Chapter Two

Understanding the Landscape

"I wouldn't want to be totally alone. I'm not able to cook, and do all these things, or wash myself. How am I going to be able to do that? When I need to get dressed, or get out of bed and have a shower, they help me do that."

Delores B., age 70, stomach cancer
and breast cancer survivor

CHAPTER 2: UNDERSTANDING THE LANDSCAPE

Identifying Where Seniors Live

Capacity and Focus

Attaining Knowledge as a Place to Start/Establishing a Baseline for Measurement

Targeting High Risk Seniors by Leveraging Common Assessment

Transitioning from Supportive Housing to Supports for Daily Living

Understanding Past Practices

Identifying Where Seniors Live

One of the keys to developing a Supports for Daily Living service is recognizing where seniors reside within your LHIN. A Supports for Daily Living framework is based on a 'clustering' model. This means that the model is focused on those areas in the community where there are high density populations of seniors (65+). High density could exist within apartment buildings, condominium or townhouse complexes or within pockets of residential areas/neighbourhoods.

Determining where your populations of seniors reside within your LHIN can be accomplished by reviewing the postal codes of seniors (65+) who have been admitted to, and discharged from, hospital inpatient units and/or emergency departments, overlaying this information with CCAC client postal codes of seniors on service and then overlaying that information with LHIN population density mapping or Stats Canada population data. This exercise allows the LHINs to target specific areas where seniors reside in order to potentially fund an SDL program (building, hub & spoke models) to open in that area. Potential clients for an SDL program that opens in the area would be those coming from hospital as ALC inpatients or who are frequent users of the Emergency Department with MAPLe scores of 'moderate' 'high' or 'very high' needs (MAPLe 3, 4, 5) and who require *frequent care* throughout a 24 hour period that cannot be addressed through a visitation model of care.

> ***"Supports for Daily Living addresses the lack of programs available to support high need seniors in the community which is essential to address the need for the 4Rs – Right Care, Right Place, Right Time at the Right Cost."***
>
> Narendra Shah,
> Chief Operating Officer
> Mississauga Halton LHIN

Capacity and Focus

By placing Supports for Daily Living services in these more densely populated areas you have the capacity to:

- divert from and reduce, long-term care placement,
- provide support for clients who use the emergency department as a result of a decline in activities of daily living (e.g. dehydration due to poor nutrition, dizziness due to lack of eating, medication mismanagement due to lack of reminders to take the medication or taking too much),
- reduction in length of stay (LOS) in hospital that leads to a designation of ALC as a result of having no one at home to supervise or because of needing extra supports while taking longer to recover.

By focusing on clusters of seniors' populations within your community, you can:

- make the most efficient and effective use of human and financial resources in supporting the needs of high risk seniors living in these areas.
- reduce the need for extensive travel between clients,
- allow for the effective scheduling of personal support workers to respond to multiple daily service requirements of high risk seniors within a targeted area,
- accommodate and avoid displacement of seniors who may have lived in their communities for many years

Attaining Knowledge as a Place to Start/ Establishing a Baseline for Measurement

In 2008, the Mississauga Halton LHIN commissioned a retrospective review/research study with Dr. John Hirdes, Professor at the University of Waterloo, on appropriate level of care in various settings including the supportive housing program. The review/study encompassed MH LHIN agencies/facilities/providers that included 6 LTC Homes, MH CCAC, 3 hospitals and 11 Supportive Housing. The objectives of the review/study were to:

- Describe the populations in various MH LHIN service settings
- Examine appropriateness of service environments
- Pilot test the RAI Community Health Assessment (CHA) and supplementary modules in supportive housing
- Demonstrate the utility of the RAI suite of instruments to support MH LHIN decision making regarding resource allocation and service planning related to the continuum of care.

Overview of Results of Dr. J. Hirdes

- Many individuals with lower level needs based on RAI scores (less than 2 domains triggered) and based on staff ratings, were in more intensive service settings than they needed to be
- Many individuals who were waitlisted for LTC were in fact individuals with lower level needs that could have other community services provided in order to divert them from LTC (eg: CSS, CCAC, Adult Day, Supportive Housing, Homemaking, Respite, etc.)
- Few individuals with more intensive need requirements were inappropriately placed in a lesser need service setting

The following information identifies a brief overview of the number of assessments and data sources utilized in the review/study:

- ***Comparison of the care needs and appropriate service settings*** for persons in:
  - Home care with CCAC services -1,624 clients
  - Supportive housing – 367 clients
  - Long term care homes – 832 residents
  - Complex continuing care (hospitals) – 425 patients
- ***Data sources***
  - Pilot implementation of the RAI CHA in supportive housing settings
    - Among clients NOT receiving CCAC services
  - Abstracts of assessments already completed as part of normal clinical practice
    - RAI-HC
    - RAI 2.0 (CCC and LTC early adopters)
- ***Staff rating supplement on appropriateness of service setting*** (least intensive service setting that would appropriately meet a person's needs – now, @30 days, @60 days)
  - What supports/services are needed to transition to a less intensive service setting?
  - What barriers exist to transition to a less intensive service setting?
  - Is there a "fit" with the person's needs to the current service setting?

Summary Results of Dr. J. Hirdes

Long Term Care (LTC)

12% of the residents in LTC (from the assessments utilized in the review/study) within the MH LHIN LTC Homes, have lesser needs that could be more appropriately met in less intensive settings. This means that:

- In the 6 LTC homes involved in the review/study, 100 individuals did not need to be there – MH LHIN did not utilize data from the other 21 LTC Homes for the review/study, suggesting that far greater numbers exist that do not need placement in LTC

Complex Continuing Care (CCC)

- Upwards of 25% (106 patients) that were designated as ALC would be able to be cared for in settings ranging from LTC to home with CCAC services (all less intensive settings for individuals whose treatment had been completed ie; ALC).
- For those that were deemed non-ALC, upwards of 17% (64 patients) could be cared for in settings ranging from LTC to retirement homes (again, all less intensive settings)

Community Care Access Centre (CCAC)

- For those individuals on a LTC waitlist and receiving CCAC services, upwards of 37% (76 individuals) would be able to have their care needs met by either no home care or community support services (could come off of CCAC services)
- Upwards of 18% (37 individuals) receiving CCAC services could have their needs met through retirement homes or supportive housing, thus coming off of CCAC services
- For those CCAC clients in the community, upwards of 10% (142 individuals) would be able to have their care needs met by either no home care or community support services (could come off of CCAC services) while 7% (99 individuals) could have their needs met through retirement homes or supportive housing

Community Care Access Centre (CCAC) – cont'd

These results indicate that upwards of 22% (354) of the CCAC clients assessed for this review/study (N=1624) could be more appropriately served in another setting if the appropriate services were available.

Considerations by the MH LHIN on these findings included:

- The most cost-effective alternative, presuming that community support services (CSS) were less expensive than the CCAC and that the same level of care was provided:
  - Egs: 354 CCAC clients (presuming PSW service need only @ 1 hr per day X $30.00/hour X 365 days/year) = $3,876,300 or 354 clients X 2 hrs per day X $30.00/hour X 365 days/year = $7,752,600 or 354 clients X 10 hrs/week X $30.00/hour X 52 weeks/year = $5,522,400. ***Any of these examples could provide the availability of those resources to be re-focused to higher level need clients/pulling from hospital – if greater community capacity in CSS was achieved and discharge from CCAC services of lower level need clients was achieved***
  - If the CCAC has a greater caseload @ any given time than was utilized in this review/study (N=1624) and presuming the same percentage of 22% was utilized, a higher amount of resources could be re-focused

- Greater frequency of care needed throughout a 24-hour period to divert those who were LTC waitlisted

- The types of services that were needed in the community to address less intensive client needs (eg: adult day programs, bathing + homemaking services)

- "Off-loading" from CCAC caseloads those less intensive care need clients or those requiring more frequency/day care – re-focusing CCAC budget expenditures to higher acuity need individuals and pulling individuals from hospital as well as working more closely with supportive housing and CSS in order to sustain individuals in the community.

The results of the review/study created a good deal of discussion about the inappropriateness of individuals in more intensive settings for service than they needed to be as well as "right-sizing" the system. To create a sustainable system with a focus on the right care, in the right place, at the right time and at the right cost, the MH LHIN realized it needed to find alternatives for individuals by creating appropriate capacity within community and home settings as well engaging its' hospitals, LTC homes, CCAC, CSS and supportive housing sectors to examine practices and assumptions as well as contribute to ideas that would increase "flow" through the system. This approach would require an investment in the community to support individuals as well as service providers to shift their service focus from lower level to higher level need clients while transferring individuals to more appropriate care need settings.

Targeting High Risk Seniors by Leveraging Common Assessment

In 2008 the Mississauga Halton LHIN invested considerable effort in evaluating a standardized assessment tool that would be potentially beneficial to the CSS sector and effective in *determining client eligibility* for the supportive housing service. Supportive Housing providers evaluated the Common Health Assessment (CHA) instrument for appropriateness and effectiveness for their client population. During this time, 367 RAI-CHA assessments were completed, the results of which created a baseline and informed the development of the Supports for Daily Living framework. As with other inter-RAI assessment tools, the CHA includes an "algorithm" known as the MAPLe which is defined as a "Method for Applying Priority Levels". The MAPLe is scored from 1 to 5 with 1 being low risk needs and 5 being very high risk needs. The MAPLe scoring can be utilized as part of an effective strategy to prioritize clients requiring community or facility-based services.

Through the use of the CHA and the MAPLe algorithm, the Supports for Daily Living framework proposed targeting a *minimum of MAPLe level 3 clients*, with an emphasis on those at MAPLe levels 4 and 5, for eligibility to the new SDL services. This has represented a shift in the eligibility level of clients for supportive housing who have traditionally provided care to clients with lower level needs, (eg: MAPLe levels 1 and 2). However, the capacity within this sector to address high level client needs has been proven through the implementation of the Supports for Daily Living service models within the Mississauga Halton LHIN.

The following chart showcases how the SDL program adapted to its new role of meeting the needs of high risk seniors by transitioning from a supportive housing, lower client need service to a higher need SDL service within the course of 2-3 years.

	Pre SDL (2007/2008)	Post SDL (2010/2011)
% MAPLe Score 1,2	42%	8%
% MAPLe Score 3	53%	42%
% MAPLe Score 4,5	5%	50%
% 65+	74%	100%

Source: MH LHIN multi-year data indicators

The use of the CHA instrument and the MAPLe algorithm was essential for the transformation of supportive housing to SDL in order to shift the focus to higher needs seniors which in turn, delayed or permanently diverted these seniors from long term care or assisted a reduction in hospital length of stay (LOS) for those who needed a frequency model of service. With needs being met in the SDL models of service delivery, long term care beds were more readily available for those who required an even higher level of care. Similarly, those individuals who were SDL clients and needed hospitalization were returned home faster knowing that SDL service was in place to assist clients who needed a longer time for recovery. The benefit to the health care system, not to mention clients and their families, has been a resounding success. Examples of this "return on investment" or ROI is shown in Chapter 7 and highlights savings to the health care system.

Transitioning from Supportive Housing to Supports for Daily Living

An SDL Work Group, comprised of supportive housing service providers, Mississauga Halton LHIN staff and representation from the Mississauga Halton Community Care Access Centre (CCAC) conducted an assessment of the existing supportive housing service program and discovered a fragmented system of services driven by provider versus client need. The SDL Work Group began the task of developing a regionally integrated community service delivery model by establishing a common vision, a common model, common definitions and common assumptions on the road to developing a framework for this new "entity" known as Supports for Daily Living (SDL). The foundation piece to their work was utilizing the former supportive housing model as articulated in the MOHLTC's *Assisted Living Services in Supportive Housing policy, 1994* – updated 2001. From this foundation, the group identified information needs that included:

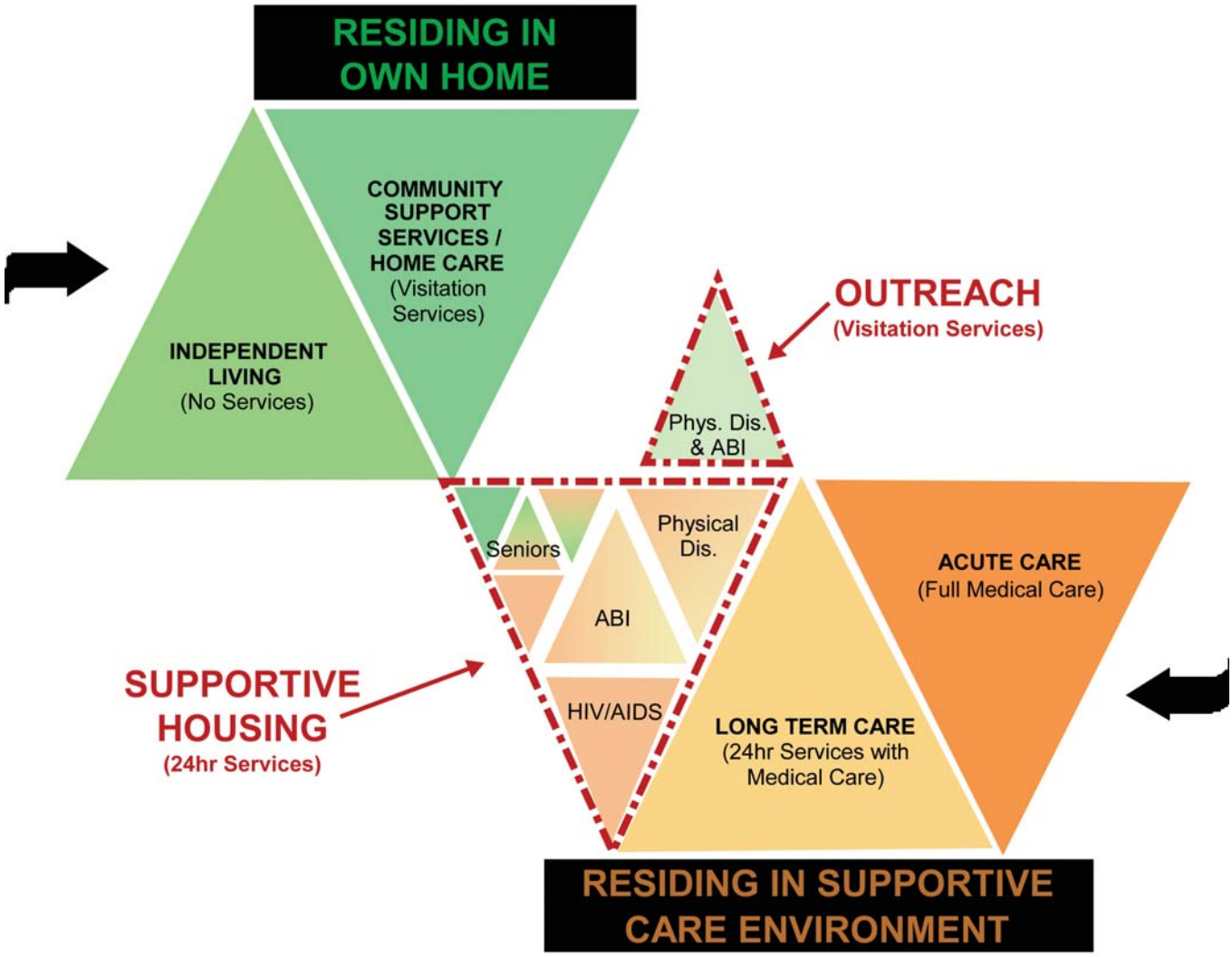
- defining the LHIN populations that would be using the service
- identifying designated neighbourhoods based on population density over the age of 65 and in all home settings (e.g. townhouses, condos, co-ops, single dwelling homes, social housing, etc.)
- developing a profile of client needs for the service (e.g. light, right, heavy)
- establishing eligibility criteria and a decision tree
- establishing a baseline amount of service time and frequency as well as service costs, and
- developing standardized core services.

The SDL Work Group reported into the Mississauga Halton LHIN's ALC Steering Committee, with the SDL Work Group Chair sitting on both groups. The ALC Steering Committee consisted of key leadership from the broader health system including the Mississauga Halton LHIN, hospitals, the Mississauga Halton CCAC, community service provider agencies and long-term care. This group provided an ideal forum for testing system-wide reaction and support for the proposed delivery model. Once the framework for the Supports for Daily Living service was approved, three lead agencies represented on the SDL Work Group, each piloted one of the three SDL models for close to a year before the model was rolled out to another five service providers within the LHIN.

The following diagrams identify the "pre-SDL" framework and the "post-SDL" framework within the continuum of care

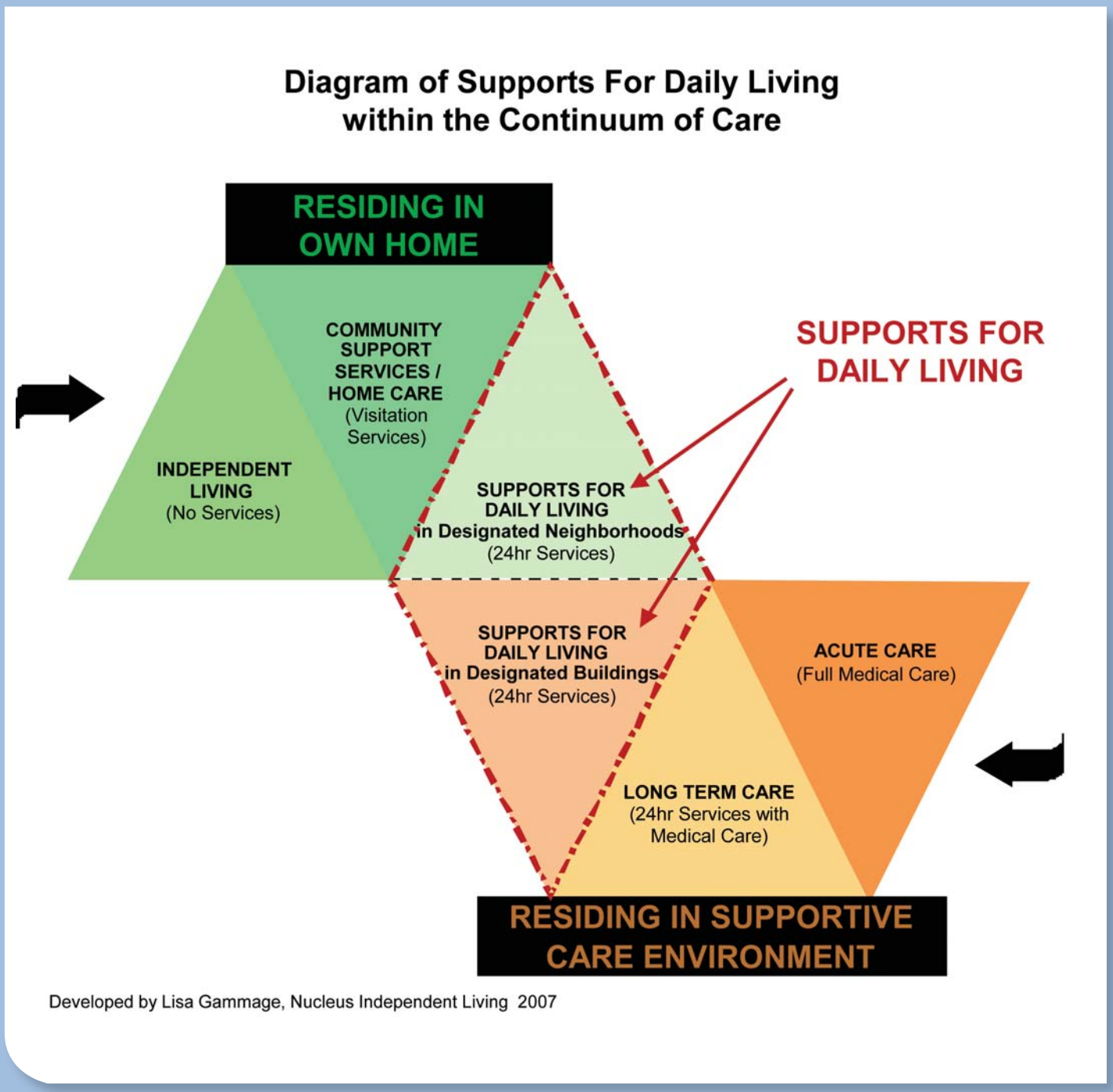
Pre-SDL Framework

Diagram of Supportive Housing within the Continuum of Care



Developed by Lisa Gammage, Nucleus Independent Living 2007

Post-SDL Framework



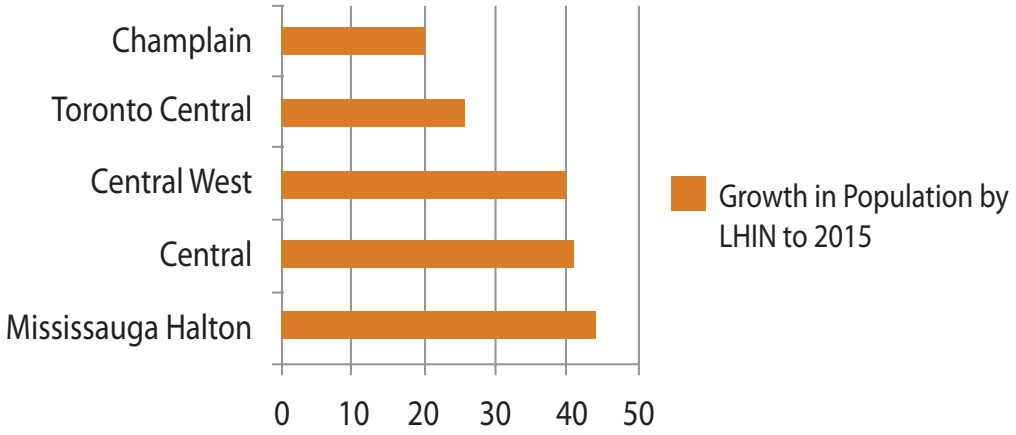
In evolving the service from the existing supportive housing model, the group ***changed the focus from providing a program in certain designated buildings to a focus on service wherever seniors lived throughout the region***. Further, the group clearly articulated that "housing" needs were separate from "service" needs. This meant that it could no longer be assumed that service would automatically be provided in a designated building just because you lived in that building as this thinking placed "service" needs at a lower priority than "housing" needs. The provision of service was to be based on eligibility criteria obtained through a standardized assessment instrument that provided objective data.

Understanding Past Practices

To change a current practice, it is often necessary to understand past practices, what was emphasized, and what had value. It is also beneficial to seek information that can provide insight to guide future direction. To this last point, the MH LHIN looked at growth projections for the LHIN of those 85+ (most likely to need assistance for daily functions) as well as the experience of other jurisdictions in the number of LTC beds for the population.

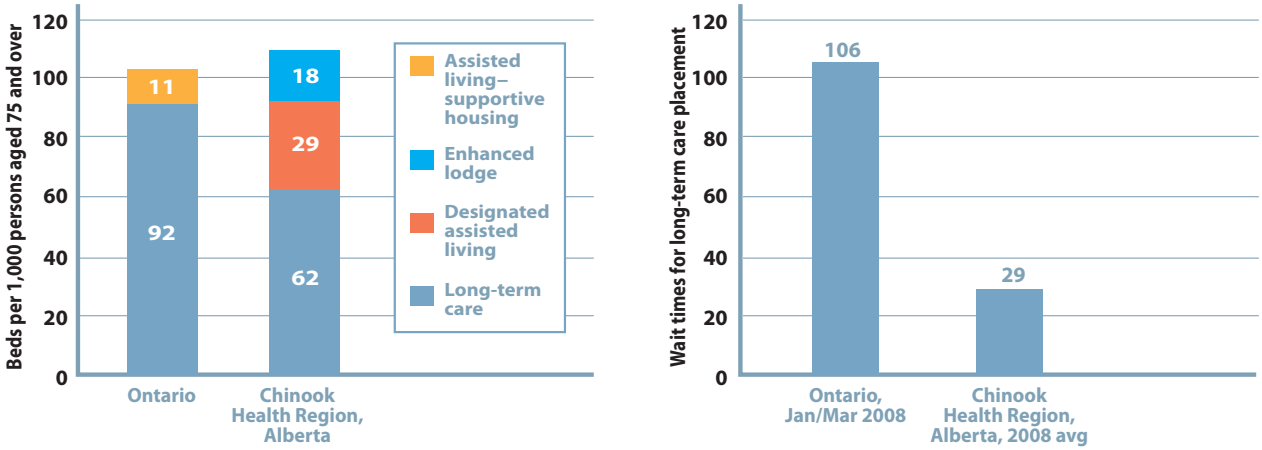
The following chart paints a clear picture of future growth in the MH LHIN of those 85+ and indicates that the LHIN will have the fastest growing population of this age group amongst those LHINs with the oldest populations.

% Growth In Population by LHIN to 2015 of Those 85+



Considering that those 85+ may have more likelihood of utilizing LTC beds and that MH LHIN already had one of the lowest ratios of LTC beds per 1,000 population, thought was given to funding more of these beds. However, in the end, the MH LHIN chose to see what the new SDL program was able to provide. The following chart as an example from Alberta in comparison to Ontario, can clearly articulate the benefit to the MH LHIN of choosing to invest in SDL. As the example identifies, Ontario as a whole has invested in LTC beds over those of assisted living/supportive housing while this Alberta region has invested in proportionately more assisted living/supportive housing. The result is that the Alberta Region has significantly shorter wait times for LTC admission than Ontario with more LTC beds.

Supply of long-term care beds and wait times for long-term care placement in Ontario and Chinook Health Region in Alberta, 2008



Source: Alberta data supplied from Chinook Health Region, Ontario data from Ontario Ministry of Health and Long-Term Care

In attempting to design a new service, such as SDL, on the foundation of the established supportive housing/assisted living service, old concepts and practices would need to be understood first in order to help them "give way" in the future. The following information comprises the "profile" of the original assisted living/supportive housing service in the MH LHIN:

Former State	Description
Target population	People who require low income housing + "some" service - no objective measurement of "most in need" for those brought on service – assumption that since an individual was in the building, service would be provided
1 model of service delivery (buildings & units)	No other innovation – this type of service delivery model often can support housing/landlord focus and mandate
Expansion	Costly capital requirements to build specific assisted living/ supportive housing buildings - permission to expand can create a NIMBY mentality Housing sites not targeted/poor rationale for where sites established
Inconsistencies	Core services not articulated and not all provided across agencies - landlord agreements superseded service agreements – some services duplicated other services available in the community - funding, amount of service per client, yearly costs, costs per hour of service

Former State	Description
Measurement	Anecdotally based - qualitative and quantitative measures lacking - no indicators – variety of agency specific assessment tools utilized (minimal validity and reliability) – no joint gathering of data for the sector – inability to show value to the system
Getting a place	Long wait lists (2 to 10 years) – lower needs clients were the norm on service
Role/function	Not understood – not positioned within continuum of care between acute, LTC or CCAC Community services – lack of clarity in moving people through the health system (ie: either keep clients requiring a higher level of care or discharge early – can't handle)
Service outside of the building (known as "outreach")	Part of assisted living/supportive housing policy mandate, but never enacted – only available for physically disabled and ABI populations and not seniors - designed and funded to only be available between 6:00am and 12:00am