ID	Project Name	Brief Project Description	Partners	ALC/ER Strategy (which of the 4 MOHLTC priorities the project will impact)	ER/ALC Indicators (Performance)	Financial Requests	Financial Requests	Financial Requests
						One Time	Operation	TOTAL
1	First Link (New)	The First Link Dementia Referral program offers coordinated support, education and linkage to individuals with dementia and their families/caregivers as soon as possible after the point of diagnosis and throughout the continuum of the disease. The primary objective of First Link is to provide recently diagnosed individuals with dementia and their caregivers comprehensive and coordinated services by identifying and reaching out to them as early as possible in the disease process. First Link targets community health care partners to enable them to improve their ability to recognize and treat Alzheimer's disease and other related dementia in their patient population early in the disease (primary care) and refer people directly to education and support to the Alzheimer Society and other community partners and as the Alzheimer journey unfolds, for home supports as needed. The Alzheimer Society Chapters would offer ongoing links to the wide and complex network of health and community support services in Central West LHIN so that appropriate services can be called upon at the appropriate stage.	Alzheimer Society of Dufferin, Alzheimer Society of Peel, Trellis, Central West CCAC, Mel Lloyd Family Health Team, Orangeville Family Medical Centre; Dr. Carol Mills, Telecheck Dufferin, Dr, Dianne Giacomelli, Physicians at Credit Valley	Admission Avoidance / Timely Discharge Initiatives Enhanced Home Care	Frequency of calls, frequency of calls from hospital, frequency of calls from CCAC, Trellis Mental Health, Family Health Teams, frequency of calls from specialists at time of diagnosis, # and type of referrals received, # and hours of volunteers, self report on coping and confidence indicators	18600	165900	184500
2	Telecheck Peel (Expansion)	TeleCheck, a program dedicated to Seniors operates from 8.30am-5pm on all working days of the week. By reminding a senior about their medication or checking on them so as to see how they are doing instills hope and a sense of well-being in them thereby reducing anxiety and feelings of fear/worry. The staff at TeleCheck continues to provide educational tips on "Injury/fall prevention", "Elder abuse", "Diabetes and heart care programs and workshops" happening in the region to all the seniors in its program. By doing this, the program aims to empower the seniors with pro-health information and hence reducing the repeated visits to the ER.	Alzheimer Society of Dufferin, Alzheimer Society of Peel, Telecare Distress Centre, Community Torchlight Wellington/Dufferin, WOHS, Central West CCAC, Salvation Army: Brampton, Fibromyalgia Group, Peel Senior Link	Admission Avoidance / Timely Discharge Initiatives Enhanced Home Care Outreach Teams	Total number of TeleCheck clients who are experiencing isolation as well as complex health issues and the proportion of ethno-specific seniors in that group Total number of TeleCheck clients who are given medication reminders regularly Total number of TeleCheck clients with complex health care needs and have made a visit to ER in the last few months An annual evaluation conducted by an outside consultant	4000	91697	95697
3	Transportation Network (Expansion)	The Transportation Network will support seniors throughout the service area to attend medical appointments and related treatments. 16,500 rides are projected for 2010/11 and an estimated 10% of these rides for rehabilitation and medical treatment will result in an ER diversion. The transportation network with enhanced coordination, scheduling and support plus an expanded fleet of vehicles will also underpin the Home at Last discharge program that is funded LHIN wide and supports both Headwaters Health Centre and William Osler Health System – Brampton Civic and Etobicoke General Hospitals. Currently the Home at Last Program is funded for 350 discharges annually and under a separate funding request, if approved, would expand to 750 discharges and 1500 units of service.	CANES, Red Cross, Etobicoke Service for Seniors, Punjabi CHS, Dixon Community Services, United Achievers	Enhanced Home Care	Number of patients diverted from ER ALC rates, Wait Time to discharge destination) Rate of rides for medical appointments Rate of rides met for rehab medical appointments		112993	112993
4	Home First (New and Expansion)	The funding will be utilized to expand the current "Wait at Home" service to support more patients to be discharged home sooner with enhanced community services resulting in reduced ALC days and increased acute care capacity. A second component of the initiative will be "Home First" which will offer an enhanced service package to a larger proportion of ALC patients. In addition to patients waiting for LTC the "Home First" program will be expanded to include ALC patients currently waiting for in-patient reactivation/convalescent services to go home and receive enhanced services for up to 6 months. The expanded service would capture the population currently classified as ALC/CCC LTLD (long term long duration rehabilitation), ALC/ Rehab/LTLD and ALC/Convalescent Care. This service will also be available to clients presenting in Emergency Departments who are at risk of being admitted to acute care due to high service needs in the community. It is anticipated that this funding will support 100 ALC clients to be discharged home in 2010/11. In order to reduce confusion and support smooth transitions, the enhanced service package	Central West CCAC, WOHS, Headwaters Health Care Centre	Enhanced Home Care	# of Clients enrolled in the Home First program, # beds days saved in acute care as a result of Home First, client/family satisfaction with the program, # of clients diverted/delayed from LTC though Home First, overall reduction or reduction in rate of increase in new LTC Home applications per LHIN area, % of clients deciding to remain at home vs. LTC admission, cost per client/year.		1344107	1344107

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5	Palliative Outreach (New)	This project proposes a consultative palliative care model, built around three Advanced Practitioner Nurses (APNs) and a shared care approach to community and hospital based outreach. This model will have a favorable impact upon the use of ERs and ALC beds across all cohorts of seniors' hospital and care bed use. Three APNs will be supported by a hub of centralized leadership provided by the Network's Executive Director.	Central West CCAC, Central West Palliative Care Network, Dorothy Ley Hospice, Palliative Care Consultation Program, Headwaters Health Care Centre, Heart House Hospice, Hospice Caledon/Bethel House, Hospice Dufferin, Leisureworld Brampton Woods, WOHS	Admission Avoidance / Timely Discharge Initiatives Outreach Teams	Number of unnecessary hospital ER visits avoided, Number of unnecessary hospital admissions avoided. Currently the ED Notification System is in place through our regional hospitals. Triggers, such as known CCAC clients, allow embedded ED Case Managers to be alerted when this population comes into the ED. Building on this established system a matrix can be added that allows the ED Case Manager to indentify SCR 95 clients and alert the SCT. Once contacted the SCT can mobilize to problem solve with ED staff to bring the client back home and avert hospital admission.		620000	620000
6	Francophone Health Promotion Services Central West LHIN (New)	The Francophone Health Promoter plays a key role in the development, implementation, and evaluation of community health initiatives in the community, working within Bramalea CHC Service Delivery Frameworks (Asset Based; Anti-Oppressive; Harm Reduction; Advanced Access; Fluid and Mobile Service). The Francophone Health Promoter will specifically provide health promotion activities to the Francophone community, including to Bramalea CHC priority population groups– Youth; Families who are under-resourced; People who are homeless, under-housed, or at risk of homelessness; People who are dealing with addictions and/or mental health issues; isolated Seniors; Newcomers; and Racialized communities. The Francophone Health Promoter will offer health promotion and education services for those who wish to receive services in French.	Centre de Services De Sante: Peel et Halton, Bramalea Community Health Centre	Enhanced Home Care Outreach Teams	Number of clients, improvement in self-perceived health status, reduced ER visits of participants by 10%, Currently the ED Notification System is in place through our regional hospitals. Triggers, such as known CCAC clients, allow embedded ED Case Managers to be alerted when this population comes into the ED. Building on this established system a matrix can be added that allows the ED Case Manager to indentify SCR 95 clients and alert the SCT. Once contacted the SCT can mobilize to problem solve with ED staff to bring the client back home and avert hospital admission.		91063	91063
7	Bridging You Home (Expansion)	Care and accommodation services will be provided for seniors in a retirement home setting on a short term basis (average of 21 days) to prevent hospital admission or to assist in the transition from acute care to the community. In addition care will be provided for three days on discharge to assist seniors in transitioning home. Currently one bed is being funded. This proposal is requesting funding for an additional bed.	Lord Dufferin Centre, Dufferin County Community Services, Compassionate Care, Eglinton-Bayview Physiotherapy Centre	Additional Temporary Care Bed Capacity	Occupancy rate and hospital readmission rate		74372	74372
8	Seniors Social Worker Support (Change)	The purpose of this proposal is to include the expertise of a Social Worker in existing assisted living supportive housing programs aimed at maintaining seniors in their homes. This person would be responsible for enabling seniors and their families to be active participants in their own care and life choices, assisting them in making decisions concerning suitable housing and care options. They will work collaboratively with the mental health services in the community (ie. CAMH; Psycho geriatric Assessment, Consultation and Education [PACE] Peel) to provide care to those identified with mental health issues, dementias and/or behaviors. He/she would also be instrumental in providing bereavement counseling and facilitating caregiver support groups. Group approach provides an economy of scale:One professional can facilitate discussion; the group setting provides emotional support in an understanding and accepting atmosphere, and enhances each participant's self worth.	Holland Christian Homes, Peel Senior Link, Ontario March of Dimes	Enhanced Home Care	There are 800 +/- seniors potentially eligible for the services of a social worker at any given time. Performance Indicators will include:Clients served, Number of ER visits avoided as a result of intervention, Number of transfers to hospital and hospital admission avoided, Number of discharges home vs. ALC waiting for placement. Targets:20 % reduction in transfers to ER-Of those transferred, a 10% reduction in admission to hospital-Of those admitted, a 10% reduction in ALC. We will use last year's statistics as a benchmark.		90500	90500

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9	Adult Day Program and Support Services (Expansion)	Project to build on existing Adult Day Program to accommodate waitlisted clients. Currently, there are 18 individuals on the waitlist with a utilization rate of 138% with 24 clients waiting for additional days. With this expansion 150 additional South Asian seniors residing in Brampton, Malton, Caledon, and Etobicoke North can be served. Adult Day Program and comprehensive enhanced basket of support services will assist seniors in managing their care and remain in their own homes safely as long as they are able, thus reducing ER visits and addressing the ALC issues.	India Rainbow Community Services of Peel, Supportive Housing in Peel, Central West CCAC, WOHS - BCH, Alzheimer's Society of Peel	Enhanced Home Care	Regular attendance in our program, request for additional days, waitlisted clients, request for extended hours, number of referrals received, improved mobility and reduced falls, increased participation level in various stimulating activities, reduced social isolation, agitation, positive attitude, wellbeing and increased muscle endurance, increased safety for clients, and healthier environment reducing ER visits, clients progress, number of seniors served from the diverse South Asian community		351195	351195
10	Treat at Home: Integrated Psychogeriatric Response Program (New)	The TREAT AT HOME Integrated Psychogeriatric Response Program (IPRP) is a seamless continuum of key health provider partner services which will both deliver and coordinate an intensive level of specialized clinical, health and community-based treatment and supports to seniors with serious mental health concerns and other complex, comorbid health issues. Through established service agreements, partner organizations will serve seniors in their homes who require assessment, clinical and supportive monitoring, and intensive in-home delivery of mental health and primary care treatment services in order to prevent unnecessary use of ER (visits and length of stay) and inpatient facilities.	Reconnect Mental Health Services, CHMA Peel, CANES, Telecare Distress Centre, Bramalea CHC, Rexdale CHC, Central West CCAC, WOHS	Admission avoidance / Timely discharge initiatives	# admissions avoided based on documented pre-program ER admissions of TREAT AT HOME cohort, %ER admission reduction of mental health presentations at WOHS ER, decreased ER time for individuals with mental health concern, # seniors with mental health issues accessing TAH program; # units of service delivered, # volunteers recruited/trained (10 from core language/cultural groups: Punjabi, Urdu), decrease in ALC days for mental health seniors	35000	274290	309290
11	Malton Village - Respite Care (Expansion)	The Respite Care program (2 beds) will provide temporary caregiver relief from the emotional and physical demands of caring for a friend or family member. This program aims to prevent burnout and may prevent ER visits and/or defer LTC placement, decrease the social isolation of both the client and caregiver and promote healthy aging in place. Clients will receive socialization opportunities, nutritious meals and snacks, physical and recreational programming, and medical and nursing services as needed during their temporary stay.	Region of Peel, India Rainbow, Central West CCAC	Additional Temporary Bed Capacity	Number of clients served, number of units of service provided, number of nursing interventions that divert ER visits, client/caregiver satisfaction rate, occupancy rate of two dedicated respite beds at Malton Village LTC (Target 85%)	5000	109091	114091
12	Telemedicine Services/Nurse Practitioner Program (New)	The purpose of the Telemedicine / Nurse Practitioner (NP) proposal is aimed to reduce Emergency Room (ER) demand by improving access to the WOHS and an array of health care services where they live through the use of OTN's technology. The LTC Telemedicine specialist will facilitate consultation with WOHS NP through regular prescheduled case conferencing. This proposal is a proactive strategy aimed at offering LTC residents the opportunity to make optimal use of health services on-site to prevent medical acuity / crisis leading to hospital visits.	Region of Peel, WOHS, Ontario Telemedicine Network, CANES	Enhanced Home Care	Number of Nurse Practitioner interventions that divert ER visits, number of residents served by Nurse Practitioner, will obtain data from the hospital NP initiative as baseline data and measure from the date of commencement	52350	53690	106040

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13	Peel Manor - Expansion of Adult Day Service to Saturdays and Sundays (Expansion)	Peel Manor Adult Day Program is an integrated day service for older adults who are functionally frail, physically disabled as well as those with Alzheimer disease and other progressive cognitive disorders. The goals of the program are to achieve and maintain clients maximum level of functioning, prevent premature and inappropriate institutionalization, provide day respite, provide support and assistance for caregivers, promote health, wellness and prevention activities, provide social, recreational and therapeutic activities, support clients to live in their own homes with the provision of enhanced levels of care i.e. personal care, bathing, nursing, registered dietary services and physiotherapy	Region of Peel, Central West CCAC, SHIP	Enhanced Home Care	Decreased wait time for admission to ADS, increased number of clients served, increased number of units provided, number of nursing visits preventing unnecessary ER visits, level of satisfaction with service documented via Client/Caregiver Satisfaction Survey		70634	70634
14	Rural Geriatric Seniors Outreach (New)	The Central West CCCAC working with partners will support seniors to "Age at Home", reduce demand for Long Term Care and reduce hospital ALC days, particularly in the Dufferin/Shelburne and Caledon/Bolton areas. The program will integrate services that support seniors transitioning from hospital to home, and maintain rural seniors at home. Services will maximize health gain and independent living, prevent unnecessary admission to an acute hospital bed, support timely discharge, and reduce use of long-term care. The goals include facilitate discharge home for rural elderly patients in hospital, provide services for new clients to support them at home, prevent hospital admissionand, increase CCAC rural presence with satellite offices in close proximity to existing community services. Services include PSW Support, professional services (e.g. nursing for chronic disease monitoring, therapy for assessment and maximizing functional support). Improve connections (through system navigation and community linkages) for clients to community services and initiatives.	Head Waters Health Care Centre, William Osler Health Centre, Dufferin Community Support Services, Caledon Community Services,Mel Lloyd Family Health Team	Enhanced Home Care (Building community based services)	# of Clients enrolled in the rural geriatric care initiative over 75 years old # beds days saved in acute care as a result of discharge home Client/family satisfaction with the program (will target increased sample selection from this area) # of clients diverted/delayed from LTC Overall reduction or reduction in rate of increase in new LTC Home applications per LHIN area % of clients deciding to remain at home vs. LTC admission Cost per client/year Decrease in readmission rate to hospital or ED within 72 hours from hospital discharge		244899	244899
15	Occupational Therapy - Specialized Geriatric Services (New)	Data identifies that sixty percent of the patients that currently occupy continuing complex care beds at Headwaters Health Care Centre require slow stream rehabilitation. In order to maintain access, flow and challenges due to length of stay and ALC there is need to provide additional rehab services to move patients through the system. This initiative proposes adding 1 Full time Occupational Therapist to the interprofessional team. The addition of an Occupational Therapist will provide timely intensive rehabilitation support to meet the complex senior's needs and increase the hopsital's ability to discharge patients earlier to home. This will allow a seamless transition from hospital to community.	William Osler Health Centre, CCAC, Headwaters Health Care Centre	Additional Temporary Care Bed Capacity / Timely Discharge Initiatives	Inpatient Consultations -Number of patients seen by Occupational Therapist. Length of stay – Reduced Average Length of Stay including ALC days for patients in CCC slow stream rehab		100000	100000
TOTAL FINANCIAL REQUESTS						**114950**	**3794431**	**3909381**