Appendices

"[Supports for Daily Living] has made a big difference because I just get so tired. I couldn't handle it. I can't even get [my husband's] stockings on. They make you feel good when they come in. They're always smiling and happy. They seem to love their job. I would recommend [SDL] to anyone."

June W., wife of client with Parkinson's disease

Contractual Letter – LHIN – Administration & Sign-Back (Attachment A)

Mississauga Halton LHIN

700 Dorval Drive, Suite 500
Oakville, ON
L6K 3V3
Tel : 905-337-7131
Fax: 905-337-8330

[Date], Year
[Name – Individual]
[Title – Operational Head eg: Executive Director, CEO]
[Organization]
[Address]
[City & Postal Code]

Dear [Individual's Name]:

Re: **Year [X] Aging At Home Strategy Proposal – [Name of Proposal Related to SDL Services]**

The Mississauga Halton Local Health Integration Network (MH LHIN) is pleased to support your proposal for "[name the proposal related to SDL services]" as part of the Year [X] Aging at Home Strategy. The approval for this expansion is an [new/additional] allocation. The [new/additional] annualized operating approval of [$$$$] were communicated to you by [Board Chair name], Board Chair, MH LHIN in [his/her] letter dated [date, year].

Objectives

The MH LHIN Aging at Home Strategy's overall objectives are to:

Increase community support services capacity in MH LHIN to support frail and "at risk" seniors by:

1. Reducing acute care pressures through reduced Alternate Level of Care (ALC) patient days in hospitals
2. Providing an alternative to Long-Term Care (LTC) Home placement
3. Reducing unnecessary Emergency Department (ED) visits by seniors and avert admissions from ED
4. Reducing ED treatment time.

Funding

As noted in the letter to your Board Chair, funding for Aging at Home [year] will be on a one-time basis with the understanding that continued funding will be determined by the LHIN based on performance targets met in [year] and the ability of the LHIN achieving the Alternate Level of Care (ALC) 8% target set with the ministry for [year] fiscal year. Adequate notice will be provided in the event funding is not to continue or reduced in accordance with the agreement with MH LHIN.

In addition the MH LHIN reserves the right to reallocate funding to other agencies to achieve the most effective use of the funding in meeting the MH LHINs' priorities and the above objectives. It is understood that these priorities may change.

700 Dorval Drive, Suite 500
Oakville, ON
L6K 3V3
Tel : 905-337-7131
Fax: 905-337-8330

The following are the administrative details regarding the funding:

[Year]	Annualized Operating Allocation (12 months)	**[$$$$$]**
[Year]	[X] months operating funding Other one-time expenditures* TOTAL	**[$$$$]** **[$$$]** **[$$$$$]**

*Other one-time funding is approved for specific non-recurring start-up expenditures. Examples include consultation, training, computer related items, office supplies and minor renovations. These one-time costs need to be specified in the detailed budget resubmission Attachment B.

This funding is contemplated by Article 4(section 4.4) and Article 12 of the Multi-Sector Service Accountability Agreement (M-SAA) between *[Agency]* and the Mississauga Halton LHIN. This letter and its appendices (Attachments A and B) form part of, and are subject to, that agreement as an amendment under section 4.4 and schedules 2b, 3a and E of the M-SAA.

As a dedicated program, *[Agency]* is required to maintain separate financial records for this allocation for year end audit and evaluation by the MH LHIN. Reporting requirements for this funding is included in Attachment A.

Evaluation
Evaluation of your program/service will be based on the achievement of the performance deliverables and requirements outlined in Attachment A.

Please complete the following:

1) Attachment A - Sign Back Agreement for Aging at Home Year [X] Funding
2) Attachment B - Updated Aging at Home Budget – Summary of Revenue and Expenses (for this proposal)

Return both Attachment A & B to MH LHIN, to the attention of *[Staff Member @ LHIN]* [staff member's email] no later than [date, year]. With the return of your sign-back on this date, your first payment for the initiative will be on [date, year].

If you have any questions, please do not hesitate to contact *[LHIN Lead person and telephone number]* or *[LHIN Lead Financial person and telephone number]*.

Mississauga Halton **LHIN**

700 Dorval Drive, Suite 500
Oakville, ON
L6K 3V3
Tel : 905-337-7131
Fax: 905-337-8330

I would like to take the opportunity to thank *[Agency]* for your work with the MH LHIN and commitment to improving services for seniors in our community.

Sincerely,

[CEO Name]
Chief Executive Officer

c: *[Name of Board Chair or Individual to Whom Board Letter Was Addressed + Agency Name]*
[Other Appropriate People within the LHIN]

Mississauga Halton **LHIN**

700 Dorval Drive, Suite 500
Oakville, ON
L6K 3V3
Tel : 905-337-7131
Fax: 905-337-8330

ATTACHMENT A
Sign-Back Agreement for Aging at Home Year [X] Funding
[Agency Name]

1.1 Funding for Proposal – [Name Proposal]

Annualized Operating Funding Allocation	Cash Flow	Performance Deliverables *(Example Deliverables Provided Below)*	Start Date	Coding for Service (OHRS)
[$$$]	*[$$$ (based on start up of date & year)]*	• Maintain & support the additional [xx] clients (xx to xx from previous funding) • Continue to provide the additional [xxx] hours of service (for the xx clients) • [XX] clients (annualized) • [XXXX] (annualized) hours of service • Ability to track & trend: o Admission & annual RAI CHA – MAPLe scores (average, range)	*[Date & Year]*	Functional Centre Code [XXXX] *[Name of Program applicable to Code]*

Annualized Operating Funding Allocation	Cash Flow	Performance Deliverables *(Example Deliverables Provided Below)*	Start Date	Coding for Service (OHRS)
		o Admissions & source (ALC, Acute Hospitals, LTC and community) o Discharges & destinations (LTC, Community, Death) o Average length of stay (LOS) – months/days o Falls equation (#of transfers to ER/ total falls) o ER diversions (ill clients diverted to more appropriate practitioners) o #of urgent/emergency, staff responses to clients/total client days per quarter • Completion of performance parameters as per the monthly [Program] Reporting Template • Submission of computerized CHA data • Annual client satisfaction Survey results		

1.2 Performance Requirements:

- Give priority to the frail elderly and their caregivers whose needs may require additional community programs and/or services to continue to stay at home and ensure they receive care in the most appropriate setting.
- Must communicate program/service details to other providers and the broader community through a variety of methods (e.g. newspaper, advertising, 211, 310-CCAC, etc.).
- Must commit to working with the MH LHIN, sector colleagues and/or other MH LHIN community partners such as the MH CCAC, hospitals and/or LTC Homes to reduce one or more of the following:
  - % of ALC patient days in hospital (caregiver stress may preclude discharge)
  - ED visits by seniors that could have been managed elsewhere
  - LTC Crisis Placement
  - Wait times and wait list for LTC Homes
- Must work with the MH LHIN and other sector colleagues and/or community partners to improve health system performance (e.g. common intake and assessment processes; common assessment instruments; creation of a centralized waitlist; streamlined referral processes; data collection tools and/or methodologies; common, targeted indicators and outcome measurements; etc.) for this initiative.
- Must be able to show on monthly or quarterly data reports (e.g. MAPLe scores, CPS scores, CHESS scores, RUGS scores, combination of scores, or other methodologies) that the program/service provides care and/or all available vacancies in the program/service were prioritized to those clients with the highest needs (as per performance deliverables).

1.3 Reporting Requirements: (See MSAA – Schedule C)

- The agency will maintain separate financial/statistical records and provide full accounting for this allocation since it is a dedicated program. Unspent funding and funds not used for the intended and approved purposes are subject to recovery.
- Quarterly Supplementary Reporting Template for Initiatives – [Fiscal year due dates: Q2-[*date*]; Q3-[*date*]; Q4-[*date*]]; and on-going quarterly periods until notified by MH LHIN.
- The agency will include Aging at Home revenue and expenses as well as statistical information with the quarterly WERS actual/forecast reporting. If other reports are required by the LHIN, a template with instructions will be provided.

I acknowledge that the funding for [*Agency Name and Proposal Name*] has been allocated with the understanding that [*Agency name]* will achieve:

- the performance deliverables (1.1),
- the performance requirements(1.2), and
- the reporting requirements(1.3)

I also acknowledge that continued funding for this program/service is based on:

- the program achieving the performance deliverables and requirements,
- the ability of MH LHIN achieving the ALC 8% target set with the ministry for [*Year*], and
- the MH LHIN priorities and objectives continuing to align with my agency's program in order to achieve the most effective use of the funding.

XXX

XXX	[Board Chair] Signature	Date
[Agency name]		

XXX

XXX	[ED/CEO] Signature	Date
[Agency name]		

Note:

Please return this form by [*Date*] to [*Staff Person's Name*] at the Mississauga Halton LHIN using one of the following methods:

- **fax: [*Number*]**
- **scan copy and send by email to: [*Staff Person's email address*]**

Sample Client Profiles & Care Plans

Scenario #1: Mr. Doe

Mr. Doe is 87 years old and has been living in the same house, on the same street for the past 40 years. He has Parkinson's and is currently very frail. His wife was his main assistance for personal care before she passed away last year. Since her passing he has lost interest in his own personal care or is too weak most days to take proper care of himself. His only son lives an hour away and works full time.

The Mississauga Halton Community Care Access Centre has one hour of service scheduled for Mr. Doe every morning during the week, however once the hour is complete Mr. Doe is on his own for the rest of the day and mainly stays sedentary on his couch or in bed until the next morning when the service provider returns.

Mr. Doe's Case Manager felt that Mr. Doe would benefit from the availability of intermittent care throughout the day or he would soon face admission to long term care to halt further deterioration. Along with admission to a Senior's Day Program and application for a Friendly Visitor, the Case Manager filled in the Supports for Daily Living referral form and attached Mr. Doe's RAI HC assessment and results. The referral was received by the Supports for Daily Living Systems Manager who handles the SDL Central Referrals. A home visit was scheduled with Mr. Doe and the SDL Systems Manager determined that he was eligible and would greatly benefit from the SDL intermittent care.

Mr. Doe now receives two visits per day for personal care, light meal prep and light homemaking, seven days a week, 365 days a year and also receives two security check phone calls in between visits to ensure he is well and to remind him to take his medication at the prescribed time. During the night he receives an additional two visits at 1:30am and 4am for toileting assistance due to his prostatitis.

Mr. Doe has become more social and confident in himself with the assistance of the Supports for Daily Living program. He now makes weekly trips to the mall and has old friends over for euchre tournaments.

Scenario #2: Ms. Jane

Ms. Jane is 92 years old and lives alone. She had a stroke and was admitted to hospital. The stroke was severe and caused her left side to be very weak and impaired which resulted in an unsteady gait and extreme imbalance while walking and performing ADLs and IADLs. She was designated ALC while waiting to move to Long Term Care. Ms. Jane had improved while in hospital and her health team decided that she may be able to return home with intermittent assistance from the Supports for Daily Living program.

After spending 53 days as an ALC patient, Ms. Jane was released home after an SDL Assessor had been to the hospital to see her and concluded that the SDL program would be appropriate for her once home.

Ms. Jane receives three visits and five security checks by phone each day. She is receiving assistance with personal hygiene, dressing, medication reminders, light meal prep and light housekeeping. Ms. Jane has also had a lifeline system installed and her SDL provider is set up to be the first responder.

Ms. Jane is safe and happy to be back in her own home. Her family has also noticed a big difference in her personality and wellbeing as a result of the support.

Scenario #3: Mrs. Smith

Mrs. Smith, 74 years old, lives in a townhouse with her husband. Her husband, Mr. Smith has had 3 heart attacks in the past which have left him quite frail. Mrs. Smith was admitted to hospital after a fall at her home which resulted in a hip fracture, she also has a diagnosis of diabetes. The health team noticed that while difficulty with diabetes was not the reason for admittance to the hospital, Mrs. Smith has not been testing her blood sugar or taking her insulin at appropriate times and may be missing some meals that would allow her blood sugar to remain steady. After treatment and recovery, Mrs. Smith was healthy enough to return home however was not able to perform all of her personal care independently due to an unsteady gait and fluctuating blood sugar. Mr. Smith is also not able to help her once home due to his own health concerns.

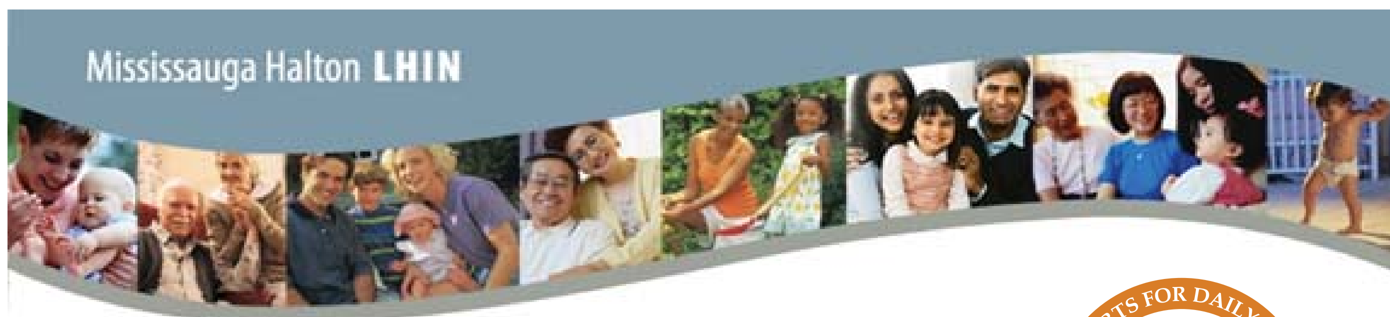
The hospital gave the Supports for Daily Living Central Referral Line a call to see if the SDL program would allow Mrs. Smith to safely return home with assistance. The SDL Systems Manager visited with Mrs. Smith at the hospital and determined based on her assessment score and her needs that the SDL program would be able to fulfill her needs safely in her own home and allow her to remain there avoiding a possible long term care placement or extended stay in the hospital.

Mrs. Smith was discharged with a care plan from the Supports for Daily Living program that scheduled 3 visits a day that provide assistance with transferring from bed, bathing, personal hygiene, light meal prep, medication reminders and light homemaking.

A security check by phone is performed at noon by SDL program staff to ensure Mrs. Smith remembers to test her blood sugar before having lunch.

The SDL program staff are also available for 24 hour emergency response if Mrs. Smith ever needed to call during the day or night.

As a result of the SDL program staff and the assistance provided, Mrs. Smith's hip has healed completely, she has a better understanding of her diabetes and thrives with the assistance of the SDL staff. Mr. Smith's health has also been maintained and unnecessary injury or illness due to trying to assist Mrs. Smith has been avoided.



Supports for Daily Living (SDL)

Information for Hospital Discharge Planners and CCAC Case Managers

What is Supports for Daily Living?

Supports for Daily Living (SDL) is a community-based, publicly funded health care service that effectively meets a client's frequent needs throughout the day. By providing access to 24/7 personal support and/or attendant care coverage, it allows seniors and persons with a physical disability the ability to remain living independently within their own homes, thereby preventing premature admission to long-term care. Services are funded under the umbrella of the Mississauga Halton LHIN's Aging at Home Strategy.

What services does Supports for Daily Living offer?

Supports for Daily Living provides non-medical services that include:

- personal support services (personal hygiene, activities of daily living)
- homemaking services
- attendant services (prescheduled tasks)
- safety and reassurance checks (via phone or in person)
- 24 hour urgent response

Services are available to clients at scheduled times based on client preference, anytime of the day within a 24 hour period, seven days a week, 365 days a year, and are designed for clients with overnight needs or more frequent visitation than those services offered through the CCAC. It would not be unusual for a client who has been on CCAC services to transition to SDL as their needs change and they require more frequent visitation.

SDL services can be delivered in conjunction with professional services offered through the CCAC. The goal of SDL is to support individuals to continue living independently as long as possible and to reduce premature admission of seniors and persons with a physical disability to long-term care environments.

Where are services provided?

Services are delivered to clients in their homes who live within designated geographical 'clusters' or 'hubs' in the Mississauga Halton LHIN. Clients unable to continue living in their own homes for safety or accessibility reasons, but who are still capable of living independently with support, may be eligible to apply for residence in a Supportive Housing program building serviced by SDL agencies.

As of January 2009, a 24 hour mobile SDL service is available to eligible individuals who live in their own homes, apartments, condominiums or townhouses and whose residence is not served by an onsite SDL agency. This means people can access services in their current neighbourhoods without having to move. The mobile service is also available on-call to respond to urgent client requests for support that fall outside the prescheduled client visits by SDL staff.

Who provides Supports for Daily Living services?

Supports for Daily Living are provided by designated agencies that meet approved standards for the delivery of high quality SDL services within the Mississauga Halton LHIN. Each designated agency carries the Supports for Daily Living Approved Service Provider symbol (as seen in the top right corner of page one).

Each agency applies best practice in the delivery of care, offering clients throughout the LHIN the same high quality, level and range of services, without exception. Agencies serve designated geographical service areas within the LHIN, or provide service within designated residential buildings where there are clusters of seniors or persons with a physical disability living on their own or with an informal caregiver.

In some cases, SDL agencies may be housed within designated residential buildings, while in others, services may be provided to residential buildings by SDL agencies located within the geographical area.

Who is eligible for Supports for Daily Living services?

Supports for Daily Living services are suitable for seniors or persons with a physical disability who are 65 years of age or older, and who live in their own home within the community, or in a residential setting such as an apartment complex or senior citizens' residence and who:

- demonstrate a need for daily access to personal support and/or attendant services throughout a 24 hour period (i.e. may have a history of falls, may require toileting assistance at night, assistance transferring)
- are able to direct their own care or have an SDM or a live-in caregiver to direct care
- are able to communicate their needs (with or without aides)
- are medically stable (medical/professional needs can be met by CCAC, family physician or other community providers)
- pose no risk to themselves or others
- may or may not require homemaking services

The RAI CHA evidence-based assessment tool will be used to help health professionals determine eligibility for the service.

How do I refer a patient to Supports for Daily Living?

Supports for Daily Living (SDL) Coordinators are available within hospitals in the Mississauga Halton LHIN and can facilitate patient referral to the service. Patients can also be referred to SDL through the Mississauga Halton CCAC. Efforts are currently underway to develop a central referral line to facilitate SDL referrals from both hospitals and the community.

Living independently, safely and with peace of mind.

Supports for Daily Living (SDL)

Information for Patients, Families and Informal Caregivers

When illness or disability increases your dependency on others for support, it can often lead to questions about independent living and whether or not you can still manage living in your own home. Perhaps you have been using homecare services offered through the Mississauga Halton Community Care Access Centre (CCAC), but recent changes in your health mean they're no longer adequate to support your needs. Perhaps you've had the support of a family member or friend, but they're not always available at times in the day when you most need their support. That's where Supports for Daily Living can help.

What is Supports for Daily Living?

Supports for Daily Living (SDL) is a publicly funded, community-based health care service that provides eligible seniors and persons with a physical disability with the personal support and/or attendant services you need to allow you to continue living on your own for as long as possible. There is no cost to you for the services provided.

Services are offered through approved SDL agencies within Mississauga, Halton and South Etobicoke in designated geographic areas or in designated residential buildings. Each agency is dedicated to providing the same high quality, level and range of services, regardless of where you live or what your circumstances are.

Whether you live in a private home or a residential setting (i.e. apartment building, senior citizens' residence), on your own or with an informal caregiver, Supports for Daily Living can help bring peace of mind to you and your family, delivering personal support and/or attendant services where and when you most need them – anytime – day, evening or overnight.

What services does SDL provide?

Supports for Daily Living provide non-medical services that include:

- personal support services (personal hygiene, activities of daily living)
- homemaking services
- attendant services (predetermined tasks)
- safety and reassurance checks (via phone or in person)
- 24 hour urgent response

SDL services focus on activities of daily living that you can no longer do or find challenging to do on your own such as:

√ washing/bathing
√ mouth care
√ hair care
√ menstrual care
√ preventive skin care
√ transferring/positioning/turning
√ dressing/undressing
√ assistance with eating
√ toileting
√ reminders re: pre-measured medications
√ range of motion
√ exercising
√ escorting to medical appointments
√ light dusting, sweeping, vacuuming
√ mopping floors
√ washing dishes/countertops
√ light meal support
√ bed making and laundry
√ cleaning and disinfecting bathrooms

SDL staff work together with you to determine the best mix of services to meet your needs, and then pre-schedule the services at the times of day when you most need them. They are available to come to your home at any hour within a 24 hour period of time, offering services seven days a week, 365 days a year. SDL clients receive daily security checks either in person or by phone to make sure you are okay. Electronic emergency response systems are recommended to clients, providing you with 24-hour access to SDL staff in the event of an urgent situation.

With the exception of personal support services, you can supplement these services with those offered through the CCAC and through community support services, as needed.

How do I know if I'm eligible to receive Supports for Daily Living?

Your hospital discharge planner or CCAC case manager will work with you and your family to determine whether you are eligible for Supports for Daily Living services. These services are currently available to individuals, 65 years of age or older who:

- live in their own private home, or within a residential setting such as an apartment building or senior citizens' residence
- demonstrate a need for daily access to personal support and/or attendant services throughout a 24 hour period (may or may not require homemaking services)
- are able to direct their own care or have a substitute decision-maker or a live-in caregiver to direct care
- are able to communicate their needs (with or without aides)
- are medically stable (medical/professional needs can be met by CCAC, family physician or other community providers)
- pose no risk to themselves or others

How can I find out more about Supports for Daily Living?

To find out more about Supports for Daily Living, talk to your hospital discharge planner or CCAC case manager who will be happy to talk to you about your eligibility for these services.

Living independently, safely and with peace of mind.

Supports for Daily Living Communication Plan

COMMUNICATION GOAL

To generate awareness and understanding of the role of Supports for Daily Living as a means for reducing ALC and for encouraging independent living in support of the Aging at Home Strategy.

To effectively brand Supports for Daily Living so that it is recognized as a valued service within the local health system continuum of health care services.

COMMUNICATION OBJECTIVES

1. To generate increased referrals to Supports for Daily Living and decrease premature referrals to long-term care.
2. To initiate a change in the way health care professionals, informal caregivers and seniors/frail elderly think about independent living options versus long-term care.
3. To firmly establish Supports for Daily Living as a health care service versus a community support service within the Mississauga Halton LHIN.

KEY STAKEHOLDERS

Ministry of Health and Long-Term Care

Hospitals

Community Care Access Centre

Hospital Patients

CCAC Clients

Informal Caregivers (incl. families)

Seniors, Frail Elderly and Physically Disabled

Family Physicians

Other Health System Providers (i.e. long-term care homes, community support services, complex continuing care, etc.)

Supports for Daily Living Agencies

General Public

TAGLINE

Helping you to live independently, safely and with peace of mind.

KEY MESSAGES

1. Supports for Daily Living is a publicly-funded, community-based health care service that addresses an existing health system gap between CCAC services and long-term care.
2. Supports for Daily Living supports the ability of seniors, the frail elderly and physically disabled to continue living independently in their own home settings as long as possible, preventing premature admissions to long-term care.
3. Supports for Daily Living are provided by designated agencies that meet approved standards for the delivery of high quality SDL services within the Mississauga Halton LHIN. Each agency applies best practice in the delivery of care, offering clients throughout the LHIN the same high quality, level and range of services, without exception.
4. SDL agencies serve designated geographical service areas within the LHIN, or provide service within designated residential buildings where there are clusters of seniors, frail elderly or physically disabled individuals living on their own or with an informal caregiver.
5. Supports for Daily Living include personal support services, homemaking services, attendant services, security checks, 24 hour emergency response and friendly visiting. SDL services can be supplemented by CCAC services (with the exception of personal support) and community support services. A mobile service will offer transitional support in areas beyond designated geographic boundaries, and urgent care support, as needed.
6. SDL services are available to clients at pre-scheduled times based on client preference, anytime of the day within a 24 hour period, seven days a week, 365 days a year, and are designed for clients with heavier needs than those services offered through the CCAC.
7. SDL services are suitable for seniors, the frail elderly and physically disabled individuals who live in their own home, or within a residential setting such as an apartment complex or senior citizens' residence and who:
    - demonstrate a need for daily access to personal support and/or attendant services throughout a 24 hour period
    - are able to direct their own care or have an SDM or a live-in caregiver to direct care
    - are able to communicate their needs (with or without aides)
    - are medically stable (medical/professional needs can be met by CCAC, family physician or other community providers)
    - pose no risk to themselves or others
    - may or may not require homemaking services

8. SDL Coordinators are available within each hospital in the Mississauga Halton LHIN and can facilitate patient referral to the service. Patients can also be referred to SDL through the Mississauga Halton CCAC.
    - Efforts are currently underway to develop a central referral line to facilitate SDL referrals from both hospitals and the community.
9. Supports for Daily Living supports the Mississauga Halton LHIN's Aging at Home Strategy and a local health system commitment under the ALC Strategy to refer patients to the right service by the right care provider at the right time.

DEVELOPING THE SUPPORTS FOR DAILY LIVING 'BRAND'

The development of a distinct wordmark will help visually 'brand' Supports for Daily Living among SDL agencies, health care providers, clients and informal caregivers. Through its application on signage, print and online materials, it will lend itself to identifying agencies that provide the same high quality, range and level of SDL services within the Mississauga Halton LHIN. Only those agencies that are approved by the Mississauga Halton LHIN to carry the SDL brand will be considered official providers of SDL services, sharing the same values, standards and practices for the delivery of services.

The wordmark will become a symbol for consumers of quality, community-based health care services, and will allow clients to challenge SDL providers if the quality, level and range of services expected of SDL providers is not delivered.

COMMUNICATION STRATEGY

The Mississauga Halton LHIN and SDL Steering Committee will adopt a multi-faceted approach to communication, embracing multiple communication vehicles and education initiatives over the next several months for the purposes of raising awareness, understanding and support for SDL's role within the local health system and generating increased referrals to SDL agencies.

COMMUNICATION PLAN

AUDIENCE	TACTIC	TIMING	RESPONSIBILITY
Branding	Develop a visual SDL 'wordmark' for use by approved SDL providers	Completed 2010	XXX
Approved SDL Providers	Develop an SDL Standards Kit for approved SDL providers, providing templates for communication materials they can use	Completed – revisions with new materials in 2011/12	XXX/SDL Steering Committee
Mobile SDL Launch	News Release – provide SDL providers with copy of launch news release for posting to their respective websites Incorporate quotes from one or two SDL providers involved with mobile service Consider newspaper photo op of SDL Mobile service	January 5, 2009	XXX/MH LHIN
HOSPITAL DISCHARGE PLANNERS & CCAC CASE MANAGERS			
Education/ Awareness Meetings	Develop key messages for use at awareness meetings with hospital discharge planners and CCAC case managers Service Eligibility Decision Tree	Week of Dec. 1, 2008	YYY/ZZZ
Education/ Awareness Meetings	Develop 3-5 vignettes that vividly characterize who SDL clients are and how they benefit from SDL services	By January 2009	YYY/SDL Resource Group
HOSPITAL INPATIENTS & FAMILIES/CCAC CLIENTS			
Patient/Family Meetings	Develop key messages/script for use in materials or delivered verbally by discharge planners, CCAC case managers and SDL coordinators	December 2008	YYY
Patient/Family Meetings	Develop patient fact sheet for eligible hospital inpatients preparing for discharge (this can be adapted for CCAC clients transitioning to SDL services)	Week of Dec. 1, 2008	YYY

AUDIENCE	TACTIC	TIMING	RESPONSIBILITY
FAMILY PHYSICIANS			
Family Physician Meetings	Prepare powerpoint presentation for introducing SDL at Central West/Mississauga Halton Family Physician Network or MH LHIN Family Physician meeting or hospital family practice rounds	TBD	MH LHIN
Mailings/ E-Mailings	Develop fact sheet or top 10 list to help family physicians better understand why they should refer their patients to SDL before considering a referral to LTC	TBD	MH LHIN
COMMUNITY-BASED SENIORS & INFORMAL CAREGIVERS			
	Develop key messages for use in materials or delivered verbally by SDL providers and other health care providers	December 2008	YYY
Family Physicians' Offices	General information brochure on SDL for patients to pick up in family physicians' offices	December 2008	YYY
OTHER LOCAL HEALTH SYSTEM PROVIDERS			
Announcement of SDL as a health care service within MH LHIN	E-mail announcement with accompanying SDL fact sheet from MH LHIN to all member providers	MH LHIN eLetter -	MH LHIN
HOSPITAL COMMUNITY/CCAC/GENERAL PUBLIC			
Introduction of SDL (Hospitals/CCAC)	Provide introductory article for hospitals and CCAC to use in internal newsletters and/or in announcements of service on intranets Provide introductory article for use in hospital community newsletters	2009/10 and onward	MH LHIN

AUDIENCE	TACTIC	TIMING	RESPONSIBILITY
Introduction of SDL (General Public)	Develop powerpoint presentation that can be used by MH LHIN and/ or SDL Providers in presentations at gatherings of seniors (i.e. seniors citizens' residences, seniors' recreation centres, etc.)	Ongoing	SDL Providers/ MH LHIN
Introduction of SDL (All)	Post information about SDL for health care professionals and consumers on MH LHIN website	Completed 2010	MH LHIN Website Author
	Have SDL providers ensure that their existing agency listing on both their websites and on other websites (i.e. 211.ca, etc.) list their service as SDL and not Supportive Housing	Completed 2010	SDL Providers
	Write feature article on SDL and submit to local newspapers, publications that target seniors (i.e. CARP), and local ethnic newspapers and any seniors' information sites on internet that list health care services	Ongoing	MH LHIN (eLetter); SDL Providers; Request from Newspapers

Reporting Template for SDL Stats – circa 2009/10"

Statistics for Supports for Daily Living (SDL)

HSP Agency Name: ________________________

<table>
<tr><th></th><th colspan="3">REPORTING REQUIREMENTS</th><th colspan="2">____/09</th></tr>
<tr><td rowspan="13">All SDL Agencies Report on These Categories</td><td colspan="3">Impact on Hospital (ER, ALC, General Beds)</td><td colspan="2" rowspan="13"></td></tr>
<tr><td colspan="3"># of ALC clients taken out of hospital into SDL (not previously SDL clients – new)</td></tr>
<tr><td colspan="3"># of general hospital clients taken into SDL (not inclusive of ALC – not previously SDL clients – new)</td></tr>
<tr><td colspan="3"># of ER visits diverted (24 hour response)</td></tr>
<tr><td colspan="3"># of clients returned back to SDL from hospital (clients on SDL services prior to hospitalization)</td></tr>
<tr><td colspan="3">Impact on LTC Homes</td></tr>
<tr><td colspan="3"># of clients taken out of LTC homes into SDL</td></tr>
<tr><td colspan="3"># of clients diverted from LTC (may or may not be waitlisted – avoidance of crisis placement)</td></tr>
<tr><td colspan="3"># of clients that came off of the LTC waitlist</td></tr>
<tr><td colspan="3">Impact on Turnover of Clients in SDL Buildings</td></tr>
<tr><td colspan="3">** Turnover rate of clients (defined as: leaving SDL)
<u>Please specify destination (eg: Death, placement, etc.)</u></td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3"></td></tr>
<tr><th></th><th colspan="3">SPECIALIZED REPORTING REQUIREMENTS</th><th colspan="2">____/09</th></tr>
<tr><td>OSCR</td><td colspan="3"># of days reduced from hospital LOS – Recovery Unit</td><td colspan="2"></td></tr>
<tr><td>Mobile</td><td colspan="3"># of "Restore" patients taken into SDL</td><td colspan="2"></td></tr>
<tr><td>Mobile</td><td colspan="3"># of hospital patients d/c and resettled at home with Mobile Services</td><td colspan="2"></td></tr>
<tr><td></td><td>Post-Hospital Days =</td><td>0-30</td><td>30-60</td><td>60-90</td><td>90-120</td></tr>
<tr><td>Mobile</td><td># of Home First clients taken into SDL</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mobile</td><td># clients transitioned to an SDL provider's unit and their LOS on Mobile Services</td><td></td><td></td><td></td><td></td></tr>
</table>

Reporting Submission:

- 2nd Tuesday of each month
- Complete form above and submit via email to XXX
- Please ensure that your agency name is provided at the top of the form and that the date you are submitting is identified in the column to the right

Indicator Definition Explanation

The indicators provided on the reporting form are those that are most important to identifying impact on the ALC/ER/LTC diversion agenda. Definitions have been incorporated into the indicator as much as possible (see chart). However, in some circumstances, greater clarification is needed.

INDICATOR	DEFINITION
# of ALC clients taken out of hospital into SDL (not previously SDL clients – new)	• Straight count of clients that have come onto SDL service and who have been designated "ALC Patients" by the hospital • Clients were not previously SDL clients – new to service • Clients come either directly from hospital to SDL services (hospital referral) or come via referral from CCAC or are transferred from CCAC service to SDL within 14 days post hospital discharge
# of general hospital clients taken into SDL (not inclusive of ALC – not previously SDL clients – new)	• Straight count of clients that have come onto SDL service from within the general hospital population –have not been designated ALC • Clients were not previously SDL clients – new to service • Clients come either directly from hospital to SDL services (hospital referral) or come via referral from CCAC or are transferred from CCAC service to SDL within 14 days post hospital discharge
# of ER visits diverted (24 hour response)	• Straight count of the number of visits that were diverted from the ER by SDL clients on service • Anytime that the SDL service being provided has prevented the ambulance from having to respond to a call (would otherwise have responded if SDL was not in place) • Anytime that the SDL service being provided has allowed the ambulance to treat and release the client back to the service (would otherwise have transported the client to ER if SDL was not in place) • Anytime that staff have been able to avoid injury to a client (assuming that the injury had the potential to be treated in ER) as a result of the SDL service being in place
# of clients returned back to SDL from hospital (clients on SDL services prior to hospitalization)	• Straight count of clients that are already on SDL service at the time of hospital admission and who returned "home" to their residence and continued on SDL services • Each time a client on service enters hospital and returns to SDL services, this client is counted – multiple entries and discharges/frequent admissions and discharges

INDICATOR	DEFINITION
# of clients taken out of LTC homes into SDL	• Straight count of clients where the previous residence was a LTC facility – client now coming onto SDL services – moved out of LTC facility
# of clients diverted from LTC (may or may not be waitlisted – avoidance of crisis placement)	• Straight count of clients that, as a result of coming onto SDL services, were delayed from entering a LTC facility – as a result of caregiver stress or other factors, clients were in a situation where they would have been crisis placed into a LTC facility unless SDL services were available • Clients are counted once and once only (eg: if a client has entered hospital more than once and each time the client has been in danger of a LTC admission coming out of hospital, the client is still only counted once as a diversion from LTC as a result of being on SDL services or initially coming onto SDL services) • If clients who fit this category also came off of the LTC waitlist (following CCAC confirmation), then the same client is counted once in this category and once in the following category - # of clients that came off of the LTC waitlist).
# of clients that came off of the LTC waitlist	• Straight count of clients that, as a result of coming onto SDL services, had their name removed from the LTC waitlist – in order to count, this removal must be confirmed with the CCAC Case Manager • This count would also include clients that have died while on service
** Turnover rate of clients (defined as: leaving SDL) **Please specify destination (eg: Death, placement, etc.)**	• Straight count of clients that leave SDL service as a result of death or having been placed in a LTC facility or having gone with family – essentially anyone who leaves SDL service and where they went

Reporting Template for SDL Stats – circa 2011 onward: MOBILE Example

SDL Monthly Report (MOBILE)

Mississauga Halton LHIN

Reporting Period	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	YTD
Impact on Hospital (ER, ALC, General Beds													
# of ALC Clients taken out of hospital into SDL (not previously SDI Clients - new)	0	0	0	0									0
# of general hospital clients taken into SDL (not inclusive of ALC clients - not previously SDL clients -	30	16	2	0									48
Total number of clients taken out of hospital in SDL (new - not previously SDL Clients	30	16	2	0	0	0	0	0	0	0	0	0	48
Number of ER visits diverted (24 hour response)	3	3	0	0									6
Number of clients on SDL service entering hospital	15	19	12	0									46
Number of clients returned back to SDL from hospital (clients on SDL services prior to hospitalization	7	10	8	1									26
Impact on LTC Homes													
Number of Clients taken out of LTC homes into SDL	0	0	0	0									0
Number of clients diverted from LTC (may or may not be waitlisted - avoidance of crisis placement	0	0	0	0									0
Number of clients that came of LTC waitlist	0	0	0	0									0
Discharge Disposition													
Discharged into other SDL Program	4	7	11	4									26
Deceased	0	4	0	0									4
Hospitalized	0	5	1	4									10
Discharged LTC	2	3	0	0									5
Improved and no longer required service	6	3	7	0									16
No longer eligible for service	0	8	0	2									10
Other	2	1	3	1									7
Total	14	31	22	11	0	0	0	0	0	0	0	0	78
Specialized Reporting Requiements													
Number of "Restore" patients taken into SDL	0	2	0	0									2
Number of hospital patients dicharged and resettled at home with Mobile services	0	0	0	0									0
Number of hospital ED patients discharged and resettled at home with Mobile services	0	0	0	0									0
Number of Home First clients taken into SDL	0	0	0	0									0
Number of clients transitioned to an SDL providers unit	4	7	11	4									26

SDL Monthly Report Definitions:

Number of ALC clients taken out of hospital into SDL (not previously SDL clients - new)
This is a straight count of clients that have come on to the SDL service and who have been designated "ALC patients" by hospital
These are clients that were not previously SDL clients - they are new to service
The client has come either directly from hospital to SDL services (hospital referral) or via referral from CCAC or have been transferred from CCAC service to SDL within 14 days of discharge from hospital

Number of general hospital clients taken out of hospital into SDL (not previously SDL clients - new- not designated ALC)
This is a straight count of clients that have come on to the SDL service from within the general hospital population - they have not been designated ALC
These are clients that were not previously SDL clients - they are new to service
The client has come either directly from hospital to SDL services (hospital referral) or via referral from CCAC or have been transferred from CCAC service to SDL within 14 days of discharge from hospital

Number of ER visits diverted (24 hour response)
This is a straight count of the number of visits that were diverted from the ER by SDL clients on service
This is counted any time that the SDL service being provided has prevented the ambulance from having to respond to a call. In other words if SDL service was not being provided an ambulance would have to be called and they would have responded
This is counted any time that the SDL service being provided has allowed the ambulance to treat and release the client back to service and prevent the client from being transported to the ER
This is counted any time that the SDL service being provided has prevented injury to a client, which otherwise would have had to be treated in the ER.

Number of SDL clients on service entering hospital
This is a straight count of clients that are already on SDL service that have been admitted to hospital

The client is counted each time they are admitted to hospital - calculating frequency of admissions

Number of SDL clients that return back to SDL service post discharge from hospital
This is a straight count of clients that are already on SDL service that have been admitted to hospital and are returning "home" to their residence and are continuing with SDL service

Number of clients that were taken out of LTC homes and put on SDL service
This is a straight count of clients who are now on SDL service whose previous residence was a LTC facility

Number of clients diverted from LTC (may or may not have been waitlisted - avoidance of crisis placement
This is a straight count of the number of clients on SDL service who were delayed from entering a LTC facility
As a result of caregiver stress or other factors the client was in a situation where they would have been crisis placed into a LTC facility if SDL services were available.
Clients are counted only once. For example if a client has entered hospital more than once and each time the client has been in danger of a LTC admission coming out of hospital, the client is still only counted once as a diversion from LTC as a result of being on SDL services.
If a client who fits into this category also came off of the LTC waitlist (as confirmed by the CCAC) then the client would be counted once for the LTC waitlist removal and and once for the LTC diverted count

Number of clients that came off of the LTC waitlist
This is a straight count of clients who have had their name removed from the LTC waitlist as a result of coming on to service with SDL.
In order for this to count this removal must be confirmed with the CCAC case manager.
This count would also include clients that have died while on service

Discharge Disposition
This is a straight count of clients that leave SDL service. This just indicates where the client went.

SDL Quarterly Report

Mississauga Halton LHIN

Reporting Period	Q1: Apr 1-Jun 30th	Q2: Jul 1-Sept 30th	Q3: Oct 1-Dec 30th	Q4: Jan 1-Mar 30th	YTD
	Admissions				
Hospital	47				47
Another Community HSP	1				1
Community					0
CCAC					0
LTC Waitlist					0
LTC Home					0
Total Admissions	48	0	0	0	48
	MAPLe Scores				
5	5				5
4	33				33
3	10				10
2					0
1					0
Average Admission MAPLe score	3.9	#DIV/0!	#DIV/0!	#DIV/0!	3.9
	CHESS scores				
5	0				0
4	0				0
3	8				8
2	19				19
1	16				
0	5				5
Average Admission CHESS score	1.4	#DIV/0!	#DIV/0!	#DIV/0!	2.1
	Age				
19-64	2				2
65-74	12				12
75 and older	34				34
% 75 years and older	71%	#DIV/0!	#DIV/0!	#DIV/0!	71%
	Gender				
Male	15				15
Female	33				33
% of Male Admissions	31%	#DIV/0!	#DIV/0!	#DIV/0!	31%
% of Female Admissions	69%	#DIV/0!	#DIV/0!	#DIV/0!	69%
	Referrals				
Hospital	45				45
Restore Program	2				2
Non - Hospital					0
CCAC					0
CSS Provider	1				1
Other					0
Total Referrals	48	0	0	0	48
	General Stats				
Client Capacity	168				168
Total Clients on Service	186				186
Total Discharges	67				67

SDL Quarterly Report Definitions:

Client Summary Tab

Admissions:
This is the number of new clients that have come on to SDL service for the quarter, when including this count please indicate where the client is coming from. For example if they were previously living in your building but were not on service they would be counted as an admission from the community.

RAI -Score
This is the MAPLe scores of only those clients that have been accepted and received SDL service. All other clients who may have been assessed but not accepted should **not** be included. The average is calculatd by a pre-populated formula.

CHESS -Score
This is the CHESS scores of only those clients that have been accepted and received SDL service. All other clients who may have been assessed but not accepted should **not** be included. The average is calculated by a pre-populated formula

Admission Age
This is the age of the clients that have been accepted and received SDL service for the quarter. This is only those clients that have been accepted on to SDL service for that quarter

Age Group	*Total # of SDL Clients*
less than 65	
65-74	
75-84	
85+	
% 75+	**#DIV/0!**

Referrals:
This is a count of referrals and where they were recived from.

Client Capacity:
This is the number of clients that you have been approved to accept on to SDL services at any given time for the

Total Number of SDL Clients Discharged:
This is the total number of clients stop recieving SDL service and are discharged from the SDL program for the fiscal year. Fiscal 2009/10 is from April 1, 2009 to March 31st, 2010 and fiscal 2010/11 is April 1, 2010 to March 31, 2010.

Total Clients on Service
This is a count of the total number of clients that received SDL service for that quarter. This includes both those that may not be reciveing service currently but did receive service at some point during the quarter as well as those that are currently receiveing service

Total Discharges
This is a count of the total number of clients that are no longer recieving SDL service currently but did receive service at some point during the quarter.

MH LHIN SDL Service Provider and LHIN Contact List

SDL Service Provider & LHIN	Contact	Contact Information
MH LHIN	Judy Bowyer	judy.bowyer@lhins.on.ca
M.IC.B.A. Forum Italia Community Services	Nancy Caro	ncaro@forumitalia.ca
Nucleus Independent Living	Lisa Gammage	lisa@nucleusonline.ca
Oakville Senior Citizens Residence	Angela Katunas	akatunas@oakvilleseniors.com
Ontario March of Dimes (Etobicoke)	Marilyn Daley	mdaley@marchofdimes.ca
Peel Senior Link	Ray Applebaum	ray@peelseniorlink.com
Region of Halton	Karen Aikman	karen.aikman@halton.ca
Victorian Order of Nurses – Peel	Caroline Countryman	caroline.countryman@von.ca
Yee Hong Centre for Geriatric Care	Angela Lui	angela.lui@yeehong.com