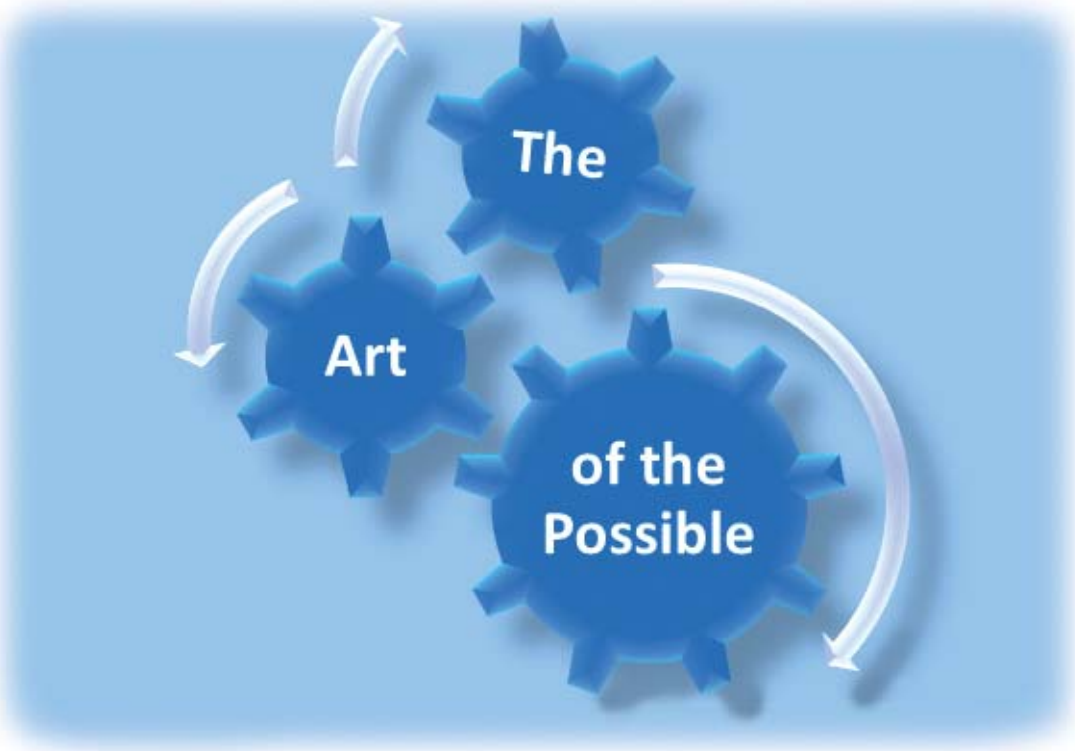
Chapter Four



Setting the Stage for Success – Critical Factors

"If we want to effect change, we have to be visionary in our thinking. It's no longer acceptable to say 'that's the way we've always done it'. We have to think outside the box and put ourselves in the shoes of our clients/patients and our partners. We have to think cross-collaboratively and build on each other's strengths – only then will we see the art of the possible."

Kristina Hall, Executive Director,
Nucleus Independent Living

CHAPTER 4: SETTING THE STAGE FOR SUCCESS - CRITICAL FACTORS – cont'd

Identifying Opportunities

Client-Centred/Customer Focused

Solutions Driven

24-Hour Service Cycle and Timely Response

Communications

Ongoing Evaluation

Laying the Foundation for Change

Strong Leadership and Champions

Funding and Accountability/Resourcing the New Models of Service

Identifying Opportunities

Within every health system is untapped potential waiting to be realized. Within the context of Supports for Daily Living, that potential exists within the diverse, yet often overlooked, community support services (CSS) sector.

As health care moves towards more in-home community-based care, there is a wealth of knowledge, expertise and experience within this sector that should be leveraged when looking at assisted living models that address policy and LHIN priorities. The people who live and breathe community-based care everyday recognize and understand what it means to deliver care within a home environment, and it is within this sector that the best opportunities exist for developing assisted living solutions that meet the needs of high risk seniors with complex needs.

Client-Centred/Customer Focused

One of the driving factors behind the development of a Supports for Daily Living service is a focus on client-centred care and customer focused solutions. Maintaining this focus throughout the development of the service is critical to its success. Therefore, a clear understanding of what we were all here to do was essential to keeping forward momentum and people on track. This clarity is provided in the following messages:

Frequency Messaging:

- Focus on a service that doesn't close its doors
- Focus on a service that runs 24/7 – 24/7 availability doesn't mean 24/7 bedside
- 12:00 midnight is just another number
- Needs of clients do not stop with the clock reaching a certain hour

Customer Service Messaging:

- Demand + response = service – if you can't respond to the demand, you are not providing service
- Clients are those who will have service delivered to them; customers are those that depend on the services being delivered to clients
- Know the needs of your customers, respond quickly and efficiently, suggest/find solutions – guaranteed to always place you in demand!
- Hospitals and the CCAC are customers, not just stakeholders

Client-Centred Messaging:

- Consistently address the needs of the client from the referral, assessment and intake processes to delivery of, and eventual discharge from, services.

Solutions Driven

One of the reasons why the Mississauga Halton LHIN's approach to the development of the Supports for Daily Living service has been so successful is due to its solutions-driven approach from the brainstorming and planning stages through to implementation. In aligning outcomes with local and provincial health system priorities, the focus never waivered from the LHIN's goal of helping to keep high risk seniors living in their own homes for as long as possible.

24-Hour Service Cycle and Timely Response

One of the key game-changers when it comes to developing an effective Supports for Daily Living service is recognizing and responding to the fact that the support required by high risk seniors with complex needs doesn't conveniently fit into a 9-5 timeframe. From the client perspective, seniors need help with essential activities of daily living throughout a 24-hour day from getting up in the morning to going to bed at night, to medication reminders and urgent response for unscheduled help. The need can span an entire day, every day of the week – morning, evening or night.

From a health system perspective, it's also important to respect the day-to-day reality of key health system customers/partners, particularly hospitals. Hospitals operate on a 24-hour cycle. To effectively contribute to enhanced patient flow throughout the system, the Supports for Daily Living service has to have the capacity to provide timely responses to incoming referral requests, particularly those coming from hospitals. The goal is to help seniors transition back home and/or into the community quickly and with as little disruption to their lives as possible. One of the reasons the Supports for Daily Living model works so well is because it recognizes and responds to the way its major customers work within the system. Key successes include:

- responsiveness of service design
- recognizing the pressures of major customers and adapting service response accordingly
- working with major customers to find solutions and flexible alternatives

Communications

Communication plays a key role throughout the transition process and is particularly important during the pilot and implementation phases to keep key stakeholders abreast of progress and outcomes being generated in alignment with key objectives.

Throughout the implementation phase, ongoing and consistent communication is important, particularly with health system partners including the CCAC, hospitals, community support service providers and family physicians. On an individual basis, key stakeholders include hospital social workers, discharge planners, nurses and physicians, hospital and community case managers, and SDL staff. Communications should be leveraged to help support education and training as well as to build knowledge and acceptance.

Another key stakeholder is clients/patients and families. Communication materials should be developed that are specifically targeted to this audience which can include fact sheets and/or brochures. Scripts or speaking notes for staff are also an essential component when discussing the Supports for Daily Living service. In our experience, having a "common message" and talking points to provide information and knowledge about a new service are a fundamental necessity for the development of confidence and security not only in patients/clients and their families, but also staff.

Though perhaps surprising to some, the LHIN is also another key stakeholder that should not be overlooked. It is one thing to agree to take a risk, and it is completely another to instill faith in "staying the course" with the risk that is taken. When a LHIN is navigating unknown seas, it is essential that the LHIN Lead for the initiative communicates effectively and consistently within the LHIN in order to gain and sustain support. Effective communication means that the LHIN Lead must know the details, the issues and the build of the initiative from the bottom up. Participation in the initiative from the outset and as a member of the "building" provides the perspective to understand and champion "staying the course". Though this level of involvement in an initiative is not necessarily a good fit for all LHINs, it has been our experience that it worked in the MH LHIN.

Every opportunity was taken within the MH LHIN to "spread the word" about the new SDL program, its focus, what made it different from a visitation model of service, the type of clients that were targeted for the service, why the need for the 3 different models, etc. Communication tools and mechanisms such as business meetings, department/unit meetings in hospitals, physician meetings, fact sheets, PowerPoint presentations, scripts, brochures, bulletins, e-mails, newsletter articles, etc., were utilized to provide clarity, answer questions and ease doubts. Examples of some of the communication tools and the communication plan utilized are provided in the Appendices.

The path was not an easy one and it has taken time and effort to build the SDL service to the level of trust and confidence it enjoys today. However, as in anything else, continued effort and vigilance to deliver on the promises of the service must continue if that trust and confidence is to be maintained.

Ongoing Evaluation

During the pilot phase for Supports for Daily Living, be sure to identify key metrics for evaluating the success of the service as measured against your objectives. Ongoing evaluation is important to ensure continuous quality improvement and return on investment as the service evolves and to evaluate whether or not it is achieving its' objectives.

The selected metrics should be monitored on a monthly basis to evaluate the impact the service is having on the referral of high risk seniors from hospitals, the CCAC and other health system providers and to quickly identify if an impact is not materializing. Aligning trending data to show the direct correlation between the service and system impacts on length of stay in hospitals, ED visits, long-term care admissions and ALC days is of primary importance in providing "proof" of effectiveness. Further, monthly monitoring is a useful way to spot the "uptake" of the service within the health care environment and to recognize when adjustments or further discussion/clarification should take place with health system stakeholders. When a new program/service is being "born", it is essential to stay on top of the data in order to be alert to a misalignment.

Metrics should also be used to evaluate whether those being referred to and admitted into the SDL service, meet established eligibility criteria and are, in fact, high risk seniors with needs at the MAPLe 3, 4 and 5 categories of assessment. Examples of the metrics and definitions utilized for monthly and quarterly reporting are provided in Chapter 7.

Laying the Foundation for Change

The effective implementation of a Supports for Daily Living program requires the full support of the entire health system, particularly that of hospitals, the CCAC, and the community support services sector. Every effort should be made to engage these broader health system partners as the success of the service relies on the active participation and support of others within the system. Equally important to the success of the program implementation is the leadership requirement of the LHIN. The MH LHIN was an active partner in the planning, design, evidence-based research, resourcing, policy input, implementation, communication and collaboration of the new program. It was a strategic decision to enable this partnership as the LHINs primary role is to manage health system transformation and this requires change. A change of this nature can be weighed down with many barriers, the least of which could halt progress. Given that the community support services sector hadn't traditionally addressed the needs of higher acuity clients, implementation of the new Supports for Daily Living service required a shift in thinking across the system. This type of change, in terms of recognizing the ability of Supports for Daily Living service providers to meet the needs of higher acuity patients, required the support and active participation of the LHIN.

Within the Mississauga Halton LHIN, the Supports for Daily Living (SDL) service evolved from the existing supportive housing program. With the infrastructure already in place for the 'Hub (in building)' service delivery model, changes in thinking were necessary to move supportive housing into a Supports for Daily Living/Assisted Living model that separated service from the bricks and mortar as well as providing a focus for acceptance of the higher need senior.

Supportive housing programs stand as a good starting point for any communities looking to implement an assisted living model of care like Supports for Daily Living (SDL). Having a current "stock" of supportive housing programs creates a centralized point of origin for utilizing the "hub" or "hub and spoke" model of service. If this "stock" is not available, a grouping of apartments/townhouses/homes/trailers/etc. where high risk seniors are located will provide the centralized "community" to create a "hub" or "hub and spoke" service. SDL providers have looked at a variety of changes that have either been implemented or are being considered for situating an office for staff to work from within these communities. Some examples are:

- acquiring an apartment within a building
- acquiring a rented house within the community
- acquiring a store-front office
- transporting staff into the community for their shift and then transporting them out of the community at the end of the shift

Even though the implementation of the SDL program was new to most of the supportive housing providers, some creative thinking and progressive planning enabled the transition or "shift" to a 24/7 frequency service model. This shift can be considered as the most significant change to the "old" supportive housing model and requires careful planning and scheduling of staff. The "hub and spoke" model makes such "shifting" considerably easier, as staff have a "hub" to work in and are readily available

for scheduled or unscheduled assistance or when emergencies occur. This availability has:

- played an essential role in decreasing the amount and frequency of emergency department visits
- allowed for greater efficiency as staff onsite can do other work, such as charting and reporting when not responding to client needs
- given SDL providers more flexibility in service provision in order to provide more frequent visitation to clients
- provided better continuity of client monitoring and service provision
- allowed for greater client satisfaction with service provision
- allowed clients and families a greater sense of comfort that safety and security are better assessed and monitored.

If the LHIN has groups dedicated to ED or ALC initiatives, these groups provide an ideal forum for the exchange of information regarding progress being made in the development of a Supports for Daily Living service. Referral patterns, processes, and tools need to work seamlessly throughout the system to ensure high risk seniors with complex needs that may be eligible for the service, are identified early on and the appropriate referrals are made.

Creating a sense of urgency for implementing the change based on provincial and LHIN priorities and client need and identifying leaders to champion the change are critical, as is frequent, consistent and relevant communication to gain acceptance across the health system and to support providers throughout the transition period. Quick wins and key milestones in the development of the service should be celebrated to keep people engaged and moving forward.

However, as with any change management initiative, it takes time for systems and providers to refocus their thinking around: a new paradigm of service, a requirement for higher levels of care, a greater turnover of clients as a result of increased levels of client acuity and the need for a more agile intake process to accommodate, in particular, hospital discharges. Barriers exist and need to be acknowledged in an open and frank manner – *change does need friends!*

Perhaps the greatest barrier to SDL implementation can be found in the culture of the agencies, institutions and stakeholders themselves. Breaking down the biases within organizations requires tearing down the walls and silo culture, that have taken years to build, and replacing it with mutual respect. Biases exist within healthcare – we have acknowledged and taken responsibility for the contribution these biases have made in blocking the flow of clients/patients throughout the system. Working to resolve these biases continues to be our greatest burden and our greatest success.

Cross-organizational trust, cooperation and collaboration are of paramount importance. It involves educating and re-educating across organizations, reinforcing concepts at every opportunity, correcting perceptions, following up with issues in order to resolve conflicts, ensuring a "culture" of no blame, coaching thinking and performance, utilizing fact and data to dissolve resistance, reinforcing benefits, believing in the vision and staying the course of action.

Patience is the greatest skill needed and the hardest to maintain! And just when you thought you had it right...you will need to re-educate and reinforce once again in order to sustain the gains made, to clarify roles and responsibilities and to foster trust. This is not said to dissuade you, but rather to provide the reality of true and effective change.

If you want change to "stick", you need to be prepared to continue the "journey" over the long haul. In the words of Winston Churchill, *"difficulties mastered are opportunities won."*

Strong Leadership and Champions

The development of a Supports for Daily Living (SDL) service requires not only visionary leadership, but the right individuals within the local health system to champion the initiative. Given the cross sector collaboration required for success, *strong leadership* is critical for ensuring system-wide engagement. Choosing a champion or champions is fundamental as he/she/they will ultimately lead the group implementing the change.

In the case of the SDL initiative, the MH LHIN sponsored an initial supportive housing working group to discuss and plan for a new and innovative approach to address health system pressures involving high risk seniors. This initial working group developed a vision for the Supports for Daily Living service based on what was current policy and evidence-based research. Testing the three (3) models of service delivery fell to a small group of three (3) service providers. Of this group of three, two providers were seasoned and experienced in working with seniors while the third provider was not. However, this proved to be of no consequence as the third provider became the champion for, and developer of, the SDL Mobile service model. Ultimately, this small group of three providers tested and implemented in 2008/09 the "hub (in buildings)" model, the "hub and spoke" model and the "mobile" model of SDL service. These champions laid the foundation of change for the remaining five (5) SDL provider agencies that followed in 2009/10.

With the progression of work, the initial supportive housing working group became the SDL Leadership Group sponsored by the LHIN. A chair was chosen from amongst the group to lead the initiative from a systems-level perspective while further shaping a model for Supports for Daily Living that focused on client need. In order to provide continuity and further a collaborative approach, the SDL chair was invited to sit on the LHIN Health Systems Leadership Committee that brought together hospitals, CCAC, LHIN and other system partners to discuss health system issues. This was one of the first occasions where a CSS sector provider had been invited to participate as an equal partner in health systems' issues. Under the LHINs sponsorship, this signalled a new change and the necessity of a new perspective.

The *leadership qualities* of those involved in the SDL initiative and that proved successful in the Mississauga Halton LHIN experience were those of establishing credibility, providing knowledge transfer, perseverance, the ability to challenge the status quo, the willingness to take risks and stay the course of action, the motivation to work long hours over an extended period, the capacity for innovation and new ideas, the aptitude for humour and motivating others, the talent for "selling" and communicating the initiative and the proficiency in gaining participation.

Funding and Accountability/Resourcing the New Models of Service

Embarking on a new program, like that of SDL, requires significant funding and with funding comes accountability (oversight and managing). However, before the journey began on the development of a new program, a solid foundation needed to be built and that foundation consisted of knowledge, data, targeted information and "placement" of the new program within the health care continuum as a frame of reference.

In 2007 the MH LHIN began studying supportive housing within the region. The LHIN was able to determine that:

- greater than 500 spaces were funded as supportive housing
- wait times for housing and services was 8 to 10 years
- there wasn't a standardized assessment for services
- there wasn't a differentiation between entry criteria for housing versus services
- a much younger population utilized the housing and services
- services were situated only in buildings
- a plan did not exist for where services and housing were situated (criteria not found)
- HSPs did not have standardized funding – funding was wide-ranging and did not permit higher need clients to stay on service if an HSP was funded at the low range
- standardization within supportive housing and across HSPs did not exist
- turnover was fairly high and HSPs identified that trained staff were being lost to LTC as a result of higher wages and full-time positions with a certainty of hours
- the number of supportive housing clients on service, though cumulatively large, were small in number at numerous sites

Supportive housing HSPs across the LHIN were surveyed to identify the number of service spaces funded, the number of clients served per year (turnover incorporated), the number and the status (FT/PT/Casual) of staff or whether services were contracted out to a third party, the cost per hour of service, and the amount of service provided to clients on a daily basis.

Following discussion with HSPs and the analysis of survey results, a new funding structure and performance standards were proposed. An example of the contractual letter for funding and performance expectations is provided in the Appendices section. The proposed new funding and performance standards structure:

Funding Structure	Rationale
Minimum of 30 clients in each site or new sites	• Allows for the hiring (greater retention) of staff – this number of clients would allow for FTE positions through consolidated service throughout the day/night
***Average* of 1.5 hours of service per client/per day**	• Average care by HSPs in MH LHIN was 30 mins per day (range: 20 mins to 2 hours per day/per client often offered in a one-time block)
Service funded at a rate of $34.00 per hour ($51.00 per day/per client - $18,615 per year per client) –	• LTC funded hours per person/per day = 2.4 hours • Significantly higher RUGs scores requiring greater resources to care for individuals in LTC

Funding Structure	Rationale
greater economies of scale in certain sites due to larger volumes of clients – in some sites cost has increased as smaller volumes of clients with higher acuity **MOBILE service rates are higher as a result of travel** **Ongoing evaluation of costs and effectiveness - efficiencies in delivery of services are a necessity**	• SDL program is not LTC and cannot exceed daily costs in LTC – if costs exceeded, need to question whether clients are appropriately placed in SDL – SDL program must "fit" within health care continuum and not cost the system greater than what can be produced • Hourly rate based on survey: if LHIN was wanting a higher level of acuity, then funding needed to match need and resource utilization (cost range per hour: $17.50 to $32.50 prior to standardized costing – only one provider @ the high-end range and needed to find greater efficiencies as well as move those clients who were at great risk and with a rapidly deteriorating condition (non-appropriate setting) • LHIN monitoring a requirement

Performance Standards (Accountability) Structure	Rationale
Implementation and use of the Common Health Assessment (CHA) instrument	• Reliable & valid data to show acuity levels of clients; was there a change in acuity?; highlighted profiles of clients; assisted in the formation of base measurement and ongoing evaluation
Ability to deliver on performance deliverables and targets	• New funding structure, ongoing funding predicated on outcomes of performance and meeting LHIN priorities along with return on investment
Availability of service throughout a 24 hour period	• Frequency model of care – testing the need for this type of service – core principle of the new models
Delivery of the 3 core services in the program (Personal Care, Homemaking, Attendant Care)	• Standardization – had to deliver on these services to be an SDL provider and be known in the community to be able to deliver on these services – staff levels brought up to standard where necessary
Collection and reporting of indicators and stats to the MH LHIN on a monthly and quarterly basis utilizing the document developed by the MH LHIN for the purposes	• Standardization of definitions for indicators and starting point to enable the measurement of return on investment
Contractual Letter signed by the HSP formed an amendment to the M-SAA and constituted a legal and binding document with the LHIN	• CEO/ED and Board Chair of HSP sign letter to bind organization

The Aging at Home strategy allowed the MH LHIN to strategically invest in the new SDL program, both to open new services and to change the majority of supportive housing over to the SDL models. In 2012 there are three small supportive housing providers remaining that have not been changed to the SDL models. Changes to two of the providers would not be a worthwhile investment since numbers are small and the geographic area has little demand for this level of intensity. However, one provider in a high demand geographic area with a need for increased intensity would be a worthwhile investment and will be considered as a potential site for resourcing. Further sites to consider are those with high densities of seniors that are high users of the health care system. These considerations will be a priority focus for the MH LHIN in the future in order to build on the success of the SDL program and to meet the needs of seniors in their familiar communities. Having already shifted approximately 1% of direct dollars to the community, the MH LHIN will be reviewing how future funding can be maximized to achieve specific targeted objectives. With future funding being limited, new ways of allocating existing funding to those areas that are able to deliver on priorities will be the new way moving forward. The SDL program will be required to continue to show efficiencies and effectiveness as well as new ways of delivering service in order to benefit from the new reality of healthcare funding.