SHARE

# Housing with Health Supports- Northern Experience

NOSDA

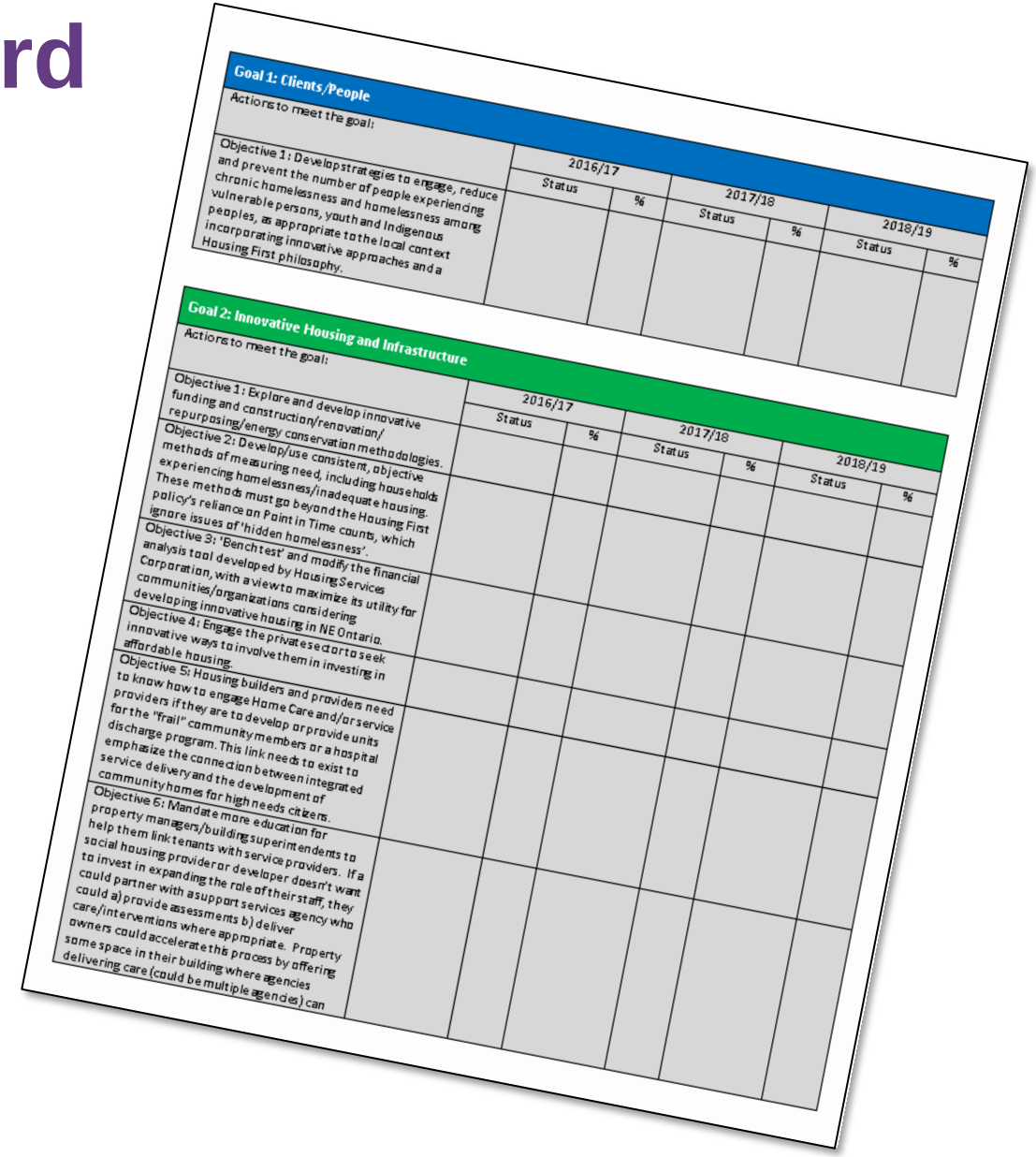
CDSSAB

HSC

# Housing with Health Supports
# NE LHIN Experience

Sherry Frizzell– North East Local Health Integration Network (LHIN)

# Moving Forward



| Goal 1: Clients/People | | | | | | |
|---|---|---|---|---|---|---|
| Actions to meet the goal: | 2016/17 | | 2017/18 | | 2018/19 | |
| | Status | % | Status | % | Status | % |
| Objective 1: Develop strategies to engage, reduce and prevent the number of people experiencing chronic homelessness and homelessness among vulnerable persons, youth and Indigenous peoples, as appropriate to the local context incorporating innovative approaches and a Housing First philosophy. | | | | | | |

| Goal 2: Innovative Housing and Infrastructure | | | | | | |
|---|---|---|---|---|---|---|
| Actions to meet the goal: | 2016/17 | | 2017/18 | | 2018/19 | |
| | Status | % | Status | % | Status | % |
| Objective 1: Explore and develop innovative funding and construction/renovation/ repurposing/energy conservation methodologies. | | | | | | |
| Objective 2: Develop/use consistent, objective methods of measuring need, including households experiencing homelessness/inadequate housing. These methods must go beyond the Housing First policy's reliance on Point in Time counts, which ignore issues of 'hidden homelessness'. | | | | | | |
| Objective 3: 'Bench test' and modify the financial analysis tool developed by Housing Services Corporation, with a view to maximize its utility for communities/organizations considering developing innovative housing in NE Ontario. | | | | | | |
| Objective 4: Engage the private sector to seek innovative ways to involve them in investing in affordable housing. | | | | | | |
| Objective 5: Housing builders and providers need to know how to engage Home Care and/or service providers if they are to develop or provide units for the "frail" community members or a hospital discharge program. This link needs to exist to emphasize the connection between integrated service delivery and the development of community homes for high needs citizens. | | | | | | |
| Objective 6: Mandate more education for property managers/building superintendents to help them link tenants with service providers. If a social housing provider or developer doesn't want to invest in expanding the role of their staff, they could partner with a support services agency who could a) provide assessments b) deliver care/interventions where appropriate. Property owners could accelerate this process by offering some space in their building where agencies delivering care (could be multiple agencies) can | | | | | | |

# Goals & Objectives

**There are 4 broad Goals and 43 specific Objectives in the Innovative Housing with Health Strategic Plan:**

- **Goal 1 –** People/Client – Client orientation
- **Goal 2 -** Innovative Housing and Infrastructure
- **Goal 3 -** Innovative Health/Social Support Provision (service design and delivery)
- **Goal 4 -** Innovative Leadership and Sponsorships

# Goal 2 - Innovative Housing and Infrastructure

- Services between the SM and NELHIN to be collaborative and held within a hub model to service tenants in the community.

- In conjunction with priorities 3 and 4; the NELHIN review and consider consolidation of services, in cluster model, to allow for better on-site services to residents.

- Identify and share addresses of DSSAB housing and overlay with NE LHIN HCC services within those geographic areas. Work together to develop service delivery plan which ensures; reduce number of service providers in the building, service delivery model developed to reflect clustered care

# Goal 3 - Innovative Health/Social Support Provision (service design and delivery)

- Ongoing Commitment of the NELHIN for funding Transitional Community Support Worker
- Transitional support workers approach
- Develop/Incorporate a centralized waitlist/Registry to prioritize persons requiring support services and housing.
- Work towards common intake form which identified support service and/or health needs

# Goal 4 - Innovative Leadership and Sponsorships

- NE LHIN invests 25% of community funding to supports and services for vulnerable populations -provide report back Goal 4 recommendation 8

- Develop urgent priority waitlist for social housing for persons without shelter or with inadequate shelter or supports. Priorities individuals identified as ALC in hospital to return to community.

- Continuation of the NELHIN to advocate for additional housing and health investments from the Ministry of Health to support “aging in place”.

## Progress on NE LHIN priorities

- 76 Mental Health and Addiction rent supplements and 9.5 FTEs across NE LHIN 2017/18, 2018/19
- Invested 67% of  discretionary funding (Community+ MN/A) to vulnerable populations- First Nation, MH/A and frail seniors
- Channelview, Sunset Court – neighbourhood model
- Priority wait list for ALC patients in some areas not all
- Mental Health First Aid training

# Next steps

- Naturally Occurring Retirement Community
- Determine how are we going to move 10 priorities forward – collaboratively or separately
- Set timelines/milestones
- Establish Housing Lead position with NE LHIN

# Even better if

- Health assessment tools need to be considered as part of intake into housing.
- Common language
- Continue building relationships
- Knowledge transfer in order to continue building towards common goals

# Things we can work on together

- Understand competing interests
- Recognize portfolio / work demands
- Understand geographic challenges
- 8 unique housing, 1 LHIN, 168 providers
- Strive towards common intake process – address needs across sectors
- Ongoing collaboration
- Focus on priorities

# Thank You

**Quality health care when you need it.**

**Des services de santé de qualité au moment voulu.**

**Ezhi gshkitoong go waani zhi mino yang naadgo wendming pii ndo wendaagog**

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North East **LHIN** | **RLISS** du Nord-Est

# ONE Client ONE Plan (OCOP)

## A Project of Partnerships in Home & Community Care

## Rethinking Housing for Better Outcomes in Northern Ontario Presentation

## June 12, 2018

Ontario

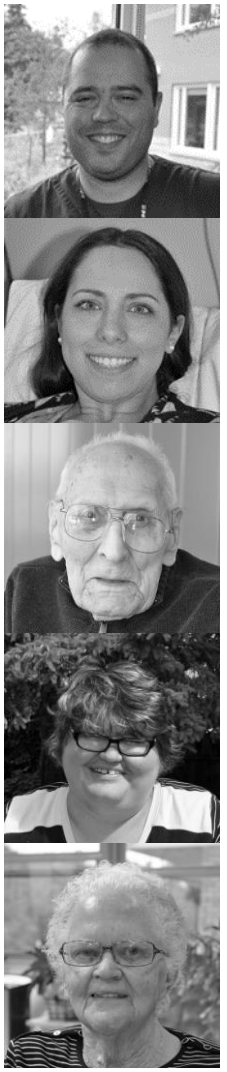
North East Local Health Integration Network

Réseau local d'intégration des services de santé du Nord-Est

# ONE Client – ONE Plan: VISION

ONE Client - ONE Plan is to deliver a consistent person-centered approach to care planning with clients/families that is inclusive of, and accessible to all authorized personnel/providers.

Resulting in clients telling their story ONCE.



# System Alignment

**Patients First**

Improve the Patient Experience

## Mandate Letter – Ministry/NE LHIN Collective Priorities

- Improve access to primary care & reduce wait times for specialist care, mental health and addictions, home and community, acute care
- Break down silos between sectors and providers to ensure seamless transitions for patients
- Support innovation by delivering new models of care and digital solutions

## NE LHIN Current Integrated Health Service Plan

**Access –Coordination – System Sustainability**

**One Client One Plan**

Client-centred, seamless service delivery, improving the client experience

# One Client One Plan: Goals

- **Improve the client experience when accessing Home and Community Care.**
- **The client will be informed of and connected to their service choices based on their identified care needs**
- **The client will tell their story once and add to their story as their needs change.**
- **Transform home and community care services into one cohesive system**

# ONE Client ONE Plan: Objectives

- **Develop a single point of contact for HCC clients**
- **Develop a standard process with appropriate tool to identify services**
- **Remove duplication in Home & Community Care assessments by further sharing of assessment data**
- **Develop a standard approach to the coordination of services**

The following peripheral enabling systems and processes may be leveraged to achieve OCOP objectives:

- Client/Patient engagement
- Naturally Occurring Retirement Communities (NORCS)
- 10 Point Digital Health Action Plan
- Maximize existing enabling technologies
- Housing with Health Supports
- Levels of Care Framework
- Family Managed Care

**ENABLING SYSTEM & PROCESS**

# Road Show: Engaging with Our Providers

**Feb & March, 2018: 35 engagements** logged so far **…** and more to come. Providers are ready and see the need to create a seamless HCC experience for our clients:

- *The onus should not be on the clients to initiate services between providers when their care needs change*
- *The time for change is now and we are ready!*
- *Our clients need us to change."*
- *We cannot continue to do things as we always have. We all have to move past our old ways of thinking, come together and work together better for our clients' sake.*
- *We can now finally see where all the work we are doing and have done fits in.*

# Betty's Journey Workshop – March 27 & 28

- 120 Home and Community Leaders + Patient & Family Advisory Committee
- Workshopped15 scenes from Betty's story – to create current state (challenges, issues, needs)
- Mapped ideal state paths for both Betty and HCC Providers
- Generated improvement ideas to address issues/needs

**Action Plan ready May 31st**


# Accomplishments from Betty's Journey Work Shop

- Conducted analysis of the work shop data and confirmed that the project goals & objectives are aligned with identified issues and needs of the Home and Community Care system
- Prioritized improvement ideas by prevalence and generated themes for the OCOP work plan
- Task lists were created for each theme to build the OCOP work plan
- Identified solutions already in place that can be spread across the HCC continuum e.g. technical solutions, assessments, etc.
- Leaders encouraged creativity beyond organizational walls, e.g. sharing resources, sharing work to remove duplication, etc.

# What are the benefits for Betty?

- Single point of access to all NE LHIN funded home and community care services.
- Betty only needs to **tell her story once** to benefit from coordinated care, focused on her needs.
- Her **privacy** will continue to be highly respected and upheld.
- Betty will have **one care plan that all home and community care providers can access within her circle of care.**
- With the OCOP, Betty won't get lost trying to find the care she needs.
- Betty will receive programs and services, based on her needs and eligibility, **seamlessly without being transferred or discharged** from programs or providers.

# Next Steps…

- Engage with other projects, other LHINs and local providers to leverage and expand successfully implemented ideas
- Continue building the post-work-shop OCOP Work Plan
- Request OCOP be a standing agenda item at regional and local planning tables
- Recruit people from the tables to participate in OCOP project focus groups to help with decision-making and executing project tasks
- Work on identified project focus areas…

# Work plan focus areas for the next 3 months are:

- Define “Single Point of Access”
- Requirements gathering for technical solutions
- Environmental scan to determine technological needs of each organization
- Privacy and network security requirements gathering
- Define Health Information Custodian to enable further information sharing among partners
- Further develop project metrics

# …To Ultimately Achieve ONE Client ONE Plan

…as one system:

# HOME AND COMMUNITY CARE

# Thank you, Merci, Miigwetch