Central West **LHIN**

Meeting Senior Care Needs Now and in the Future

Highlights and Key Findings

from the Report Submitted to:
the Central West Local Health Integration Network (LHIN)
to inform a Community Capacity Plan for the Central West LHIN

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Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Abbreviation List

ABCD	Asset-Based Community Development
ACP	Advanced Community Practice
ADL	Activities of Daily Living
ADP	Adult Day Programs
ALC	Alternate Level of Care
BSO	Behavioural Supports Ontario
CAN-Marg	Canadian Marginalization Index
CCAC	Community Care Access Centre
CCC	Complex and Continuing Care
CCRS	Continuing Care Reporting System
CSS	Community Support Services
DAD	Discharge Abstract Database
ED	Emergency Department
FY	Fiscal Year
GI	Gastrointestinal
HC	Home Care
LHIN	Local Health Integration Network
LTC	Long-Term Care
MAPLe	Method for Assigning Priority Levels
MH	Mental Health
MOF	Ministry of Finance
NACRS	National Ambulatory Care Reporting System
NE	North East
NP	Nurse Practitioner
NW	North West
OCCM	Occupancy Monitoring Database
OH I P	Ontario Health Insurance Plan
OPH ROC	Ontario Physician Human Resources Data Centre
PACE	Program of All-Inclusive Care for the Elderly
PSW	Personal Support Worker
RAI	Resident Assessment Instrument
SOL	Supports for Daily Living
SEC	Socio-Economic and Culture

Introduction and Executive Summary

The Central West Local Health Integration Network is home to approximately 870,000 residents, comprising six percent of Ontario's total population. The population is predominantly urban with 86% of residents residing in urban centres and the remaining 14% living in mixed urban/rural (8%) and rural communities (6%). The LHIN has one of the highest population growth rates in the province. Between 2006 and 2011, the number of residents increased by 11%, compared to 6% across the province. This growth is projected to continue, climbing another 10% over the next 7 years to 960,000 residents by 2021.

The Central West LHIN will experience unprecedented growth in the local seniors population, rising 52% by 2022 compared to 43% growth predicted for Ontario. The fastest growing age group is those 65 to 74 years of age, with a projected increase of 38% by 2022. This population trend has significant impact on planning and delivery of health services in the Central West LHIN with the key challenge to meet the increasing demand for care and services as the local population continues to grow and age at a rate above the provincial average. The need to find sustainable solutions to health care continues to intensify. Bricks and mortar will not continue to address increasing service needs. Moving forward, the strategy is to re-organize and integrate existing local resources and improve care delivery, identifying areas where there are unmet needs, and seeking to address them through sustainable solutions. This is cost effective while ensuring equitable, quality and patient centred health care.

To sustain health care the Central West LHIN will support seniors to live independently at home by creating improved access to care in the community. Understanding how to meet service demand for seniors over the next 5 years with projections into the 10 and 20-year planning horizon is vital.

To ensure the needs of the growing and aging population in the Central West LHIN is met now and in the future, the Central West and Mississauga Halton LHINs and CCACs contracted with Preyra Solutions Group (PSG) to develop a Community Capacity Plan ("the Study"). The objective of the Study was to evaluate the level and mix of health services required by the growing and aging populations in the LHINs, including a comprehensive assessment of current and future capacity and need for community-based health services for seniors. Over the past year, the project consulting team, along with members of the project steering team, engaged community and hospital care providers, planners, seniors and caregivers about their priorities for community based senior care.

The objectives of the Study:

- Assess community based health service need for seniors now and in the future; based on current practice, provincial averages, leading LHINs, and better practice jurisdiction
- Assess community health service capacity
- Examine current and forecast gaps between community needs and capacity, across sectors and along the continuum
- Estimate community investment requirements and potential saving across the continuum
- Identify services and sub-populations that should be prioritized for access improvements
- Identify system reconfigurations and resource redistributions to achieve an integrated system of seniors' services.

The Study included fifty-six (56) structured interview sessions across the two LHINs, the collection of survey data from over 200 respondents across the LHINs, jurisdictional reviews, and data analysis.

The Study contains recommendations for a Senior Care Model which is to be developed based on the assets and characteristics of the Central West LHIN, including a focus on targeting and tailoring interventions for specific types of seniors, enhanced care coordination to facilitate placement and transitions between care settings, and outcomes evaluation and performance measurement. It also outlines five and 10-year implementation plans that can be delivered in a phased approach. The model recommendation suggests combining elements and best practices from many promising models. Five key elements were identified and explored including:

- Population Segmentation
- Care Coordination
- Providers and Networks
- Outcomes and Performance Measurement
- Resource Adequacy.

The report informs program design and evaluations, priority setting, data collection, planning and resource allocation. While this process is only the beginning, data collected indicate priorities in which care coordination was incorporated among best practice care models.

In addition, PSG created a Scenario Planning Tool to simulate funding allocations based on different assumptions. The Tool compares funding scenarios and estimates the amount of services that can be provided with new funds.

While challenges to the implementation of a senior care model exist, there are significant immediate and long-term opportunities to help build and strengthen a sustainable health care system.

In the pages that follow, this Community Capacity Plan seeks to lay out the findings and recommendations to enable the Central West LHIN to integrate conceptual framework, findings, and suggestions into practice.

The Community Capacity Study began in December 2013 and completed in May 2015. The report does not necessarily represent the views or actions of the Central West LHIN or its health partners.

Summary of Overall Findings and Recommendations

Tailoring Initiatives to Populations is a Key to Success

The Study identified that senior care models designed and assessed for specific population segments are the most effective. The Study reviewed population segmentation used in Ontario and other jurisdictions and examined how important population characteristics varied within the Central West LHIN.

Based on the analysis of clinical, census, and geographical data, five areas that would greatly help the Central West LHIN and its providers match population need with services were identified:

1. Demographics and Aging
2. Communities within the LHIN
3. Diagnosis
4. Functional Status
5. Social Determinants of Health

Key Findings

- Communities within the LHIN: Health risks, assets and population characteristics vary within the LHIN. The five Health Links in the Central West LHIN were created to improve community based care coordination for high-risk patients across multiple providers. Differences in the growth and proportion of seniors, population density and characteristics, and service availability in each Health Links will mean that differences in service need and service delivery within the LHIN that are better addressed at the Health Link level.
- Social Determinants of Health: Social determinants of health are important for community based service planning. Among measures reviewed, the Ontario Marginalization Index was most promising. This was adapted to construct a Socio-Economic and Cultural (SEC) index. Seniors from the highest SEC Group are at a greater risk for institutionalization and socio-cultural risk varies enough within the LHIN's Health Links and neighbourhoods to make SEC an important segmentation factor.
- Demographics and Aging: The risk of institutionalization and chance of a person residing in a Long-Term Care home increases with age and varies by gender. In addition, the oldest age groups will grow the fastest over the next twenty years. During this period Central West LHIN's senior's population is expected to be 2.3 its current size, a growth rate larger than any other LHIN in the Province.
- Diagnosis and Functional Status: Population segmentation is important since it includes all people at risk, whether or not they have access to a specific service. Age, specific functional limitations and diagnoses, and social health determinants can combine to predict risk of admission to a Long-Term Care home for multiple years into the future. Once estimated, planners can use this trajectory to target early interventions to reduce risk of LTC admission and other adverse health events.

Know Your Neighbourhoods and Their Assets

Among the striking differences between acute and community care capacity planning is the role of neighbourhood assets. A neighbourhood's human, physical and organizational assets can complement, or even substitute for, health care resources. Neighbourhood assets are important as they reduce the need for additional capital expenditures or high-rent space to deliver seniors' programs. Community businesses, agencies and institutions are already touch points in seniors' routines and a key to maintaining seniors' health is regular contact and health monitoring. Neighbourhood awareness about seniors' health needs helps coordinate the efforts of volunteers, local organizations, and providers to maintain seniors' independence, health and well-being in the community.

An asset profile identifies and classifies all assets and related resources in the community across settings, organization types, and geographic locations and includes both a health care and community care component. A comprehensive Central West LHIN Asset Profile was created and includes six dimensions: setting, asset type, geography, resource type, service, and resource or service volume.

Key Findings

- Including neighbourhood assets in the overall capacity plan requires mapping assets and neighbourhood assessments. Existing assets in the Central West LHIN could be used immediately to develop senior hubs, and can be enhanced to a Campus of Care model if redevelopment is possible.
- As the Central West LHIN increases its Assisted Living services and identifies Long-Term Care beds for redevelopment, it should consider developing sites as hubs, and undertake site-planning analysis that incorporates existing capacity, population growth, and resident activity.

Care Coordination Can Reduce Health Risk

Care coordination is now widely understood as a necessary condition for an effective senior care model. All leading practice care models include a strong care coordination component that share many common elements such as:

- Smooth transitions between services and sectors
- Quick and accurate patient information sharing between providers
- Interdisciplinary teams that determine what services seniors should receive and how those services should be coordinated among providers
- Linking frail seniors and caregivers with the services they need
- Seniors and caregivers are often unaware of the programs and service available and fear they are not accessing all the right resources.

The Study reviewed senior care models revealing many common elements. Among the most established with proven results, is the Program of All-Inclusive Care to the Elderly (PACE). PACE programs coordinate the preventive, maintenance and restorative services for seniors who would otherwise be in Long-Term Care homes. Australia recently began implementing a new model of senior care, with care coordination being the model's central component. The PACE and Australian Gateway model can be used to guide the development of coordination initiatives in the LHIN.

Key Findings

- Care coordination is a health service and requires a holistic view of a person's social and health status and could be substantially improved in the Central West LHIN.
- There are many levels of senior care available, ranging from self and informal care to high intensity institutional care in long-term care homes and hospitals. An essential care coordination function is to ensure a continuous pathway for seniors, based on their needs and avoid seniors "skipping levels of care."
- Ideally, most seniors have a continuous care path across intensity levels, making use of community support services, and then adding home care services and low intensity residential care services when necessary.
- Improve transitions from hospital to home by implementing care plans that extend into the community and improve post discharge communication between hospitals and community providers.
- A mixed model is most likely to benefit the Central West LHIN in the future, where frailty is managed on a continuum - from those who are vulnerable but not dependent to those who are mildly frail to the severely frail and to the terminally ill.

Long-Term Care Homes are for the Highest Needs Seniors

Transforming, not expanding the Long-Term Care sector, is the strategy seniors and planners want. The Long-Term Care home acuity trend is rising, but the LHIN should further accelerate its efforts to keep people at risk of Long-Term Care admission in the community. Currently, the Central West LHIN has 12 per cent fewer beds per senior than the provincial average. Long-Term Care days per senior are lower in the Central West LHIN than in other LHINs because their seniors are less likely to be admitted, not because length of stay per resident is different. Reducing length of stay should be the main area of focus for making better use of the existing bed capacity in the Central West LHIN. By admitting the highest need seniors and caring for those that can be cared for in the community, the length of stay will decrease and more seniors can be served without adding beds.

Key Findings

Current Practice

Without changes to admission criteria, seniors in the Central West LHIN who occupy Long-Term Care beds would require bed increases to 3,750 in 10 years, a 57% increase in beds. Under ideal practice, the number of Long-Term Care beds would not be required to be increased.

Ideal Practice

1) The ideal practice forecast is an aspirational target that could be achieved through a mix of new policies, staffing, and resource allocations.

2) Increased resources in Long-Term Care homes, home care, assisted living, adult day programs, and other supports will be needed, and these increases will vary by population segment.

High Risk Seniors Can Live at Home with Supports for Daily Living

Supports for Daily Living (SDL) services, also known as Assisted Living programs, enable seniors who are frail or cognitively impaired safely live at home, or in a homelike environment, with 24 hours access to homemaking, personal support and care coordination services. Assisted Living supports better resource use in other sectors, reduces emergency room visits and avoidable hospital use, decreases Alternate Level of Care pressures and diverts or delays admission to long-term care homes.

Key Findings

- Congregate living and residential service delivery models are preferable to Long-Term Care homes according to research, policy and senior advocates
- Assisted Living programs currently serve 630 clients. To sustain current access level, the Central West LHIN would need to serve 990 Assisted Living clients in ten years. Under better practice, the Assisted Living program would serve 1,740 clients in ten years, helping reduce the demand for Long-Term Care beds.

Community Care and Clients with Frailty Living

The Community Care Access Centre (CCAC) is a gatekeeper and coordinator of senior community and residential supports, concentrating on the frailest clients. The CCAC's most prominent functions are currently Long-Term Care home, Assisted Living and Adult Day Program assessment and placement and purchaser of personal support, nursing and allied health services for sub-acute and functionally dependents seniors. Within two years of CCAC assessment, 30% of all seniors in the LHIN will be in a LTC home, 31% will have an emergency department visit, and 29% will be admitted to hospital. Of Central West CCAC's 2013/14 budget, 17% is spent on care coordination and case management, and 68% is spent on purchased services. Adjusting for morbidity, the Central West LHIN has 22% less use of home care services than the provincial average. With adequate resources, coordinated with other services and targeted at the right populations, the CCAC could substantially reduce Long-Term Care home admissions and hospital use.

Key Findings

- Well-coordinated population-specific CCAC services reduce Long-Term Care home admission and hospital use.
- Using health care and community data in new ways can greatly improve case finding and service design.
- CCAC should make best use of information available to tailor its services to those that can benefit most.

Expand and Consolidate Adult Day Services

Adult day programs offer physical, recreational, and therapeutic group activities to stimulate physically frail or cognitively impaired seniors. Day programs also provide respite for caregivers. Currently residents in the Central West LHIN have less access to adult day programs compared to most other LHINs. The Central West LHIN has an estimated 110 adult day program spaces. In order to achieve the better practice in LTC the LHIN would need to provide 510 adult day program spaces in ten years, an increase of 400 adult day program spaces.

Key Findings

- Expand and consolidate services at adult day programs.
- Expand capacity to provide care to more clients and increase service frequency.
- Expand services to cognitive behaviour clients at designed adult day programs.
- Establish adult day programs for low intensity clients; coordinate with municipalities to use senior centres as a possible location for these sites.
- Improve awareness of the program through promotion and advertising; Improve coordination between hospital discharge planners and CCAC case manager to avoid overlooking referrals.
- Expand respite services, develop overnight options, and increase caregiver-training initiatives.

Invest in Transportation

Only four per cent of the LHINs 75+ population is served by Community Support Service agency transportation services, much less than the 10 per cent provincial median. The Central West LHIN funded over 71,000 rides in 2012/13. At the current trips per senior, the LHIN's future seniors are projected to need 141,200 trips in ten years. Under better practice, the LHIN would provide an estimated 489,300 trips in ten years to improve seniors' ability to remain in the community.

Key Findings

- Improve transportation across provider service boundaries.
- Improve efficiencies, such as high cancellation rates.
- Work with municipalities and health service providers to ensure efforts are not duplicated and organizations can benefit from the strengths of the other.

Informal Care: Seniors and Care are the Most Important

Informal care delays or avoids admission to Long-Term Care, reduces use of inpatient and emergency hospital services, and helps realize the wishes of seniors near the end of life who want to die at home. However, informal caregiving can be distressing enough to affect the health and well-being of caregivers.

Without initiatives that make it easier for caregivers to support seniors at home, the demand for formal health care services may increase substantially. On average, in the Central West LHIN, home care clients received 4.2 hours of informal care for every hour of PSW care provided by the CCAC. In ten years, the seniors in the Central West LHIN will need 5.2 Million informal care hours to main today's informal care supports. Today's per capita and hours per caregiver, implies a future gap of 900,000 informal care hours in the LHIN. In the Central West LHIN demand for informal care will grow faster than the supply needed.

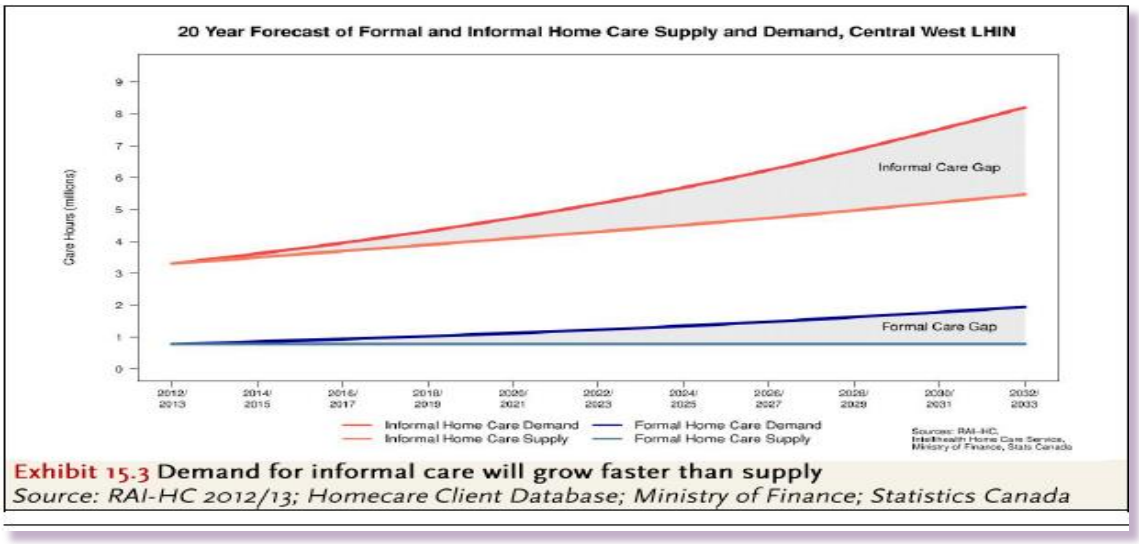

Exhibit 15.3 Demand for informal care will grow faster than supply
Source: RAI-HC 2012/13; Homecare Client Database; Ministry of Finance; Statistics Canada

Key Findings

Reduce demand for informal care by…

- Making better use of technology, including telemedicine to deliver, monitor, and coordinate medical care.
- Prioritizing primary and secondary prevention to improve avoidable morbidity and disability of future seniors.
- Improving care coordination and system navigation to reduce duplication of services and need for transportation.

Increase supply of informal care hours by:

- Provide services and initiative that reduce caregiver burnout, improve care competency, and support working caregivers.

Care Planning at the End of Life

The Central West LHIN has the second fastest expected growth in the number of deaths, 42 per cent higher than the provincial median. Since most deaths will need palliative care, the LHIN will need substantial expansion of end of life services in the coming years. When asked most seniors state they would prefer to die at home.

Findings from the Capacity Study imply that there are opportunities in the Central West LHIN to improve the mix of institutional and community palliative care and hospice services.

Key Findings

- There are currently 10 residential hospice beds in the Central West LHIN. Under the better practice forecast, the Central West LHIN would need 22 residential hospice beds in ten years.
- Increase supports for palliative/end of life care at home/ community, including nursing care, pain management, respite, education and social supports.
- Expand provision of respite care in the community; enhance education, hospital bereavement support, homemaking support for patients and families; develop wellness, psychological and workplace support for family members.

Senior Health Outcomes and Quality Improvement

Outcome measurement is a key element to a successful care model. Measurement activities include identifying indicators to gauge how outcomes are improving for target populations. The Capacity Study examined population based outcome measures within the Central West LHIN. While the Central West LHIN performs well in most senior heath outcome measures, some population segments are likely to experience adverse health care events.

Key Findings

- Outcome evaluation and performance measurement is the only way the Central West LHIN can know which investments are most effective. Activities to reduce adverse outcomes in vulnerable subpopulations, such as communities of low socioeconomic status and residential instability, are immediately important. The LHIN should consider identifying indicators for each of its target populations, and regularly report these results to stakeholders – a practice common in many publicly funded models of care.

Quantifying Gaps

The Study presented two futures for seniors' service in the Central West LHIN. The first continues to do exactly what is done today, and assumes that all current programs can simply scale to provide the same amount and mix of services for future seniors. In the second scenario, a new mix of services is defined that would achieve better practice for community based senior care. For each service type, better practice is defined using the information obtained from stakeholder discussions, literature reviews, and data analysis.

Exhibit 16.1 below summarizes gap analysis, showing resource use today and in 5, 10 and 20 years under better practice. Under better practice, LTC beds would grow by 39 percent of the total care for residents in the Central West LHIN, and other services would increase substantially. For example, Community Support Services would increase from $11 Million today to $131 Million to 2032/33.

Service	*Unit*	*Actual*	*Better Practice Forecast*		
		2012/13	*2017/18*	*2022/23*	*2032/33*
Long Term Care	Bed	2,390	2,540	2,730	3,330
Home Care	Expenses ($M)	$45	$64	$91	$180
Community Support Services	Expenses ($M)	$11	$30	$56	$131
End of Life					
Hospice	Bed	10	15	22	44
Paliative Care Physicians	FTE	5	12	23	60
Palliative Care Nurses	FTE	6	13	24	60
Specialized Geriatric Services					
Nurse-led Outreach NP	FTE	6	7	9	14
BSO RPN	FTE	0	0	1	1
BSO PSW	FTE	23	29	38	61
BSO Psychogeriatric Resource Consultant	FTE	4	5	6	10
Informal Care	Hours (M)	3.3	4.1	5.2	8.2

Exhibit 16.1 Under better practice, no new LTC beds are needed but other programs would increase substantially

Key Findings

- The Central West LHIN can use the gap analysis to inform investment and reallocation decisions.
- Allocations of new funding can be focused on programs with the highest projected gaps, or across programs in proportion to their projected gaps

Implementing the Capacity Planning Study

This report describes seniors' growing health care needs in the Central West LHIN and how to plan community-based care to meet those needs. Available resources for seniors in the LHIN should increase, and those resources used in different ways.

Changing the Central West LHIN's senior care model is complex and long term. Stakeholders will vary in their need to understand and collaborate on methods, processes and program specific plans.

The report findings suggest that as the Central West LHIN proceeds with its plans to meet the needs of seniors, using current assets and anticipated funding increases, progress could be hampered without a provincial senior community and institutional care resource allocation strategy.

Provincial health care resources per senior grow scarcer each year. Province wide substitution of community for institutional care, better disease and frailty management, and population based allocations would improve overall value in the system, and would therefore free resources to allow the Central West LHIN to meet local population's needs.

Long-Term Care home capacity planning is a key area where a province wide plan is needed. Currently, the age-adjusted Long-Term Care bed rate per senior of the highest served LHIN is 26 percent more than the Central West LHIN. Without any changes in Long-Term Care bed capacity, in twenty years the rate of the highest served LHIN would be 68 percent more than the Central West LHIN.

The Ministry of Health and Long-Term Care has recognized that the funding growth in the community sectors should be faster than that in the institutional sectors. Additional funding flexibility for high growth LHINs, like the Central West LHIN, to allow more rapid expansions of home care assisted living and other community support services might be considered by the Ministry.

Study Implementation Plan

The Study's implementation plan is consistent with the collaborative approach of the Study itself. The plan focuses on improvements by each care model component, creating a path to excellence for the Central West LHIN's future Senior Model of Care. Organizations in the LHIN, seniors and caregivers can use the Study's findings and suggestions to anticipate and direct their roles in the future senior care system.

Logic maps – that identify the participants, activities, and outcomes for implementing the Study – in four key domains – have been developed. These exhibits assume collaborative, multidisciplinary processes and are a road map to readiness for a new model of care in the Central West LHIN.

Steering Committee Membership

LHIN	Position
Bill MacLeod	CEO, Mississauga Halton LHIN
Liane Fernandes	Senior Director, Health System Development & Community Engagement, Mississauga Halton LHIN
Scott McLeod	CEO, Central West LHIN (Co-Chair)
David Colgan	Senior Director, Health System Integration, Central West LHIN
CCAC	
Caroline Brereton	CEO, Mississauga Halton CCAC (Co-Chair)
Jim Wright	Vice President, Corporate Services, Mississauga Halton CCAC
Cathy Hecimovich	CEO, Central West CCAC
Alan P. Iskiw	Vice President, Finance & Technology, Central West CCAC
Community Support Services	
Ray Applebaum	Executive Director, Peel Senior Link
Angela Brewer	Chief Executive Officer, Acclaim Health
Valerie Quarrie	Administrator, Dufferin Oaks Home for Senior Citizens
Kamalesh Visavadia	Director, Health Services, India Rainbow
Community Mental Health and Addictions Services	
Radhika Subramanyan	CEO, Canadian Mental Health Association - Halton
Nurse Practitioner	
Lori Brown	Coordinator & Nurse Practitioner NPSTAT; Nurse Practitioner LTC Rapid Response Team, Trillium Health Partners
Physicians	
Dr. Frank Martino	Primary Care Lead Central West LHIN; Chief Family Practice, William Osler Health System; Family Health Team family doctor; President, Ontario College of Family Physicians
Dr. Dante Morra	Chief, Medical Staff, Trillium Health Partners
Dr. Samir Sinha	Director of Geriatrics, Mount Sinai and University Healthy Network; Provincial Lead, Ontario's' Senior Strategy
Public Health Units	
Safia Ahmed	Executive Director, Rexdale Community Health Centre
Joyce See	Director, Community Health Services, Halton Region Health Department
Janette Smith	Commissioner of Health, Region of Peel
Hospitals	
Patti Cochrane	Senior Vice President, Clinical Strategy & Chief Innovation Officer, Trillium Health Partners President, Redevelopment & LHIN Lead Community Capacity Redevelopment, Trillium Health Partners

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