BELLWOODS
INNOVATING INDEPENDENCE

TRANSITION PROGRAMS

MOBILE INDEPENDENT
LIVING EDUCATION (MILE)
COMMUNITY CONNECT
CAREGIVER RECHARGE IN-HOME RESPITE
HOUSING WITH LAYERED SUPPORTS

SEPTEMBER 2019

INFORMATION SHEETS

ABOUT US

Established over 60 years ago, Bellwoods is a charitable, not-for-profit organization providing community-based, client-directed support services, independent living education programs, and accessible, affordable housing. Services are provided to adults (16+) with physical support needs, seniors, and individuals with mental health and addiction challenges as well as those at risk of homelessness. Bellwoods has been accredited by Accreditation Canada since 2007 and in 2013 and 2018 received the highest accreditation: "Accredited with Exemplary Standing."

Bellwoods provides personal support services to people living in the community and at its supportive housing sites. It also offers a range of Transition Programs that include education and care navigation as well as a reintegration unit and an in-home respite program to support clients ready to leave hospital following an illness or a debilitating injury.

Through partnership development, Bellwoods focuses on meeting the needs of clients and responds to community needs and health system priorities. Our voluntary Board of Directors represents the communities we serve.

WHAT WE BELIEVE IN

Our Vision:
We envision a future where barriers do not exist.

Our Mission:
Transforming lives through excellence and innovation in independent living.

Our Values:

- Client & family centred services
- Delivering high quality programs
- Building collaborations & partnerships
- Performance excellence
- Ensuring staff are valued, engaged & supported

300 Shaw Street

COMMUNITY CONNECT (CC) PROGRAM

The **Community Connect (CC) Program** is one of Bellwoods' Transition Programs. CC is one of the reintegration care units (RCUs) funded by the Ministry of Health and Long-Term Care (MOHLTC) and the Toronto Central LHIN (TC LHIN) as part of a series of pilot projects testing the value of Short-Term Transitional Care Models (STTCMs) in facilitating discharge from hospital.

Bellwoods CC program is a time-limited, goal-oriented program focused on supporting the transition of individuals from hospital with high physical care needs and working with them to support their health and personal care needs in a community-based setting.

PROGRAM CONTACT

Anne Dumais
Director, Transitions and Special Projects
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LOCATION

The CC program is located at Bellwoods' 300 Shaw Street site. The program has 15 apartment units (bachelor and one bedroom), providing housing and supports for participants for up to six months.

COMMUNITY CONNECT (CC) PROGRAM

GOAL(s) OF CC PROGRAM

The Community Connect (CC) program supports patients who are in hospital designated Alternate Level of Care (ALC) or at risk of becoming ALC. This time-limited, goal-oriented program focuses on increasing an individual's quality of life and well-being through direct teaching of independent living skills, prescription of and education on use of assistive devices (such as mobility aids), and case management/service navigation (as needed) to help connect clients to services necessary to support their successful transition to independent living.

SCOPE & DURATION OF SERVICES

Most clients accepted to the Bellwoods CC program require a barrier-free environment due to physical and/or mobility challenges. Many participants are recovering from a traumatic injury or health event that has resulted in a significant change to their pre-hospital level of functioning. Participants in the program reside in one of 15 apartment units located at Bellwoods' 300 Shaw Street site, with access to on-site, prescheduled Personal Support Worker (PSW) services.

In addition to PSW services, participants are assigned a facilitator, who is responsible for overseeing service coordination, treatment programming and transition planning.

Facilitators work collaboratively with the supportive housing staff, including the PSWs and Supervisors to ensure alignment of support services to the transition goals of each CC participant.

In addition, facilitators liaise regularly with outpatient rehabilitation partners, home and community care, as well as housing providers (such as Toronto Community Housing), to help transition clients back to the community following their participation in the CC program.

The maximum length-of-stay in the CC program is 180 days, during which time the focus is on preparing the client for discharge to a more permanent location back in the community.

COSTS

All program costs are currently covered by the STTCM funding provided by the MOHLTC and TC LHIN. Participants are responsible for all costs related to purchasing their own groceries, equipment, medication and/or medical supplies, cleaning supplies (including laundry detergent) and personal hygiene items.

COMMUNITY CONNECT (CC) PROGRAM

TARGET POPULATION, ELIGIBILITY & APPLICATION REQUIREMENTS

Applications for the CC program are submitted by hospital partners to the Centralized Referral Management (CRM) Team at Bellwoods. In order to be eligible and matched to a unit in the Bellwoods CC program, applicants must meet the following minimum criteria:

- Be in hospital and be designated Alternate Level of Care (ALC) or at risk of becoming ALC
- Have a valid OHIP number
- Be medically stable
- Have a confirmed transition location and discharge plan that can be met within the maximum length of stay in the program
- Have nursing and/or personal support needs that exceed available supports in the community.

Additional considerations for acceptance into Bellwoods CC' program include:

- Clients must be able to direct their own care
- Clients must be able to be left alone in an independent apartment
- Clients require time, opportunity, and support in learning to adapt to changes in function in a community-based setting
- Clients (and their support network) must agree with identified discharge location
- Clients must participate in goal-oriented transition planning with the CC team.

MOBILE INDEPENDENT LIVING EDUCATION (MILE) PROGRAM

The **Mobile Independent Living Education (MILE) Program** is one of Bellwoods Transition Programs. The program aims to maximize independence and quality of life for people living in the community by providing assessment, direct skills teaching and service coordination to improve an individual's ability to manage their health and personal care needs in a community setting.

A multi-disciplinary team offers participants goal-oriented services aimed at improving their safety and independence (e.g., home safety assessment, assessment and provision of mobility and seating aid). The program also provides help with community navigation, as well as activities of daily living/independent living skills intervention.

PROGRAM CONTACT

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Purpose of MILE Program

MILE is a community-based education program for adults (16+) with a physical support need. MILE does not replace or duplicate available Home and Community Care resources. Services are based on identified objectives, are time-limited and focus on home and community skills development to maximize safety and support independent living in the community through specialized education and supports.

MILE PROGRAM

GOAL(s) OF MILE PROGRAM

Program Facilitators and Independent Living Educators (ILEs) assist clients in achieving optimal safety and independence in their home through skill development and facilitating community linkages. Assessment and skill development focus on the following areas:

- Home safety
- Accessibility
- Community orientation
- Mobility and seating
- Self-care skills
- Household management skills
- Communication skills
- Health and wellness
- Housing, funding and linkage to community resources
- Transition from hospital or a long-term care facility to a community destination

SCOPE OF SERVICES

MILE provides a full range of services focused on achieving independent living goals. Services include:

- Assessment/consultation
- Independent living skills development
- Education
- Transition support from hospital, home and long-term care facilities to another community-based location
- Case management provided in areas related to: home safety, accessibility, community orientation, mobility and seating (incl. ADP (Assisted Devices program) authorization for mobility devices), self-care skills, household management skills, communication skills, health and wellness coaching and navigation related to funding, housing, and community resources

DURATION OF SERVICES

The program is goal-oriented. Therefore, the duration of service (s) is dependent on achievement of the individual service plan objectives established at the outset.

COSTS

There is no cost for core services offered by the MILE Team; however, clients must have a valid OHIP number to participate. Services are available to groups or other community organizations on a fee-for-service basis. Please contact the Program Director for further information.

TARGET POPULATION & ELIGIBILITY

MILE clients are typically adults (16+) or seniors residing in the community who have physical support needs; require support to facilitate their safe and effective transition between hospital or a long term care facility and the community; and/or who require assessment, teaching, equipment, supports or other services to help them reside safely in their home environment. Participants must reside within the TC LHIN, boundaries or the City of Toronto.

MILE PROGRAM

Application Requirements
The application process for MILE is as follows:

For Bellwoods clients: Existing Bellwoods clients can access MILE services by submitting a request through the Supervisor overseeing their personal support services.

Non-Bellwoods clients (not a current Bellwoods service recipient) - Attendant Service Application Centre (ASAC) Application:

- (1) Interested individuals residing in the community, in collaboration with their care providers (if available), complete an ASAC application. Visit this link for application and guide: https://www.cilt.ca/programs-and-services/asac/asac-application-and-guide/
- (2) Once completed, the completed ASAC application should be sent directly to the Centre for Independent Living in Toronto (CILT) who will process this application and send a copy to Bellwoods.

Note: The ASAC application is not required to start the MILE assessment process. A Bellwoods (BCCL) Preliminary Referral Form for MILE Program can be completed and sent directly to Bellwoods.

This form will initiate contact with the MILE Facilitator who will triage and screen the request to determine initial eligibility. However, in order to receive service, the ASAC application must be completed.

- (3) Once the referral request (e.g., BCCL Preliminary Referral Form for MILE Program) is received, a Bellwoods MILE Facilitator will complete an initial assessment with the applicant in their home or another chosen location (referral source staff and family can also attend) to determine eligibility for service. The assessment takes approximately 1.5 hours and may include a comprehensive assessment of the client's level of function (through completion of the InterRAI-Community Health Assessment and Functional Supplement). In all cases, the applicant's goals for service will be established and their ability and willingness to participate in the program confirmed.
- (4) Once the applicant is confirmed for participation in the MILE Program, a MILE Service Agreement will be signed and the participant will begin to work with their MILE facilitator to achieve their goals.

CAREGIVER RECHARGE SERVICES (CRS)

In-Home Respite Services

The **Caregiver ReCharge Services (CRS) – In Home Respite Program** is one of Bellwoods Transition Programs. The in-home respite program was started in November 2017 as part of the Caregiver ReCharge Services (CRS) program. It was implemented as part of a series of new Short-Term Transitional Care Model (STTCMs) being pilot tested in the Toronto Central LHIN (TC LHIN). It is funded by the Ministry of Health and Long-Term Care and focused on transitioning patients from hospital who are designated as alternate level of care (ALC) or at risk OF ALC clients.

The program provides support to caregivers through provision of in-home PSW services focused on meeting the needs of caregivers (family or friends) for clients who are returning home from hospital.

PROGRAM CONTACT

Ajit Prabhu
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LOCATIONS

Bellwoods oversees the provision of the CRS-in-home respite program throughout five sub-regions in the TC LHIN.

CRS-IN-HOME RESPITE SERVICES

GOAL(s) OF IN-HOME RESPITE

The goal is to reduce the risk of caregiver burnout while optimizing caregiver's ability to continue providing invaluable care to the client in the community. Services provided by in-home respite staff do not supplement or replace personal support services provided by TC LHIN, Home and Community Care (HCC), Centre for Independent Living in Toronto (CILT) and/or Attendant Service Application Centre Program (ASAC).

SCOPE OF SERVICES

Individual service plans are developed for the caregiver based on their identified relief needs. Depending on the provider, services are offered any time of day during the week/weekend. Most clients/families receive support with activities of daily living provided by trained staff (for personal care supports routinely completed by caregiver). In-home respite offers a range of services to support caregivers.

Examples of services offered under the program include the following:

- Companionship and supervision
- Movement and transfers
- Assistance with toileting/brief changes
- Light ADL support (hygiene, set up meals, etc.)
- Medication reminders and simple exercises
- Homemaking (e.g., laundry, light housekeeping and light meal preparation
- Recreational activities (e.g., taking client out for a walk, playing cards/games, and reading
- Redirection, prompting, and cuing as well as wandering safety checks

DURATION OF SERVICES

CRS is a short-term program focused on clients who are transitioning from hospital following an inpatient stay. The program offers families/caregivers up to 90 hours of service for a maximum of 3 months following discharge from hospital.

COSTS

There is no cost for the program at this time.

ELIGIBILITY & APPLICATION REQUIREMENTS

Applications are submitted to Bellwoods through the Centralized Referral Management program, indicating the need for CRS supports. The Supervisor of Respite Services will then assess initial eligibility and connect with the caregiver to complete the intake assessment. The intake assessment clarifies the caregiver's support needs, goals of service, and plans additional supports/services necessary to support long-term sustainability of the caregiving situation after the CRS program period finishes (90 days post initiation of services).

HOUSING WITH LAYERED SUPPORTS (HLS)

Bellwoods is partnering with the City of Toronto to pilot the **Housing with Layered Supports (HLS) project**. This short-term project is aimed at residents of Toronto as part of a series of strategies that are being implemented to reduce or prevent homelessness and assist the chronically and episodically homeless, as well as those at-risk of homelessness. HLS provides flexible and individualized case management support. Eligible applicants will also be provided with a subsidized housing unit for a defined period of time.

PROGRAM CONTACT

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HLS

GOAL(s) OF HLS

- (1) Increase the availability of housing with supports to people in need
- (2) Support eligible applicants in improving physical and mental health outcomes, quality of life, social connectedness, individual resiliency and community connections
- (3) Help eligible applicants achieve and maintain longer-term housing

TARGET POPULATION & ELIGIBILITY CRITERIA

Applicants do not need to have a physical disability to be eligible for this program. Other eligibility criteria include:

- Adults in the City of Toronto who are being discharged from hospital or a transitional/reintegration program or have been in a shelter or identified as homeless for six (6) months or more
- Willingness of the applicant to work with the case manager to set and achieve independent living goals
- An income source with the ability to share in the cost of accommodation based on a rent-geared-to-income approach
- Have not applied or have plans to claim refugee status. [Note: Refugee claimants may have access to similar services through the Resettlement Assistance Program (RAP)]

REFERRAL & ASSESSMENT PROCESS

Referrals can be made by a staff member at the applicant's current site/program. The Referrals will be assessed by the Bellwoods Team and will include an initial telephone pre-screening interview with the referral source. Eligible applicants will be required to complete an income verification form and participate in an assessment with the Bellwoods Team.

COSTS

There is no cost for Case Management supports. Applicants approved for a Rent Supplement will be required to contribute a rent amount that is geared-to-total income. All furnishings, household supplies and expenses related to living in an independent apartment (e.g., food, cell phone, TTC, etc.) will be the responsibility of the applicant.

Acknowledgement: The HLS project is funded by the City of Toronto as part of a series of strategies that are being implemented to reduce or prevent homelessness and assist the chronically and episodically homeless, as well as those at risk of homelessness. The current agreement between the City of Toronto and Bellwoods for the HLS project is funded to March 31, 2020 with the possibility of renewal depending upon the success of the program.