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Central Local Health Integration Network

AGING AT HOME STRATEGY

Directional Plan – October 31, 2007

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Ontario

Introduction: The Aging at Home Strategy

Process

Draft Directional Plan for October 31, 2007

A. Objectives and Priorities

To develop a balanced infrastructure for the delivery and funding of health services for seniors and people with chronic/long term health needs in Central LHIN, through the development of a comprehensive and effective continuum of community care that is integrated with the rest of the health system.

The Central LHIN Aging at Home Interim Service Plan is divided into three Strategy Streams. Within each of these Strategy Streams there are a number of discreet initiatives. Further detail will be available on each of these initiatives for the January 31, 2008 Aging at Home Service Plan, following additional planning work and stakeholder engagements.

Strategy Stream #1: Implement Aging @ Home Priorities identified in the Central LHIN IHSP and ASP.

Responding appropriately to seniors' care needs was identified as a strategic priority early in the Central LHIN planning process. The Central LHIN IHSP identified five key areas for development of services for seniors in Central LHIN, as shown below.

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Seniors and Geriatric Services Action Plan

SYSTEM GOAL	STRATEGY	ACTIVITIES
ACCESS	Enhance Specialized Geriatric Service (SGS) capacity in the Central LHIN.	Build partnerships between providers. Develop innovative approaches to bringing services to underserved areas.
COORDINATION	Strengthen and organize system navigation resources for seniors in the Central LHIN.	Develop a pool of specialized system navigators who can work with high risk seniors and their caregivers, and who can train other providers.
QUALITY	Develop competence across Central LHIN organizations in service delivery to seniors and to individuals from ethnocultural, religious and linguistic communities.	Implement incentives for organizations to become senior-friendly and culturally competent.
EFFICIENCY	Optimize resources to ensure full utilization of services. Enhance transportation for seniors to available health services.	Conduct a transportation needs assessment and a cost/benefit analysis of transportation options.
INTEGRATION	Improve links between providers and strengthen their ability to disseminate information, make referrals and coordinate services.	Pilot a new model of care – the Doorways to Care model. This includes strengthening system knowledge and links between existing providers, consideration of a 1-800-seniors info line.

The Central LHIN Annual Service Plan has further developed these action areas and proposed the following system goals, strategies and outputs for seniors and specialized geriatric services in Central LHIN.

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System Goal	Strategy	Outputs	
		Year	Description
Access	Enhance specialized geriatric service capacity, including specialized behavioural resources and units for long-term care home residents.	08/09	Implement plan to optimize specialized geriatric services. Specialized geriatric services Network to build capacity. Develop proposal for additional specialized geriatric service enhancements.
		09/10	Implement plan for additional specialized geriatric service enhancements and continue capacity building activities.
		10/11	TBD
Coordination	Strengthen and organize system navigation resources for seniors	08/09	Specialized Seniors System Navigators Group and Training implemented via Doorways to Care Model.
		09/10	Specialized System Navigators Model evaluated
		10/11	TBD
Quality	Develop senior-friendly competence across health service providers	08/09	Develop additional senior-friendly expectations. Integrate cultural competency expectations from other LHIN work (e.g. Mental Health & Addictions).
		09/10	Implement additional senior-friendly expectations, as planned in 08/09. Develop senior-friendly certification and incentives.
		10/11	Continue 09/10 activities.
Efficiency	Optimize and enhance transportation for seniors to available health services	08/09	Implement plan to optimize transportation services. Develop proposal for enhancement of transportation services.
		09/10	Implement plan to enhance transportation services.
		10/11	Study models to bring services to seniors (e.g. geriatric health bus). Evaluate optimization-enhancement efforts.
Integration	Build an integrated system of services for seniors and their caregivers	08/09	Doorways to Care two year Pilot (Year 1) - 2 sites.[1]
		09/10	Doorways to Care two year Pilot (Year 2) - 2 sites; Results evaluated. [2]
		10/11	Year 3:Doorways to Care Model replicated if successful[3]
Other	Strategize on issues related to long-term care homes and caregiver supports within a service continuum	08/09	The Long-Term Care Working Group has identified issues such as general funding levels, diagnostic service delivery, hard-to-serve individuals (e.g., people with behavioural management needs, smokers, people needing dialysis and young adults) and alternative services to deal with alternate level of care/wait time issues. Activities in out-years will focus on developing continuum solutions.
		09/10	
		10/11	

[1] In September 007, the Central LHIN Board of Directors decided to work towards broader implementation of the Doorways to Care model rather than the testing of small Pilot Projects.
[2] Ibid
[3] Ibid

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Central LHIN has established the Seniors Advisory Network to oversee planning and implementation of the IHSP and Annual Service Plan Action Plans. To facilitate this process, 5 Work Groups have been established by the Seniors Advisory Network to develop detailed plans and make implementation recommendations. Central LHIN planning for implementation of the Aging at Home Strategy is strongly grounded in the philosophy and work plans that have been developed by the Seniors Advisory Network.

Many of the other priorities identified in the Central LHIN IHSP and Annual Service Plan dovetail with the notion of Aging at Home. For example, Central LHIN's Mental Health priority relates in part to people with mental illness aging at home in the community. Similarly, the Chronic Disease Management priority describes the needs of people with chronic diseases and the supports they require to stay independent and in the community. Primary Care planning in Central LHIN has identified the need to support primary care physicians in their capacity as system navigators for their senior clients.

The Annual Service Plan identifies a Palliative Care-End of Life Care priority which also involves community care to support people who are dying in the community. Other Central LHIN priorities such as alternate level of care, information technology and hospital services planning also relate in part to Aging at Home. These "non-seniors" priorities are also included in the Central LHIN Aging at Home Strategy Service Plan.

In addition to the initiatives in this strategy stream that follow directly from the priorities established in the Central LHIN IHSP and Annual Service Plan, related initiatives may be developed to further IHSP/Annual Service Plan objectives.

Strategy Stream #2: Build Community Capacity and Enhance Community-Based Care to facilitate Aging at Home

Over the past few decades, the community support sector in Ontario has developed from very grass roots organizations which, when recognizing an unmet need in the community, have often scrambled to meet that need with minimal resources or infrastructure. While some organizations have been able to build some technological and management capacity, many community support organizations still struggle to meet client needs with minimal staff and resources.

Initiatives in this Strategy Stream will be targeted at building skills, knowledge, and infrastructure in the community so that Aging at Home services can be delivered in an efficient, effective manner using appropriate business systems and technological supports.

An integral part of this Strategy Stream is the expansion of community-based services delivered by community support agencies, CCACs and community health centres. Service enhancements will be closely aligned to the capacity building initiative, and will be targeted at filling service gaps in the community that have been identified by stakeholders through previous and ongoing stakeholder engagement activities.

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Strategy Stream #3: Encourage Innovation to support Aging at Home

The Ministry of Health and Long Term Care has prioritized the need to leverage change through the development and funding of innovative initiatives.

Central LHIN has an ethnoculturally diverse population. Central LHIN has a population with almost twice the provincial average of visible minorities and recent immigrants. Not only is this population growing rapidly, but the number of ethnocultural communities represented in Central LHIN is also growing. There are a large number of small but distinct ethnocultural groups in Central LHIN. The innovations Strategy Stream will include initiatives that enhance service and facilitate access to health services for ethno cultural populations in Central LHIN.

Health promotion and disease prevention programs have been somewhat marginalized over the past decade. With the Aging at Home Strategy Central LHIN has the opportunity to weave a wellness approach into its planning and service delivery. The Innovations Strategy Stream will include initiatives that encompass a health promotion/disease prevention approach.

Central LHIN will work with both health and non-health providers to identify and develop innovative programs and services that will contribute to the transformation and integration of health services in Central LHIN.

It is important to note that while Central LHIN has identified a separate Strategy Stream for Innovative Programs, it is recognized that many of the initiatives developed under the umbrella of the other two streams will undoubtedly also be innovative.

Key elements of a community-based service delivery system in Central LHIN

Much discussion has taken place at Central LHIN planning tables about how best to deliver care in the community. While no definitive service delivery model has been selected and tested in Central LHIN, stakeholders (and the literature) have identified the following elements as critical to cost effective, integrated community care: (references)

- Build flexible service packages ("basket of services")
- Focus on individual needs of client and family (services, diversity)
- Target intensive services, including case management, at clients who are at risk of injury, institutionalization and/or deterioration
- Include a wellness and health promotion
- Develop consistent, standardized practices of assessing clients, collecting data, and measuring performance within and across health sectors

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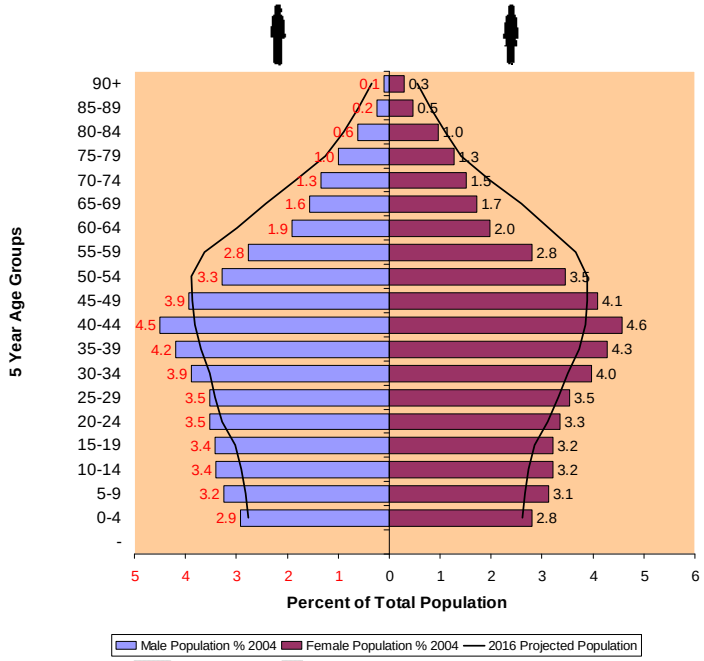
- Increase efficiencies by building capacity, maximizing resources, and collaborations.
- Make effective use of technology (information, e-health referrals)

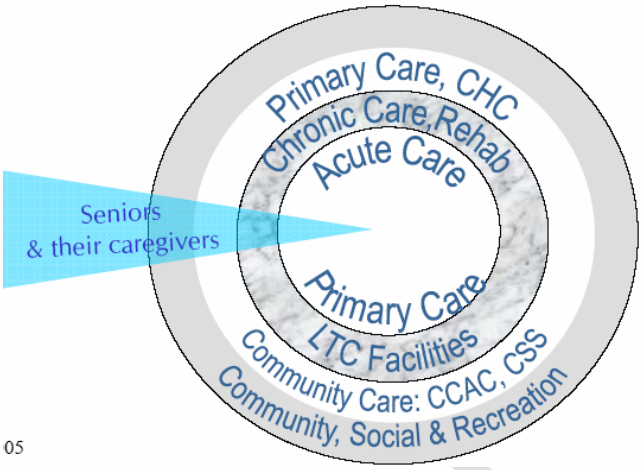
Population & Health Service Sectors That Would Benefit From Proposed Changes:

The population of the Central LHIN is aging. The number of seniors 65 and over is increasing, and this pattern will continue over the next decade. The figure below shows the bulge of seniors in the Central LHIN. By 2016 seniors will comprise 13.4% of the Central LHIN population.



While seniors aged 65 and over, currently comprise 11.3% of the total Central LHIN population (slightly less than the 2001 provincial average of 12.8% [4]) they utilize a relatively high proportion of the health services available within the LHIN.[5]

Seniors use almost all health care sectors in Central LHIN, as shown by the diagram below.[6]

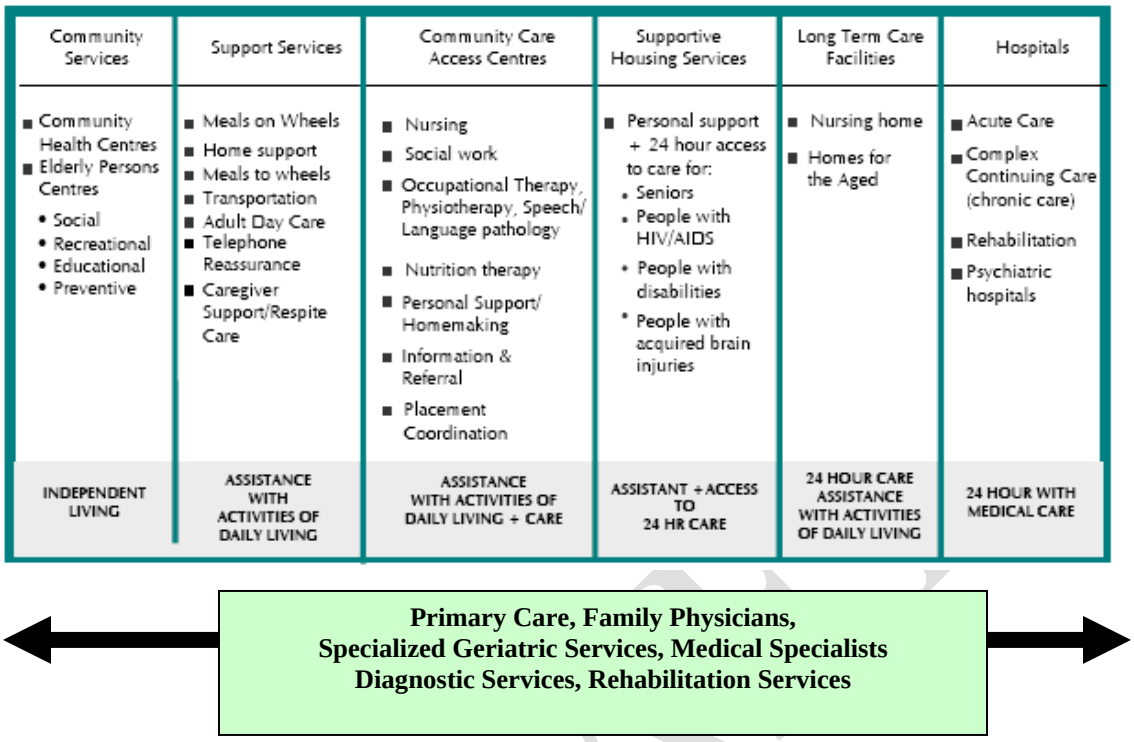


The Continuum of Care

Services for seniors in Central LHIN can be seen to fall along a continuum of services, with less intensive[7] services largely being delivered in the community and more intensive services often being delivered in supportive housing, long term care homes and hospitals. The following diagram[8] shows this continuum. When viewing this diagram it is important to note that clients move back and forth along the continuum as their needs change, and that clients often use more than one service at any particular point in time.

A Continuum of Care for Seniors in Central LHIN

[4] From Table 1: Socio-demographic characteristics in "Population Health Profile: Central LHIN." Health System Intelligence Project (HSIP), 2006.
[5] Seniors 65 and over represent 36% of all hospital discharges of Central LHIN residents.
[6] Adapted from a Toronto District Health Council presentation, 2003.
[7] Fewer hours of service, less complexity of care.
[8] Adapted from A Critical Juncture: A Review and Directory of Elderly Persons Centes in Toronto – April 2003. Toronto District Health Council. Page 13.



Over the past decade the emphasis of policies and funding for seniors services has largely focused on hospitals and long term care homes, with little emphasis on resourcing the community sector. This has lead to a heavy reliance on acute care and long term care services. Accompanying this has been the inability of community agencies to support their clients as they age in place, due to inadequate funding and infrastructure. The Aging at Home Strategy recognizes the stresses that past practices has created in the health care system, and attempts to redress current inadequacies. By providing appropriate supports to seniors in the community, seniors can stay at home (where most of them want to be) (reference) and they can avoid premature admission to long term care homes, unnecessary visits to hospital Emergency Rooms, long stays in hospital and burnout of families and friends who provide care to them.

The Aging at Home Strategy is supported by international research (references) which has demonstrated that if seniors are appropriately supported at home, and if they receive expert interventions when they are required, then inappropriate use of the more costly parts of the health system can be avoided.

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Priority/ Strategy Stream	Population	Sectors that would benefit	Service/Quality Gaps
Implement Aging at Home Priorities identified in the Central LHIN IHSP and ASP.	• Seniors • People with chronic diseases • Seniors with mental health problems • People who are at the end of their lives • People with physical disabilities and/or neurological disorders	• CCAC • CSS and SHS • Hospital • Primary Care Long Term Care Home • CHCs Complex Continuing Care • Rehab	• Lack of sufficient service (waiting lists) • Lack of integration making transitions between service sectors difficult • Lack of system navigation, service coordination
Build Community Capacity and Enhancing Community Based Care to facilitate Aging at Home	• Seniors • People with chronic diseases • Seniors with mental health problems • People who are at the end of their lives • People with physical disabilities and/or neurological disorders	• CSS and SHS • CCAC • CHC	• Lack of infrastructure, skills, knowledge and resources to deliver required service volumes effectively • Lack of sufficient services to meet demand
Encourage Innovation to support Aging at Home	• All populations living in the community	• All sectors • Non health agencies, municipalities • Other LHINs	• Doing things differently • Developing new models of service delivery • Lack of service/agency integration

B. Possible Performance Measures and Outcomes

Alignment with IHSP/Benefit to Seniors

The Central LHIN Aging at Home initiatives links fully with the priorities identified in the Central LHIN's IHSP.

The Central LHIN IHSP focuses on the development of an accessible and integrated system of care. At this point in time residents of Central LHIN do not have access to a comprehensive continuum of care. However through the Aging at Home initiative the capacity of the current service delivery system will be enhanced so that seniors and their caregivers can access a flexible basket of services that is customized to meet their

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individual needs in a way that supports the seniors' independence and the caregivers' ability to continue to provide supportive care.

The three Strategy Streams will provide the following benefits to seniors and their caregivers.

Strategy Stream	Benefits to Seniors and to their Caregivers
1. Implement Aging at Home Priorities identified in the Central LHIN IHSP and Annual Service Plan.	• Ability to access a comprehensive basket of services that will serve to support aging at home • Meet needs identified by seniors and family unit • Easier access to information and referral • Assistance navigating the health system • More coordinated care • Increased support for informal caregivers (so that they can maintain their caregiving roles) • Enhanced access to services that meet the ethno cultural, linguistic and religious needs of the senior and caregiver • Easier transitions from hospital to home, from hospital to LTC home • Enhanced access to specialized geriatric care
2. Build Community Capacity and Enhance Community Based Care to facilitate Aging at Home	• Enhanced access to community based services • Easier transitions from hospital to home • More integrated and coordinated care • Increase in flexibility and quality of care • Enhanced support for family caregivers • Increased ability to stay at home instead of going to long term care homes • Better monitoring of care needs and identification of those who are frail or at risk
3. Encourage Innovation to support Aging at Home	• Broad involvement of health and non health providers • Integration and coordination of health with other non health services • Individual ethno-cultural and faith-based needs met • Better access to health promotion and wellness programs • Increased independence and quality of life

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Health System Sustainability

The Central LHIN Service Plan will result in health system efficiencies and will contribute to long term sustainability in the following ways:

Strategy Stream	Health System Efficiencies
Implement Aging at Home Priorities identified in the Central LHIN IHSP and ASP.	• A new model of information and referral will provide easier access to services and reduce deterioration of seniors who are awaiting services in the community • A specialized geriatric system navigation service will facilitate access to appropriate services, help coordinate care and reduce readmissions to hospital. • Enhanced access to Specialized Geriatric Services will provide appropriate and specialized assessment, treatment and supervision of seniors in the community and reduce lengths of hospital stay, frequent visits to Emergency Rooms and need for long term care places.
Build Community Capacity and Enhancing Community Based Care to facilitate Aging at Home	• An enhanced and well-resourced community support sector will alleviate pressures on hospitals and CCACs, and maintain seniors in the community for longer periods of time. • Targeting community services to at-risk seniors will reduce premature need for long term care and decrease utilization of hospital beds and Emergency Rooms.
Encourage Innovation to support Aging at Home	• Innovative programs will demonstrate how to do things differently and will move agencies towards system change and integration • Innovative programs for ethno cultural populations in Central LHIN will increase access to community services and reduce caregiver burden and need for institutional care • Innovative health promotion and wellness programs will contribute to the maintenance of seniors in the community. • Prevention programs will reduce the incidence of falls, and other injuries, which often require medical and/or hospital care.

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Performance Indicators

The following is a draft list of performance indicators that will be considered for use to monitor the success of the implementation of the Aging at Home Service Plan. Use of these indicators, however, still needs to be confirmed and may be limited by the availability of data especially in the initial stages of the plan.

Strategy Stream	Performance Indicators
#1: Implement Aging at Home Priorities identified in the Central LHIN IHSP and ASP.	• Decrease in ALC days • Increased access to information – track number of calls to information lines • Increase in the number of referrals to CSS agencies • Increased client and caregiver satisfaction • Decrease in wait times for LTC home beds • Shorter lengths of stay for seniors in hospitals • % of seniors discharged home from hospital (comparison over time) • Number of geriatric assessments in hospital and in the community
#2: Build Community Capacity and Enhance Community Based Care to facilitate Aging at Home	• Decrease in CCAC Waiting Lists • Decrease in hospital ALC days • Decrease in LTC home waiting lists • Increase in number of respite care services provided • Number of seniors who visit emergency rooms who are discharge home (preventable admission) – comparison over time • Number of partnerships/collaborative programs developed • Number of integration activities
#3: Encourage Innovation to support Aging at Home	• Number of innovative programs implemented • Number of ethno specific programs developed / Increase in number of units of ethno specific services delivered • Number of health promotion programs developed • Decrease in the incidence of falls for seniors in Central LHIN (Emergency Room data) • Number of partnerships involving non health funded providers

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C. Workplan

Community Engagement

Collaboration

- The Central LHIN will facilitate coordination and cooperation between key stakeholders and partners (including third parties) in the following ways:

Approaches to Planning

- Central LHIN has developed its IHSP and ASP priorities with the input and involvement of multiple stakeholders and community groups. This approach is being replicated in the Aging at Home Strategy.
- Central LHIN has developed networks and work groups (populated by a broad representation of stakeholders) to develop its IHSP and ASP. This practice will continue with the planning and implementation of Aging at Home initiatives.

Development of Collaboratives

- Central LHIN will encourage and support the development of Aging at Home-related networks and collaboratives which will identify service gaps and overlaps and prioritize need.
- Central LHIN will involve networks and collaboratives in the planning and implementation of Aging at Home initiatives.

Resource Allocation Criteria

- Central LHIN will develop Aging at Home resource allocation criteria that necessitate collaboration and/or the development of partnerships
- Central LHIN will involve community partners in the development of selection criteria and in the selection of successful initiatives

Community Consultation and Participation

- Central LHIN will provide information about the Aging at Home Strategy through a variety of approaches and in a variety of venues.
- Central LHIN will consult broadly on the Aging at Home Strategy with providers, consumers and diverse community groups
- Central LHIN will invite third parties to partner with Central LHIN health service providers in the development of innovative initiatives

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Priority Activities

The Central LHIN will undertake the following activities to implement initiatives in its three Strategy Streams:

Strategy Stream	Existing/New Groups	Priority Activities
Implement Aging at Home Priorities identified in the Central LHIN IHSP and ASP.	• Seniors Advisory Network and related Work Groups • Mental Health and Addictions Network and related Work Groups • Chronic Disease Management Network and related Work Groups • Primary Care	• Develop detailed plans and budgets • Consult with community stakeholders • Support the development of networks/collaboratives which will share responsibility for implementation (e.g. Doorways to Care Collaborative, Specialized Geriatric Services Collaborative, Palliative Care Network, Specialized System Navigators)
Build Community Capacity and Enhancing Community Based Care to facilitate Aging at Home	• Central Community Support Services Network • Dementia Networks • Central LHIN Long Term Care Home Work Group • Central LHIN Standing Committees (Hospital-CEO Roundtable, LTCH Liaison Committee)	• Identify and prioritize CSS, SHS and CCAC service gaps • Identify and prioritize resource/ knowledge /infrastructure gaps in CSS sector • Develop a collaborative community process for provider selection • Develop detailed implementation plans and budgets for priority areas
Encourage Innovation to support Aging at Home	• Central LHIN Advisory Networks • Central LHIN Diversity and Inclusion Committee • Health provider networks • Ethno cultural groups • Other stakeholders (seniors groups, United Way, municipality)	• Prioritize areas of innovation • Develop criteria for innovative initiatives (based on Central LHIN objectives of integration, coordination, and access) • Do call for proposals and select innovative initiatives

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D. Policy/Legislative Enablers

Central LHIN requests assistance with the following policy or regulatory changes:

- Eliminate line by line budgeting in the community support sector
- Allow Supportive Housing Services to be provided in for profit and private housing (e.g. on cluster care model)
- Allow Community Support Service agencies to use funds to pay volunteer coordinators, service coordinators, etc.
- Build flexibility into service maximums in Community Care Access Centre services
- Make eligibility criteria for personal support services (e.g. requirement of assistance with a bath) more flexible
- Change OHIP funding limitations so that Palliative Care physicians can get paid for travel to their patient's homes
- Develop policies that protect current and future investments in Specialized Geriatric Services (hospital and community-based)
- Develop policies that protect current and future investments in Community Care Access Centre and Community Support Services for seniors

Central LHIN will not be able to implement its Aging at Home Strategy initiatives fully unless the changes listed above are implemented. The Central LHIN is not aware of any risks associated with these policy changes.

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