Chapter Five

Roles & Responsibilities

"We have an excellent relationship with the Supports for Daily Living program. They are very responsive, very collaborative and we are always impressed by how often and how willing they are to think outside the box. The ability to customize a care plan for individuals in the community with SDL as our partners has been exceptional."

Cathy Raiskums, Manager, Social Work and Patient Flow
Halton Healthcare Services

CHAPTER 5: ROLES AND RESPONSIBILITIES

LHIN

SDL Providers

Central Registry

Hospital(s)

CCAC

CSS Services

Other Providers

LHIN

LHINs are mandated by the Government of Ontario to plan, coordinate, integrate and fund health care services at the local level. Given that mandate, the role of the LHIN in generating a Supports for Daily Living service should be to:

- create a vision for 'aging at home'
- facilitate and engage service providers to implement the key elements that will help realize the vision
- be a risk taker in recognizing the potential of an initiative to generate health system improvement even if there is no concrete evidence at the time
- make the necessary investments to allow the initiative to realize its potential
- set up an effective monitoring and performance management system.

In supporting the work of the team charged with developing a Supports for Daily Living service, the LHIN should be accountable for setting the pace for the fulfillment of team goals and activities as aligned with its vision for 'aging at home'. This includes setting expectations for work group activities and providing ongoing support and encouragement to the work group chair and/or project lead. It is also important that the LHIN take a leadership role in advocating on behalf of the team at the LHIN and health system level to ensure the active participation and support of other key partners within the health system.

The LHIN is also accountable for establishing SDL service provider criteria and contract deliverables and for monitoring performance.

SDL Providers

Community Services Sector (CSS) service providers that are responsible for delivering the Supports for Daily Living service accept accountability for taking a leadership role in helping to keep high risk seniors with complex needs (MAPLe 4 and 5) out of hospital and long-term care homes by delivering services that help them to continue living in their own homes as long as possible. The services they provide help divert unnecessary visits to hospital emergency departments, prevent premature admissions to long-term care, support repatriation of eligible long-term care residents back to the community, and contribute to a reduction in alternate level of care (ALC) days in hospitals.

A commitment to quality, client-centred care delivered in a timely and consistent manner is characteristic of SDL service providers and critical to client satisfaction. It is vital that SDL service providers maintain close linkages with hospitals, the CCAC and long-term care homes to promote education and understanding of SDL services and to clarify how the services can be leveraged to support more efficient and effective use of hospital, CCAC and long-term care resources.

The value that SDL service providers contribute to health system functionality can't be underestimated. The Supports for Daily Living service is a fine example of tapping into the potential of the CSS sector to build capacity within the system.

Central Registry

SDL program referrals are funnelled through a single point of access within the MH LHIN called the SDL Central Registry. Although operated on behalf of all the SDL providers, the SDL Central Registry and its employee, the SDL Systems Manager, is charged with managing the flow of referrals in the best interests of the healthcare system to optimize resources. This successful model ensures the integrity of the SDL eligibility standards while operating with a birds-eye view of the short-term and longer-term priorities within the system.

All referrals are received at the Central Registry and priority is then determined through the combined anaysis of the healthcare system pressures coupled with the client's level of need for SDL service. Priority referrals are assessed (with the Common Assessment Tool – RAI-CHA) within 48 hours and approved based on the objective eligibility criteria. Once a referral is deemed appropriate, it is redirected to the most appropriate SDL service provider based on geographical location and service availability. Additional responsibilities for the SDL Central Registry include assisting with the balancing and transfering of clients among SDL Providers to ensure optimization of client flow and the tracking and management of referral data.

The benefits of this Central Registry model include:

- Simplifying the referral process for community partners (one number to call)
- A single knowledge base of information regarding the availability and features of each of the SDL services within the MH LHIN
- A third-party view of determining eligibility ensures an objective and consistent approach to decision-making
- A solitary waitlist ensures accurate representation of the demand for SDL services

The awareness that referral sources are, in fact, the Central Registry's 'customers' and responding to meet those customer needs is the key to success for the Central Registry model. A customer-service focus and responsiveness are illustrated by the expansion of business hours to enable access on weekends and evenings and the agility to respond to hospital surges in times of system stress.

Hospital(s)

The relationship between hospitals and SDL service providers is an important one. Recognizing Supports for Daily Living as a viable discharge option for high risk seniors with complex needs can make the crucial difference between a patient being designated ALC and prematurely discharged to long-term care or returning to the comfort of their own home with supports. When hospitals are reviewing discharge plans for high risk seniors - particularly those who require frequent, urgent and intense personal supports to allow them to return home - engaging an SDL representative in the dialogue can quickly determine whether or not Supports for Daily Living is a realistic option. That liaison might take place over the phone or in a meeting where the discharge plan(s) for one or more patients are being discussed.

Once a patient has been identified as a potential candidate, an SDL representative will visit the patient at the bedside to conduct a more thorough assessment and set the wheels in motion for discharge home with appropriate SDL supports.

It's important that hospital social workers and discharge planners receive thorough and ongoing education about Supports for Daily Living so that it is among the considered options for high risk seniors with complex needs.

CCAC

Paramount to the success of SDL services is the role of the community care access centre. CCACs are often the point of access or link to in-home, community-based and long-term care services, as well as information and referral. Seen as the 'system navigator', they are increasingly being positioned as the place to go to get information about health, community and social services.

It's important that both SDL service providers and the CCAC understand and respect the distinction between the levels of personal support services they each provide. CCAC personal support services are delivered based on a visitation model. Clients receive services between the hours of 6 am and 12 am (midnight) during larger pre-scheduled blocks of time. SDL personal support services, on the other hand, are pre-scheduled over a 24-hour period in smaller increments of time to allow for increased frequency and intensity of services as well as featuring an on-call response.

By transferring existing CCAC clients who are eligible for SDL services or in referring potential clients from hospital or community settings, the CCAC is able to free up existing personal support resources to focus on the needs of other clients in the community who are eligible for CCAC services. Given SDL is a non-medical model, CCAC clients eligible for SDL services may still require CCAC professional services like nursing and rehabilitation care. SDL removes some of the existing pressures on CCACs and long-term care homes by freeing up resources and improving access to care.

CSS Services

There lies significant untapped potential among CSS service providers. The sheer breadth of services delivered by CSS agencies within their communities is staggering. This is often why, in the past, it has been difficult to gain a handle on the services available and how they can best be leveraged along the continuum of care within the local health system.

Supports for Daily Living is a fine example of how out-of-the-box thinking, open-mindedness, and a focus on client-centred care was able to transform a cluster of like-minded agencies into a dynamic and meaningful service model that maximizes their expertise in community-based care with high risk seniors. Working with their local LHIN, CSS agencies can better understand how their services align with local health system priorities and how they might contribute to helping the LHIN and other health system partners to address system pressures.

CSS service providers will be increasingly looked upon to support clients with higher level needs as health systems experience a shift to more in-home and community based care, allowing hospitals to focus on those with higher acuity needs.

Other Providers

Family physicians, family health teams, pharmacists and other providers within the health system that come into contact or work with seniors should be educated about the Supports for Daily Living service so that they are aware of its role and how to refer to the service. As health systems transition to more in-home and community-based care options, like Supports for Daily Living, the importance of providers adopting a 'Home First' philosophy and eliminating the routine practice of referring high risk seniors with complex needs to long-term care must be continuously reinforced to effect a positive change in practice.

In the development of regional health systems, it is critical that SDL providers not only have partnerships (formal and informal) with existing health service providers, but also reach out to the broader resources that exist within communities and serve a multiplicity of client needs such as income security, nutrition, social interaction, transportation, etc. By reaching out to other resources, clients will be "put in touch" with the services and supports to function in the community. SDL providers have the ability to leverage these community resources by acquiring knowledge of the resource, collaborating for smooth transitions between providers and ensuring that clients are able to access services regardless of where they enter the system. These types of partnerships require time and effort on the part of SDL providers. However, the ability to engage with local hospitals, long-term care homes, CCAC's, Public Health, primary care such as community health centres and family health teams as well as general practitioners is essential to building an integrated and coordinated service delivery system for all clients, caregivers, stakeholders and service partners.