Chapter One

Setting the Context for Change

"We're seeing increasingly complex patients whose care needs are quite high, who want to be at home in the community and who want to have the ability to stay in their own home as long as possible. As soon as you add services to a high risk senior in their home, you're going to prevent premature visits to the hospital."

Cathy Raiskums, Manager, Social Work
and Patient Flow Halton Healthcare Services

CHAPTER 1: SETTING THE CONTEXT FOR CHANGE

Setting the Context for Change

In-Home Community-Based Care

What Do Seniors Need?

Health System Pressures

Systems Thinking

Priorities for Ontario

System-wide “Home First” Philosophy

Policy for Ontario

Some Areas to Remember

Setting the Context for Change

Created by the provincial government in 2006, the Local Health Integration Networks (LHINs) are charged with planning, coordinating, integrating, funding and monitoring health service providers (HSPs) including hospitals, CCACs, long-term care homes, community support services and mental health and addictions services. The balancing act comes in investing in the local health system in a way that maximizes capacity while ensuring people have access to the right care in the right place at the right time at the right cost.

Launched by the Mississauga Halton LHIN in 2008, the Supports for Daily Living service has since become a vital care option along the local health system's continuum of care for high risk seniors with complex needs. The program is *one of the cornerstone components of the MH LHIN's "Home First" philosophy and service initiatives*. The service speaks to a significant gap that existed for a frail population who were increasingly finding themselves ready to be discharged from hospital but with few options available to them other than leaving their homes and moving into long-term care. Although still mentally capable of living independently or with the support of a family caregiver/ significant other, many high risk seniors don't have the physical capacity to carry on essential activities of daily living without ongoing support. These are seniors whose frequent need for in-home support has grown beyond a once daily visit schedule, but who aren't yet ready for the transition to long-term care. While the personal care and support services coordinated through CCACs are able to address most in-home care needs, high risk seniors with complex needs often require more frequent and intense visits throughout a 24-hour day to help with dressing, bathing, toileting support, making meals and medication reminders. They also require safety checks and access to urgent response. In our experience, *flexibility*, *responsiveness* and *frequency* are the keystone requirements for the needs of high-risk seniors in the community. The success of the SDL program has been based on meeting these requirements.

The following are factors that were among the driving forces that were taken into consideration when developing the Supports for Daily Living solution to address the needs of high risk seniors with complex needs in the Mississauga Halton LHIN.

In-Home Community-Based Care

Health care is increasingly moving towards solutions that focus on in-home community-based care. Within the hospital sector, there has been a decisive shift in focus from inpatient care to ambulatory care thanks to advances in evidence-based care, technology and emerging best practices. (e.g. day surgery, births) and with the coordination of in-home supports and community-based services through CCACs, many inpatients are able to return home to recover rather than remaining in hospital.

The enhanced focus on in-home care is increasingly being seen as a viable option for reducing costs associated with more expensive health care alternatives such as hospitals.

Family members are also taking on a growing role at home as informal caregivers, providing support to aging parents with chronic diseases and other co-morbidities. Ensuring these informal caregivers have access to respite and supports within the community will be critical to ensuring they can maintain the ability to care for loved ones within the home environment.

What Seniors Want

Through a series of engagement sessions, here is a sample of what seniors told the Mississauga Halton LHIN they want:

Live with dignity & independence

- Be listened to, respected and have their opinions valued

More housing options

- Prefer to stay at home with services to assist them

More social, recreational opportunities

- Companionship, mental stimulation and interaction

Feel safe in their homes and in the community

- Telephone programs, security checks, devices to communicate emergencies

Assistance with household tasks

- Difficult to continue fulfilling household tasks as they age

Additional and more flexible homecare services

- Allotted hours don't meet their needs

Respite and support for caregivers

- Accessible and affordable respite care

This shift to a focus on in-home care represents a change in how society views its role in addressing individuals' health care and quality of life needs, and opens the doors to new investment opportunities within the community support services sector.

What Do Seniors Need?

What is it that seniors need from their local health system? What would help them to continue living independently in their own homes?

Knowing the answers to these questions is critical to shaping a Supports for Daily Living (SDL) service that is responsive to those *essential activities* of daily living that significantly impact high risk seniors' ability to function. The SDL service must always address and impact the need for 24 hour availability and intermittent care as well as on-call response. The actual delivery of services cannot be all things to all people and must primarily focus on the delivery of personal care and essential homemaking services. More social and/or recreational services are not delivered within the context of the SDL service, but are sought from community partners or are provided by an SDL provider as an *adjunct* to core services in order to address a "well rounded" approach to care. Some or even all of the additional services may require service fees of the client, but never-the-less should be offered and coordinated if the client wishes to participate. Services such as Friendly Visiting, Hospice Visiting, Adult Day Programs, Transportation for shopping, Meals on Wheels or other such activities can assist in overall benefits to a client.

Focus groups, open forums or other community engagement activities coordinated by the LHIN or in partnership with local service, church or seniors' organizations can help shape a service model that appropriately addresses the needs of seniors, who want to continue living at home, but also to feel safe and secure in doing so.

Health System Pressures

Communities across Ontario are facing unrelenting health system pressures increasingly influenced by the growing needs of a rapidly aging population. With a number of LHINs across the province projecting rapid increases in their seniors' populations within the next five to ten years, this has serious implications for local health systems that are already grappling with backlogged emergency departments, limited long-term care bed capacity and inpatient beds occupied by people no longer requiring acute medical care (deemed as Alternate Level of Care or ALC). Many of these pressures can be attributed to the absence or limited amount of appropriate community-based capacity to address the needs of high risk seniors outside of hospital and institutional type settings.

Within the MH LHIN region, long term care bed capacity is below that designated for the region. Further, the growth projections for an aging population are among the highest in the province over the next 15 years. These two pressures alone would be enough to provide reasons to look for alternate solutions to long term care, let alone the capital costs that would be required to build long term care facilities. However, we are also believers in maximizing the potential of the seniors' population. Though we know that long term care is appropriate for some seniors requiring greater care than the community can provide, it is not the answer for those seniors who can and do recover from an episodic event in hospital or those who are able to live independently with some assistance. Building more long term care beds was not the solution to address mounting pressures – the solution was to utilize the foundation of supportive housing, analyze what needed to be done, maximize creativity and take some risks.

"Too many seniors end up in hospitals and don't have enough community/ home supports post discharge. Rather than investing in more long-term care beds, the Mississauga Halton LHIN tested and invested in the Supports for Daily Living model to generate the right community capacity to support high need and at risk seniors in the community."

Narendra Shah,
Chief Operating Officer
Mississauga Halton LHIN

Systems Thinking

As community-based organizations, LHINs are accountable for advocating a systems approach to planning, coordinating and integrating health care services in their respective communities. Systems thinking works to break down the silos that have traditionally existed between sectors and providers and instead focuses on generating collaborative solutions to find efficiencies, improve patient flow and maximize limited resources. Systems thinking represents a cultural shift within the health care sector and calls for strategic planning at a provider level that embraces input, expertise and insights from other providers such as CCACs, hospitals, community support services and long-term care. It's this cross-pollination that allows the LHINs to tap into unrealized potential within the system thereby generating new opportunities and the possibility of enhanced capacity.

Systems thinking cannot be underrated as a tool for change. This type of thinking is not easy as it demands that organizations look at solutions from the perspective of what works for the whole and not the one or the few. It demands that organizations put themselves outside of what would be beneficial to their individual agencies/institutions and focus on solutions that are of benefit to patient/client flow, to easing other stakeholders' pressures though potentially increasing their own, to what makes sense rather than what works on paper and to finding the fit that functions well rather than fitting the function to current process(es) or historical patterns (eg:"well that's how we've always done it."). Systems thinking reminds organizations that patients/clients should not accommodate the agencies/institutions and their processes, but that the agencies/institutions need to "get back to" remembering the nature of providing service to their biggest stakeholder – clients/patients.

Priorities for Ontario

The Province of Ontario and the LHINs have well-defined health care priorities that are reflective of what the public has defined as being important factors in improving health system performance. Among these priorities is reducing emergency department wait times, decreasing the number of people awaiting alternative choices of care whether in the community or in facilities, and lowering length of stay and alternate level of care (ALC) days in hospital. These priorities were among the key drivers behind and critical to the success of, the development of the Supports for Daily Living service. In the case of the Mississauga Halton LHIN, the Supports for Daily Living initiative aligned in the following manner:

1. Improve access, quality and sustainability of the health system (emergency wait times and ALC)
    - Reduce ER treatment wait times by enhancing community capacity to provide non-emergent care
    - Reduce hospital stays by increasing supports in home and community settings

2. Enhance seniors' health, wellness and quality of life.
    - Transform community capacity and programs to help 'at risk' seniors live at home as long as possible

It was against these priorities that the Mississauga Halton LHIN was able to monitor and measure its success after the Supports for Daily Living service was implemented.

The LHIN's multi-year funding allocation to increase community capacity under the 'Aging at Home' strategy was intimately aligned with the MOHLTC's overall ALC reduction and ED wait time strategy. The investments in the Supports for Daily Living service were made under the Aging at Home strategy.

The Aging at Home initiative provided the MH LHIN with the ability to invest in those areas that would maximize the achievement of a vision and targeted priorities. This wasn't a simple task as the MH LHIN needed to concentrate funding in targeted areas that would address system pressures as well as take some calculated risks in choosing ideas that did not have a proven track record of meeting system pressures. Resourcing those areas and ideas was akin to jumping into the deep end of the pool (ie: Would this drive the change that was being sought? Would this be the right idea?). The

supportive housing program was one such area. Taking this program to a whole new level of change and developing a new vision (Supports for Daily Living) was untried and untested. Further, in order to expand capacity for care to accommodate hospital discharges, the MH LHIN chose to utilize the majority of the Aging at Home funding to resource the community in general and the community support services sector (of which SDL is a part), in particular, in order to target specific initiatives that addressed system pressures and drive change.

System-wide 'Home First' Philosophy

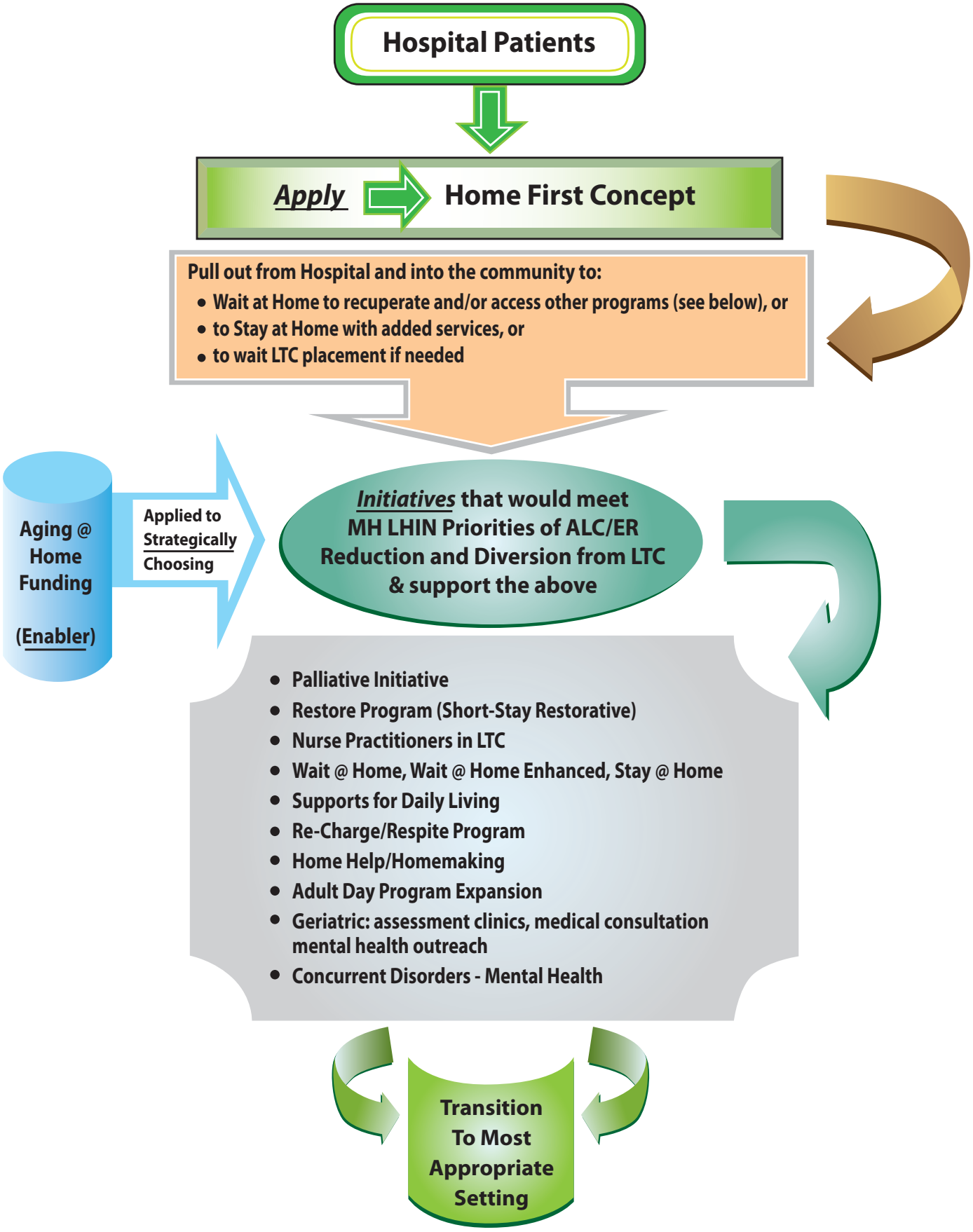
Studies have shown that well-managed patient care in the home can moderate the demand for more costly hospital/long-term care while also maintaining an individual's independence. As part of the MH LHINs' Aging at Home strategy, an initiative was developed that emphasized a new approach in thinking about high-risk seniors. This new evidence-based, person-centred approach, known as ***"Home First"***, became embedded as a distinct philosophy of managing patients in hospital to enable a transition to home wherever possible.

This philosophy is applied to all patients, but becomes specifically useful in targeting high risk seniors who require greater supports to transition home or who may be too quickly looked at for Long Term Care placement. By developing significant community programs to provide services in order to enable the transition home, high risk seniors in particular can be discharged earlier from hospitals to recover at home over a longer period of time. In some cases, these high risk seniors do transition to long term care placement. However, with the Home First philosophy in place, these seniors are able to make a life-impacting choice in their own homes and without the urgency faced in a hospital situation.

The community programs that were developed in the MH LHIN under the provisions of Aging at Home in order to support the Home First philosophy include:

- Wait at Home
- Wait at Home – Enhanced
- Stay at Home
- Supports for Daily Living
- Adult Day Program – Higher Acuity
- Short-Stay Restorative (Restore)
- Geriatric Strategy: Mental Health Outreach, Urgent Assessment Clinics, Geriatric Medical Consultation
- Home Maintenance and Repair + Home Help and Bathing
- Respite Services (Re-Charge)
- Enhanced Palliative Program

The following diagram illustrates the "strategy" behind the Home First concept:


Hospital Patients
Apply
Home First Concept
Pull out from Hospital and into the community to:
• Wait at Home to recuperate and/or access other programs (see below), or
• to Stay at Home with added services, or
• to wait LTC placement if needed
Aging @ Home Funding
(Enabler)
Applied to Strategically Choosing
Initiatives that would meet MH LHIN Priorities of ALC/ER Reduction and Diversion from LTC & support the above
• Palliative Initiative
• Restore Program (Short-Stay Restorative)
• Nurse Practitioners in LTC
• Wait @ Home, Wait @ Home Enhanced, Stay @ Home
• Supports for Daily Living
• Re-Charge/Respite Program
• Home Help/Homemaking
• Adult Day Program Expansion
• Geriatric: assessment clinics, medical consultation mental health outreach
• Concurrent Disorders - Mental Health
Transition To Most Appropriate Setting

Policy for Ontario

On January 1, 2011, the Ontario Ministry of Health and Long-Term Care introduced the *Assisted Living Services for High Risk Seniors Policy*. The policy was developed to address the needs of high risk seniors who have the ability to continue living at home with the availability of personal support and homemaking services throughout a 24-hour basis. The policy replaces the former *Assisted Living Services in Supportive Housing Policy, 1994 – updated 2001*. The MH LHIN assisted in the development of the policy through feedback to the MOHLTC. This feedback reflected the experience and development work on the new models of service delivery that had occurred in practice with the SDL service provider agencies.

The intent of the policy is to:

- enable local communities to address more fully the needs of high risk seniors so that they are able to remain safely at home
- expand cost-effective and accessible options for community care
- reduce unnecessary and/or avoidable hospital utilization and wait times of acute care services, emergency room use and admission to long-term care homes
- provide LHINs with the flexibility to adapt to client's changing care requirements
- strengthen assisted living services to achieve a more functional continuum of care for Ontario's high risk seniors within each LHIN.

Services provided under this policy are personal support, homemaking, and security checks or reassurance services. The policy points out that people receiving assisted living services in this manner may also be eligible for CCAC professional services. The policy also indicates that assisted living services are to be provided by agencies that are approved to provide these services under the *Home Care* and *Community Services Act, 1994* and that are funded by LHINs.

The Mississauga Halton LHIN's Supports for Daily Living service addresses every aspect of the new policy, providing a cost-effective solution that not only meets the needs of high risk seniors with complex needs, but also generates impressive results in reducing visits to emergency departments, diverting pre-mature admissions to long-term care and reducing length of stay and ALC days in hospital.

The success of Supports for Daily Living as a viable option for high risk seniors with complex needs rests with system-wide adoption of a Home First philosophy as it directly impacts the referral process and the ability of the LHIN to ensure people are being served in the most appropriate setting. The Home First philosophy has effectively and proactively reduced ALC length of stay (LOS) as well as reduced the demand for long term care placement in the MH LHIN. The MH LHIN continues to have one of the lowest ALC rates in the province that has been consistently evident for over 2 years running. As a result, Home First has since been launched as a provincial initiative by the Ontario Ministry of Health and Long-Term Care.

Some Areas to Remember

In the midst of trying to address what seniors need from their local health system, it is important to remember that health care funding has a limited "pot" from which to draw resources both monetary as well as human. To that end, the hours allotted in the SDL program must be focused in a targeted manner to provide the greatest impact in addressing need with a reasonable cost to the health care system. If the amount of service provided (and subsequent costs) begin to outpace that provided in another setting, it becomes imperative that SDL reassess whether the service being provided meets the criteria of ***"right care, right place, right time, right cost."***

It is also essential to remember that when the amount of service required by a client to remain with SDL services begins to outpace the SDL programs' resources, the client may be placed at serious risk for harm in that setting. As service providers, we must *remember and respect* that clients have *the right to live at risk* – they need to receive timely and factual information to make an informed choice about that risk and to understand when their needs exceed what the program can provide. These are difficult conversations, but they are essential to respecting a client's right to live at risk and the agencies' right to mitigate risk (see Standards Manual).

In many circumstances, conflicts will arise, perhaps because the family wants mom to enter a long-term care facility or dad doesn't wish to leave SDL service for long-term care even though his needs exceed what can be safely provided. In the former scenario, the SDL agency could be acting as an advocate for a client while in the latter scenario, the SDL agency is mitigating risk for the client and for itself. There are no absolutes and there isn't one way of doing things. Instead, an agency should clearly evaluate each client *individually* and *equitably* to see whether ***"right care, right place, right time, right cost"*** is or can be provided.

Policies that are *flexible within specific parameters* (an entry into and an exit from, but allow for individuality and equity in-between) are essential tools for agencies in order to avoid a "cookie-cutter" approach or keeping clients on service past the time when the risks to clients or others outpace the service that can be provided. As part of the commitment to advancing knowledge and understanding of the Supports for Daily Living program, we have developed a "package" of contents that include this SDL Resource Manual, the SDL ***Standards Manual*** that addresses the "how" of compliance in making the program work and the SDL Video. These resources are available on the Mississauga Halton LHIN website http://www.mississaugahaltonlhin.on.ca/