unnecessary and/or avoidable long term care admissions and emergency department visits, and enabling communities to address more fully the needs of high risk seniors. Individual care plans are developed for each client through the assessment and intake process which includes consulting with the client, family/substitute decision maker and other supporting community agencies. Services are delivered by qualified, registered Personal Support Workers.

Client Profile

This 92 year old woman has been living alone in the same apartment unit for the past 17 years with some family support. She suffers from coronary artery disease and arthritis. She was managing well for a long period of time receiving three hours per week of personal care and homemaking. Over time her health was declining and she was placed on a waiting list for long term care. When she suffered a fall she was identified as a high risk senior and referred by CECCAC to the Assisted Living Services for High Risk Seniors program.

Today she is thriving. Through assisted living she receives daily scheduled personal support worker visits for personal care, light homemaking, reassurance, meal preparation and 4 “pop in” visits a day for a medication reminder. She also is able to call 24 hours 7 days a week for assistance to deal with any immediate needs. Recently she was ill and the personal support workers increased the number of visits throughout the day, stopping by for a few minutes just to see how she was doing.

For this client, the regular contact with consistent staff and having her needs met daily, has improved her health and her quality of life to the point where a recent offer of a Long Term Care bed was declined. Assisted living services have also provided peace of mind for her family knowing that she is receiving regular daily supports to remain safely at home with dignity.

Adult Day Program Whitby

Community Care Durham (CCD) received funding approval from the Central East LHIN to expand our current integrated Adult Day Program services to the frail elderly and adults with dementia and/or physical limitations, by establishing a new service in Whitby. The new Whitby location will serve 40 active clients ongoing and has a target date of early February 2013 for service implementation.

CCD currently operates three locations: Ajax/Pickering, Uxbridge and Clarington. By providing social and recreational programming, we are in turn supporting the family caregiver by providing respite. Programs are offered in safe, secure, comfortable home-like settings and assist in maintaining the participants’ maximum level of independence and help them remain connected to their communities. The focus is client centered, offering appropriate programming and activities that foster the health and well-being of the participants.

This level of community support has proven to prevent premature or inappropriate institutionalization and provide valuable, affordable respite to family caregivers who are at risk of illness and caregiver burnout. Last year CCD provided over 10,000 days of service to over 200 clients at all 3 sites combined.

Access to Primary Care Service

Community Care Durham (CCD) received funding approval from the Central East LHIN to enable senior’s access to primary care services, specifically Geriatric Assessment and Intervention Network (GAIN) visits and follow up primary care physician appointments as recommended by the Psychogeriatric Community Support Program (PCSP) or GAIN. This new service will utilize the proven and successful service delivery structure of the existing Home at Last (HAL) program.

Central East **LHIN**

This service delivery model will utilize Access to Primary Care Personal Support Workers (PSW's) to accompany senior clients to critical primary care appointments, provide support, and return the client home safely following their appointment.

Community Care Durham's objective in providing an Access to Primary Care Service is to play a pivotal role in improving the health outcomes of aged clients, and prevent future avoidable visits to the hospital Emergency Department. By providing PSW accompaniment and support for clients attending their comprehensive primary care appointments, we are assuring clients have timely access to primary care support in a delivery method that is cost-effective and client focused.

This initiative identifies a strong linkage between primary care and community support services. Community Care Durham is committed to fostering this linkage to ensure the improved health outcomes of at-risk clients.

Central East **LHIN**

Victorian Order of Nurses – Peterborough Branch

Adult Day Services will contribute greatly to the Central East LHIN's *Community First* Strategy which will see seniors able to spend more time in their homes and communities. VON Adult Day Services, across the Central East LHIN and across the province, support seniors living with dementia and other diseases of aging to remain as active and independent as possible. For caregivers, programs such as Adult Day and In Home respite can make the difference by providing needed respite and caregiver counseling while their loved one is engaged in meaningful activities in a warm and caring environment.

"The Community Support Sector provides services that are key to ensuring aging seniors are able to stay at home as long as possible. VON is pleased to work in partnership with our local communities to meet the growing need for supports such as Adult Day Services and caregiver support. The communities of Lakefield, Lindsay, Haliburton and Havelock will benefit greatly from this expanded service as VON provides therapeutic programming and personal care to more frail seniors in the Adult Day Programs and support to their caregivers as needed. Adult Day Services are a wonderful example of community coming together to support a needed services and we would like to thank our community partners who provide space, supply meals make referrals and the wonderful volunteers who work with staff to make at a day at the program an enriching experience."

- **Lori Cooper, VON District Executive Director, Community Support Services**

The following testimonials are offered to illustrate more than the impact of the VON services described. The investments that the Central East LHIN is making in the community will have significant impact on our neighbours and we believe they are best able to articulate the meaningful impact of community support.

Gladys was a tiny woman, 88 years of age, who lived with her elderly husband of 62 years. They led a relatively private life as part of a rural community where they were active members of their local church. A few years ago, Gladys was diagnosed with dementia and they had to give up their home in the country to move to an apartment. They always assumed very traditional roles in their marriage but with Gladys' declining abilities, Albert had to take over many of the household duties, such as laundry and meal preparation. Combined with the loss of their home and church involvement, this was a very stressful adjustment. Gladys was neglecting to bathe or change her clothes and although he tried to assist, Albert was not comfortable providing this type of care. The couple had one son who lived three hours away with his wife and young son. While the son and daughter-in-law were supportive, they did not visit regularly and had an almost formal relationship with Gladys and Albert, referring to them as "Mr. and Mrs". They would not consider assisting with Gladys' personal care and in fact felt that Albert should not be doing so either.

Central East **LHIN**

Gladys was eventually referred to VON Respite Services by the CCAC case manager who had trouble getting Albert to agree to accept any help in their home. He felt it was an invasion of privacy and was not comfortable having an “outsider” assist Gladys with her personal care. The case manager presented the CARE In-Home Respite service as ‘respite only” with no personal care and Gladys and Albert reluctantly agreed to an intake visit from VON.

When the VON Supervisor arrived, Albert declared that he did not wish to initiate the service but through conversation stated that he used to spend a great deal of time volunteering with his church. The VON Supervisor used this as a way to offer help and Albert finally agreed that a regular respite visit would allow him to resume this important activity. Sharon, a VON Respite Worker, started to make a “social” visit to Gladys on a weekly basis, with the goal of eventually assisting with meal preparation and laundry. Over time, Sharon developed a supportive relationship with both Albert and Gladys and they came to appreciate and trust her assistance. Eventually, Sharon was able to assist Gladys with some personal care and on occasion even wash her hair.

VON Respite Services had such a positive impact for this family that Albert began to see the benefit of having more support. The VON Supervisor was able to communicate this information to the CCAC case manager and personal support services were initiated successfully. Ongoing communication between Albert and the VON Respite Supervisor revealed that he was becoming increasingly stressed as Gladys’ care at home became more challenging. The VON Respite Supervisor suggested the addition of the Adult Day Program as another opportunity for caregiver respite. Encouraged and supported by the VON Respite Worker, Albert finally agreed to bring Gladys for a visit if accompanied for the first time by her VON Respite Worker. This provided the supportive transition that both Gladys and Albert needed and over time Gladys adapted to the new setting. The frequency of attendance at the Day Program was increased to better support both Gladys and Albert. As she became more familiar with the Day Program environment, Gladys began to let staff help her more and more. Albert eventually agreed to have Gladys remain at the Centre for the Weekend Stay overnight respite program. This allowed the Day Program staff to provide even more support by laundering her clothes and ensuring that she was dressed appropriately.

The once weekly in-home respite visits continued until one Friday when the Respite Worker buzzed their apartment and got no response. A neighbour recognized her and accompanied her to knock on the apartment door. They both heard Albert say ‘let Sharon in dear”, however, on entering Sharon found Albert on the floor with the telephone in his hand, responsive but unable to move. Gladys was sitting in her chair in the next room unaware that anything was wrong. Sharon immediately called 911 and an ambulance took Albert to the hospital while she remained with Gladys at the apartment. Albert was able to communicate that his wife was at home with a VON Respite Worker and Sharon soon received a call from the GEM nurse informing her that the hospital had been unable to reach the son. The VON Respite Supervisor was alerted and eventually made contact with the family. Because they lived at a distance, she suggested that Gladys be brought to the VON Adult Day Program for the rest of the day.

The Respite Supervisor also called the CCAC case manager and updated her on the situation. While the case manager started the process to find an emergency placement for Gladys in LTC, she doubted that it could be arranged for several days. VON was able to offer the family the support of the Weekend Stay Program for Gladys while they supported their dad in hospital and made plans for the future care of their mother.

Meanwhile, Gladys remained at the centre for the weekend, in a familiar setting with staff and a routine with which she was comfortable. Sadly, Albert passed away the next day as a result of his stroke with his son and daughter-in-law by his side.

Stories such as that of Gladys and Albert occur within the services provided by Community Support Agencies on a regular basis. Caregivers are supported through respite services, education and emotional support. Clients are provided with the right services, by the right person at the right time so they can remain at home as they desire. The health and wellness of both client and caregiver are maintained through the Community Support Services they receive, and through coordination within the health care continuum.

In the story of Gladys and Albert, there are many examples of "system savings" – whether it is the avoidance of early caregiver burnout by the sensitive introduction of personal care supports for Gladys; the avoidance of a premature placement in a Long Term Care Home through the respite provided for her at home and in the Adult Day Program; or the ability of the Weekend Stay overnight respite program to provide the enhanced care required to avoid an emergency room visit or hospital admission for Gladys during Albert's health crisis.

As a letter of thanks from their family so aptly puts
"...It is no exaggeration to say that without the help of VON and the services of other home visitors their lives would have been very difficult. The home visits they received not only brightened their days but made it possible for them to stay in the comfort of their own home amongst friends and neighbours..."

Central East **LHIN**

Central East ABI Network
Welcomes Enhanced Funding

Acquired Brain Injuries are more common than breast cancer, spinal cord injury, HIV/AIDS and multiple sclerosis combined. With over 2,100 people per year, who live in the Central East LHIN, sustaining brain injuries (based on an incidence of 150 ABI's per 100,000 of population), this service improvement will provide highly specialized ABI programs to an underserviced segment of the population.

Brain injuries affect the individual and their families and the Four Counties Brain Injury Association (FCBIA) and Community Head Injury Resource Services (CHIRS) programs are both designed to meet the needs of these groups.

The emotional, social and behavioural consequences of brain injury are life-long. It is well recognized that the absence of meaningful activity is associated with poorer mental health and increased use of health care resources. Care-giver burden is known to adversely affect the physical and mental health of family members.

FCBIA and CHIRS Adult Day Program/Outreach Services provide interventions designed to increase the quality of life through meaningful engagement in a broad range of specialized activities and programs geared toward client's abilities, interests and needs. It functions as secondary prevention, helping to avoid the development of the health, social and psychological problems that often are a result of social isolation and care-giver burden.

"Building upon the existing models of service, which have a proven track record of success, we will continue to add value to our health care system. This investment will reduce wait times and keep individuals in the community rather than using more costly hospital services and reduce caregiver burden. These services are focused on improving the quality of life for adults who live with acquired brain injuries and for their families/caregivers."

- **Hedy Chandler, CEO, CHIRS**

"Increased access to services, through increased ability to focus attention on the screening, assessment and facilitation of support for individuals striving to remain independent in their own communities, has been a mission and vision in the region for many years. Increased public awareness will continue to put pressures on the health care system and on community support services. The Central East ABI Network will continue to work on a comprehensive report to spell out the existing programs and services available in the private as well as LHIN-funded agencies along with an identification of the gaps that need to be addressed by all sectors in the community."

- Cheryl Hassan, Executive Director Four Counties Brain Injury Association.

Central East **LHIN**

"The ability to provide improved access through streamlined screening and assessment will ultimately lead to more appropriate access to the services in the Association and in the region, which is intended to increase individuals' capacities to reach their personal goals."
- Colleen McLean, FCBIA Office Coordinator

"When there is an increase in numbers of individuals who join any group, it changes the dynamics. Imagine what it is like for any one of us when we join a new group. It is both exciting and overwhelming. Imagine that it is magnified stress if you have a traumatic brain injury. Trained facilitators are able to make the transition through the system a lot smoother. Additional staff means there will be the support for the adjustments involved".

- **Teryl Hoefel, FCBIA Day Service Coordinator**

Central East **LHIN**

Port Hope Community Health Centre

A senior is discharged from the hospital after surgery that repaired a broken hip (that resulted from a fall). However, her verbally abusive husband, and developmentally handicapped sister with whom she lives, continue to make unreasonable demands on her. To 'keep the peace' she begins to disregard her discharge advice and puts too much physical strain on her recovering injury. She has no appetite because of her stress and she takes up previous alcohol use in order to cope. Her physiotherapy appointments and surgical follow-up will not be enough to keep her out of the hospital. She also needs timely, in the community, practical and emotional support to prevent physical deterioration and to avoid another fall, which could easily occur if she is in pain, distressed, under the influence of alcohol, and malnourished.

At the Port Hope Community Health Centre the vision is "Healthy people, healthy relationships, and healthy communities." The CHC team understands that in order to address individual health, the social context and environmental factors that contribute to overall wellbeing must also be considered. The services that address these factors must then be accessible to the people that need them. That's why the team is welcoming these new investments that will help individuals avoid visiting emergency rooms to get their primary health care needs met and will also help vulnerable people being discharged from hospital to stabilize their health more effectively and in a more holistic manner.

"We are very pleased that this additional funding will allow us to increase access to care and our many programs & services by extending hours of service to 7:00 AM -7:00 PM during the week and 9:00 am – 12:00 pm on Saturday so that many of our working families and elderly clients can and make an appointment to see a doctor or nurse practitioner. With the hiring of an additional Nurse Practitioner, we will also be able to increase the number of clients we see, especially those who have been waiting for an appointment."

- **Lydia Rybenko NP and Manager of Clinical Services**

"With this funding, we will be able to increase our capacity to support vulnerable individuals who would typically be at risk for readmission to hospital. A comprehensive approach is required to address mental health, addictions, co-morbid conditions, chronic disease and the social issues that contribute to unstable health. Our new multi-disciplinary outreach team will make it possible for the CHC to meet people in their own environments and to help them and their families address multiple difficulties (mental, physical and social) in order to sustain health and wellbeing."

- **Linda Thompson Manager of Community & Counseling Services.**