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North East
Local Health Integration Network

AGING AT HOME STRATEGY
Directional Plan – October 31, 2007

FINAL

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1.0 Introduction: The Aging at Home Strategy

The Aging at Home Strategy is a $702 million investment over 3 years that will provide seniors and their caregivers with an integrated continuum of community-based services to enable them to stay healthy and live more instrumentally in their homes.

This Strategy involves a significant shift in emphasis away from long-term care (LTC) home beds to providing a comprehensive mix of community-based services for seniors, created by “doing things differently” i.e. linking existing services and providers with new and different approaches to service and non-traditional providers.

This implementation of the Strategy is critical in light of current and impending systemic and demographic factors within the North East. These include, for example:

- The NE LHIN covers a large geographic area of approximately 400,000 sq. km. The population of 561,882 per the 2006 Census has an older age structure, with a relatively high proportion of First Nations, Aboriginals, Métis and Francophones.

- The NE LHIN region has a higher proportion of the population age 65+ than the province i.e. 14.9% and 12.9% respectively (2001 Census). This represents approximately 91,842 of the total population.

- The NE LHIN has a projected 39% increase in the population age 65+ by 2016 (Ministry of Finance, 2005).

- There are approximately 7,700 people currently with Alzheimer disease or related dementia in the North East. This number is expected to rise by 30% to just under 10,000 by 2016 (North East Dementia Network Coalition, June 2007).

- There are over 23,000 older persons living alone in the NE LHIN. Overall, 65% of seniors live as a family, 4% live with relatives, and 30% live alone. James Bay Coast area residents show the highest percentage of older persons living as families at 77% compared to 65% in the NE LHIN as a whole

- Relative to the province, the NE LHIN has a higher percentage of unemployment, low-income rate, daily smokers, adults who are obese, overweight.

- The Alternate Level of Care issue is a particular challenge for the NE LHIN region which has one of the highest ALC utilization rates in the province at approximately 14-18.8% of all acute inpatient days between 2003/04 and 2006/07.

In their leadership role as local health system managers, Local Health Integration Networks (LHINs) will leverage significant change to improve services for seniors, and integrate and fund services at the local level. The Ministry, in its stewardship role, will continue to provide overall policy directions and enable implementation of planned services.

1.1 Process

The Aging at Home Strategy was announced on August 28, 2007 by the Minister of Health and Long-Term Care (MOHLTC). An Aging at Home Strategy Working Group consisting of representatives of all the LHINs and key Ministry staff is meeting bi-weekly to support LHINs to develop local implementation plans consistent with the principles and goals of the Aging at Home Strategy.

The LHINs are being provided with planning dollars in fiscal year 2007/08 to assist them with community engagement and other activities to determine what each LHIN area needs to enable seniors to age at home.

In the initial phase of the development of this Strategy, the LHINs will prepare two submissions:

- a high-level directional overview by October 31st, 2007; and
- a detailed implementation plan by January 31st, 2008.

Implementation of the Strategy will begin April 1, 2008 and continue over three years.

2.0 North East LHIN High-Level Service Plan

There have been numerous studies and discussions over the last 10-15 years in the North East that have identified similar challenges facing the community sector across all planning areas in the region. As these issues are shared almost universally from one area to another, many of the high level solutions are also shared.

Previous planning reports, as well as the results of recent initiatives (e.g. the NE LHIN's June 2007 ALC Summit, the ongoing NECCAC/Hospital Point-in-Time analyses, the work of the ALC Task Forces, and the NE LHIN Annual Service Plan) all point to the need for flexible and cost-efficient service capacity for seniors who wish to remain in their home and community as long as possible. Within this context, the unique needs of French speaking and Aboriginal/First Nations communities must also be met. Some of these key recurring themes include:

- early risk assessment mechanism;
- coordinated care processes between the CCAC, hospitals and community supports aimed at effective admission avoidance and LTCH placement;
- evidence-base primary and secondary prevention strategies to assist seniors to live instrumentally in their home;

- increased caregiver respite program;
- enhanced personal support and homemaking programs;
- expanded Activities of Daily Living (ADL) & Instrumental Activities of Daily Living (IADL) services; and
- enhanced supportive housing resources.
- recruitment and retention of professionals, para professionals to meet the service demands

Without going into detail, this Interim Service Plan is intended to give a high-level overview of the direction the LHIN will be taking in implementing the Aging at Home Strategy. Using the information collected in its community consultations and consolidated in the Integrated Health Service Plan (IHSP), the LHIN will identify the types of services it intends to expand or develop in order to support seniors to age at home, and how, in general terms, the LHIN will enable that to happen.

This document will help ensure joint planning by the Ministry and the LHINs for the implementation of the Aging at Home Strategy. Specifically, the service plan will:

- identify the LHIN's strategy to develop innovative programs and services to support seniors;
- enable the LHIN board to ensure that the Aging at Home plan is consistent with the IHSP and the goals and principles of the Aging at Home Strategy;
- provide the Ministry with recommendation related to legal, regulatory and policy issues affecting the creation and provision of new and innovative programs and services and approaches; and
- identify Ministry supports required to develop local implementation plans consistent with the principles and goals of the Aging at Home Strategy.

3.0 Service Plan Description

3.1 Objectives and Priorities

The following outlines the objectives for the NE LHIN high level plan. The main outcome of these objectives is to improve the overall quality of health for seniors residing in the NE LHIN.

OBJECTIVES

- To identify strategies and approaches in order to create a system of care across the North East LHIN that will allow seniors to age in place.
- To establish partnerships with traditional and non-traditional health service providers.
- To develop a comprehensive communication plan for the general public and all health service providers.

AGING AT HOME DIRECTIONAL PLAN PRIORITIES

Each of the seven planning areas in the North East LHIN had the opportunity, through various means, to identify initial local service gaps and recommendations that are included in this interim plan. Additional opportunities for input with Health Service Providers and senior consumers and senior consumer groups will be provided as further detailed planning for the January 31, 2008 submission (which will outline priorities for all three years of the Strategy) is undertaken.

The following table outlines regional themes that are reflective of the local input received, and will be used as the basis in developing the three-year plan for the North East LHIN.

Service / Quality Gaps	Proposed Strategies
Limited alternative care settings for seniors requiring 24/7 supervision.	• Affordable/subsidized supportive housing. • Expansion of community support services to include a wide range of services. related to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). • Enhancement of 24/7 support services to create supervised settings in already existing seniors' residences/apartment buildings.
High number of falls. Medication management. Timely risk assessment.	• Development of a Specialized Regional Geriatric Program/Network. • Development of collaborative medication management programming. • Enhanced falls prevention programs.
Lack of transportation options.	• Establish alternative transportation options for inter-facility transfers, and transportation as a basic community support service.
Support for caregivers.	• Increase in-home respite. • Enhance adult day programming.
Peer support for seniors.	• Enhance existing volunteer agencies and friendly visiting programming.
Appropriate care settings and levels of care for seniors with dementia and mental illness/addictions.	• Psychiatric nurses in long-term care homes. • Dementia units with appropriate level of care. • Enhanced linkages to community mental

Service / Quality Gaps	Proposed Strategies
	health services. • Build system capacity to screen, assess and treat seniors at risk for mental health and addictions.
Social isolation in urban and rural areas/seniors living alone.	• Enhanced services related to Instrumental Activities of Daily Living (IADL). • Linkages with Seniors Social Clubs/Associations.
Early risk identification and prevention.	• Development and implementation of a standard risk assessment tool in the North East. i.e. Identification of Seniors at Risk Tool (ISAR).
Appropriate care settings and levels of care for palliative clients.	• Coordinated community end-of-life strategy. • Identify areas in the North East requiring a residential hospice. • Ensure the viability of existing hospices in Sudbury and Sault Ste Marie (capital and operational dollars).
Public awareness of services available.	• Public campaign profiling services. • Ensure full implementation of Information. and Referral Program through the North East CCAC and the electronic directory of services model. • Development of a comprehensive communication plan. • Development of a wellness, prevention and promotion strategy to address the service gaps.
Increase the occupancy rate of short stay beds and convalescent care beds.	• Legislation change required to permit flexibility in using these beds for interim crisis placement.
Long-term care home bed complement and distribution.	• Culturally appropriate long-term care beds across the NE LHIN. • Identify areas in the North East requiring additional long-term care beds.

Service / Quality Gaps	Proposed Strategies
Lack of residential care/supportive housing options and culturally appropriate LTC homes.	• Enhancement of home care, nursing services, personal support, friendly visiting, and medical transportation.
Lack of LTC homes and palliative care in First Nations Communities for urban and rural Aboriginal population.	• Investigating models and best practices for culturally appropriate services in First Nations communities as well as rural and isolated areas.

In many First Nations and Métis communities, accessibility to services is often limited by: the complexity of current service delivery structures which involve several different departments and programs; and the lack of a single service entry structure at the community level. The province has moved to reduce costs through more effective coordination of health services. These economies of scale cannot be matched in First Nations communities; therefore, the gap is widening between Aboriginal communities and provincial services. There is also a major gap in quality supportive housing for Aboriginal seniors.

Based on discussions to date, the following is being proposed by Aboriginal and First Nations communities (please note that this list will be further developed in the detailed January 2008 plan as engagement with Aboriginal and First Nations communities proceeds):

- examine/analyze current conditions and solutions (e.g. Mamaweswin Tribal Council, James Bay General Hospital);
- create coordinated approaches (e.g. James Bay General Hospital, Manitoulin Island, Mamawesin Tribal Council);
- create new positions within coordination and system navigation to ensure improved case management and the streamlining of services (e.g. Manitoulin Island and Sault Ste. Marie).
- expansion and enhancement of existing Aboriginal, Métis services in urban and rural areas.

BENEFIT TO POPULATION GROUPS AND HEALTH SERVICE SECTORS

As part of the implementation plan, a formalized definition of a senior will be developed. However, for the purpose of this high level plan the NE LHIN has identified a list of potential target groups that reflect the diverse cultural and linguistic backgrounds of seniors who reside in the NE LHIN region. These include seniors:

- whose level of disability require assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (ADL);
- who require chronic disease prevention and management (e.g. falls, Chronic Obstructive Pulmonary Disease (COPD), cardiac related diseases);
- requiring optimal levels of personal care and homemaking;
- who could benefit from a Regional Geriatric Program;

- with mental health conditions (e.g. Alzheimer's and related dementia, depression, delirium);
- who require help with accommodation (e.g. assistive devices, supportive housing, long term care home);
- requiring transportation to access vital services (e.g. medical appointments, shopping);
- who are in need of social supports (e.g. friendly visiting, adult day programming); and
- who chose to die at home or in a community setting as opposed to hospital.

This Strategy also includes:

- Aboriginal seniors 55+; and
- caregivers and family members who support older adults to remain at home.

* For the Aboriginal population, seniors are defined as people 55 years of age and older. This would take into consideration the shorter life expectancy for the First Nation population which is 5 years for females and 7 years for males (Health Canada).

Implementing the identified priorities will result in beginning the process of improving the health care system and population health status in the NE LHIN. By establishing and enhancing community support services and other community linkages throughout the North East, we will experience relief in ALC pressures within hospitals, which in turn will allow them to focus on acute care. Long-term care homes will be better resourced to manage special and high needs populations across the continuum of care. As well, the Francophone population will experience improved accessibility of services provided in their language. Allocating resources to the community sector will enable the provision of quality and appropriate care where people live. This will lead to a more sustainable health system.

HIGH LEVEL DESCRIPTION OF THE IMPLEMENTATION PLAN

The Health System CEO Round Tables in six of the planning areas in the North East will be the main planning platform for the three-year Aging at Home plan. The membership is comprised of:

- NE LHIN funded sectors: Hospitals, CCAC, Long-Term Care Homes, Community Support Services, Community Mental Health and Addiction, Community Health Centres.
- Partner sectors: Public Health, District Social Services Administration Board, Primary Care.
- Three additional members selected at the discretion of the Round Table.

Each planning area round table provided input into the NE LHIN's Interim Aging at Home Service Plan. As a next step, these tables will develop local implementation plans that will be rolled up into the detailed service plan to be submitted to the Ministry

of Health and Long-Term Care in January 2008. Subsequently, the round tables will provide advice in the monitoring and evaluation plans. They will also provide ongoing input into the Aging at Home three-year plan.

In order to effectively identify the needs of Francophone residents within the detailed three-year plan, the North East LHIN will be consulting with, and seeking the advice of established FLS networks, community groups and resources across the region.

With respect to the Aboriginal/First Nations/Métis communities, the NE LHIN will have two processes. The first will be within the NE LHIN's James and Hudson Bay Coast planning area where a task force will be struck with representation from the James Bay General Hospital, Weeneebayko Health Authority and the Mushkegowuk Tribal Council. Its role will be to plan for the Aging at Home Strategy until the new Weeneebayko Area Health Integration Framework Agreement is implemented. Other engagements will occur with the Moosonee Friendship Centre and Moose Cree First Nation.

The second is to establish an interim regional process with key Aboriginal health service providers such as First Nations, Tribal Councils, Friendship Centre's, Métis health sites, Aboriginal Health Access Centres, and Hospitals.

4.0 Performance Measures and Outcomes

4.1 Alignment with IHSP / Benefit to Seniors

The Aging at Home Strategy is an investment that will provide supports to seniors and their caregivers to live healthy and instrumental lives in their own homes and communities. The NE LHIN will ensure more equitable access to health care by matching the needs of local seniors populations with the appropriate local support services.

The plan is designed to support the principles and goals of the Aging at Home Strategy, and has a strong focus on innovation and prevention in dealing with the diverse needs of seniors across the North East.

The NE LHIN Interim Service Plan addresses the gaps and recommendations identified in each of the planning areas. Positive impacts related to the IHSP priorities will be realized as we move forward with the development and implementation of the Strategy and related investments. The following IHSP priorities will be positively impacted by this service plan:

- reduction in ALC days;
- alignment with the Chronic Disease Prevention and Management priority;
- enhanced range of linguistically and culturally sensitive services for Francophone seniors;
- improved care to Aboriginal/First Nation/Métis seniors;
- alignment with the Health Human Resources priority;

- alignment with the Information and Communication Technology priority; and
- improved wait times with hospitals as ALC days are reduced.

4.2 Health System Sustainability

In shifting from the institutional model to a community-based model, seniors in the North East will be able to access the same level of care regardless of where they reside. The new model of care will ensure that seniors get the right care, at the right time in the right setting. Efficiencies across the health care system will be realized such as:

- reduced hospital admissions/re-admissions and emergency room visits;
- reduced wait times for long-term care home placements;
- reduced in ALC days; and
- enhanced range of more appropriate and cost-effective care settings.

4.3 Performance Indicators

The following performance indicators are being proposed by the NE LHIN to measure the impact of the proposed services. The following are examples of developmental indicators that are being considered.

- reduction in ALC days;
- reduction in hospital admissions/re-admissions and emergency visits by seniors;
- cultural appropriateness of services with respect to Aboriginal/First Nations/Métis communities;
- accessibility to FLHS;
- reduction in wait times for long-term care home placements; and
- increased inter-agency referrals.

It is also suggested that a standardized client satisfaction survey be developed in collaboration with health service providers to measure indicators such as access to services, types/levels of services, quality of life and quality of service delivery. As part of the annual reviews, the results from the surveys will be used to continuously improve processes.

5.0 Collaboration

The NE LHIN is establishing structures to ensure a high level of collaboration and coordination among health service providers across the North East. Included in the NE LHIN's community engagement strategy is the World Health Organization's (WHO) framework *Towards Unity for Health*. The five key partners identified by WHO are: policy makers, health professions, academic institutions, communities and health

managers. The overall goal of the NE LHIN will involve these partners in the Aging at Home planning process.

The NE LHIN will leverage the work that was accomplished by the four ALC Task Forces that have been established in Sault Ste. Marie, Sudbury, North Bay and Timmins. Additionally, the Health System CEO Round Tables in six planning areas will be used as the main platform for the annual Aging at Home planning process. The NE LHIN will also be developing an engagement strategy to ensure the voice of seniors is heard.

With respect to the Aboriginal, First Nations and Métis engagement around the Aging at Home Strategy (as well as other related NE LHIN work), it should be noted that some of the historical partnerships, relations, lines of communications and processes relating to how Aboriginal health and the broader determinants of health are dealt with in the North East have been interrupted. Time is required, especially for First Nation and urban Aboriginal communities, to determine a suitable process for collaboration with other stakeholders in relation to the evolving LHIN structure.

6.0 Policy/Legislative Enablers

There are a number of service recommendations coming from the North East that will require facilitation by the MOHLTC as they require additions or amendments to current legislations and policies. To date, the following have been identified:

Utilization of Short Stay Beds

- Due to low utilization issues, a change in the regulations of the Long Term Care Act, 2006 is required to permit the use of these beds as interim crisis placement. This would apply to clients in hospital awaiting placement, or clients in the community who are in a crisis. Having the flexibility to use these beds in an interim crisis placement capacity, will reduce hospital length of stays and prevent unnecessary admissions to hospitals.

Utilization of Convalescent Care Beds:

- Due to low utilization issues, a change in the regulations of the Long Term Care Act, 2006 is required to permit the use of these beds as interim crisis placement. This would apply to clients in hospital awaiting placement, or clients in the community who are in a crisis. Having the flexibility to use these beds in an interim crisis placement capacity, will reduce hospital length of stays and prevent unnecessary admissions to hospitals.

Case Management and In-Home Services

- Currently in the health care system, no organization has the mandate to provide in-home intensive case management and services to seniors who have a primary diagnosis of a mental illness (including Alzheimer's disease and related dementias). A change in the regulations of the Long Term Act, 2006 is required to permit CCAC to provide intensive case management and services to these clients. This will ensure that seniors with a primary diagnosis of a mental illness and/or dementia have access to the same level of services as a senior with a medical diagnosis. Furthermore, the system will experience a positive impact on the number of ALC days, and hospital admissions/re-admissions and emergency room visits.

Enhancement of in-home personal support and homemaking services

- Currently, the CCAC is mandated to provide up to 80 hours/month of personal support/homemaking in the first month of care, and up to 60 hours/month thereafter. A change in the regulations of the Long-Term Care Act, 2006 and the supporting document CCAC Client Services Policy Manual, 2006 is required to permit CCAC to exceed the level of services for seniors.

Subsidy Rate System:

- Establish a subsidy rate system to help seniors and families with financial challenges afford the Short Stay Bed per diem. A change in the regulations of the Long Term Care Act, 2006 is required. The current rate has proven to be a barrier for some individuals in accessing these beds. A rate subsidy could provide additional respite for families as well as facilitate ALC patient transfer to LTCH pending permanent placement.

Partnerships with Retirement Homes and Seniors Residences:

- Establish funding partnerships with retirement homes and seniors residences to increase access to in-home services for seniors who require 24/7 supervision. Such a partnership would expand accommodation options as an alternative to supportive housing and ease pressure on LTCH sector by avoiding premature placement of light to moderate residents.

Long-Term Care Homes:

- Given the lack of resources that long-term care homes have to respond to the complex behavioural, cognitive, and psychiatric issues of residents, it is essential that the current classification system and funding formula be revised by the Ministry of Health and Long-Term Care to allow staff to provide safe and effective care for this client population. A change is the regulations of the

Long-Term Care Act, 2006 is required to ensure these clients have the appropriate level of care.

- A change in the regulations of the Long-Term Care Act, 2006 is required to provide LTCHs with the flexibility to adjust the 40/60 split of basic/preferred accommodation when required.

Funding for Hospices:

- Revisions to the capital and operational funding structures of hospices are requested to ensure their viability. Currently, communities are expected to fundraise for both the capital and operating costs of a hospice. The only funding a hospice currently receives is through the CCAC.

Aboriginal and First Nations Communities:

- To effectively roll out the Aging at Home Strategy, the NE LHIN would need to fund Friendship Centres and Métis Health Sites within the region as they provide the only long-standing, highly cost-effective programming that is culturally appropriate to urban Aboriginal/First Nation/Métis seniors outside of the Aboriginal Health Access Centres and Aboriginal Community Health Centres. The NE LHIN recommends that the MOHLTC approve the Métis Nation of Ontario and the Ontario Federation of Indian Friendship Centres under the LTC Act (as these two organizations are the flow through funders to the local providers).

6.1 Opportunities and Risks

The following outlines the opportunities and risks as they relate to the Aging at Home Strategy:

Opportunities	Risks
Seniors will age in place.	Continued upward trend in hospital ALC days, admissions/re-admissions and emergency Room visits. Increase in wait times for LTCH placement.
A senior with a mental illness will be cared for in the same manner as a senior with a medical condition.	Seniors with a mental illness will continue to fall through the cracks of the system and not receive the appropriate level of care.
Seniors will remain in their community and close to families and friends.	Senior will continue to be isolated from their family and friends.

Opportunities	Risks
Appropriate investment in alternative care options.	Increase in health care costs with minimal alternative levels of care available.
Parity in Aboriginal senior's care, over crowded living conditions, closing the life expectancy gap and developing a comprehensive approach to Aboriginal/First Nation/Métis health services.	Upward trend of costly and fragmented service delivery structures, misdiagnoses , poverty and premature death and dying will continue to escalate.
Improve quality of life for seniors and caregivers	Continued increase in elder abuse, poor nutrition, caregiver burnout.