Mississauga Halton **LHIN** | **RLISS** de Mississauga Halton

Meeting Senior Care Needs Now and in the Future

Highlights and Key Findings

from the Report Submitted to the Mississauga Halton Local Health Integration Network (LHIN)
to inform a Community Capacity Plan for the Mississauga Halton LHIN

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

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Abbreviation List

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

Introduction and Executive Summary

The Mississauga Halton Local Health Integration Network (LHIN) is home to over 1.2 million residents, and continues to be one of the fastest growing LHINs in the province, with the population growing by approximately 20,000 people each year. This population trend has significant impact on planning and delivery of health services in the Mississauga Halton LHIN with the key challenge to meet the increasing demand for care and services as our population continues to grow and age at a rate above the provincial average.

The aging of the population will continue to be a major theme in the Mississauga Halton LHIN in the coming years as the percentage of people aged 75 and older will grow by approximately 55 per cent over the next 10 years. These 189,000 new seniors could increase LHINs expenses by $1.1 Billion (2.5 times the current level). Ontario's population aged 75 and older is, by way of comparison, projected to grow by approximately 40 per cent during the same period.

The need to find sustainable solutions to health care has only intensified. Bricks and mortar cannot continue to address our increasing service needs. Our strategy is to re-organize and integrate existing local resources and improve care delivery. We have worked diligently to identify areas where there are unmet needs, and seek to address them through sustainable solutions. This is cost effective while ensuring equitable, quality and patient centred health care.

More than five years ago, we recognized that to sustain health care we need to help seniors live independently at home by creating more access to care in the community. Understanding how to meet service demand for seniors over the next 5 years with projections into the 10 and 20-year planning horizon is vital.

To ensure we are prepared to meet the needs of the Mississauga Halton LHINs' growing and aging population now and into the future, the Mississauga Halton and Central West LHIN and CCACs jointly contracted with Preyra Solutions Group (PSG) to develop a Community Capacity Plan ("the Study"). The objective of the Study was to evaluate the level and mix of health services required by the growing and aging populations in the Mississauga Halton LHIN, including a comprehensive assessment of current and future capacity and need for community-based health services for seniors.

Over the past year, the project consulting team, along with members of the project steering team, engaged community and hospital care providers, planners, seniors and caregivers about their priorities for community based senior care, including; process changes, population targeting and service expansion.

Goals of the Study

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

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

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

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

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

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

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

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

Summary of Overall Findings and Recommendations

Tailoring Initiatives to Populations is a Key to Success

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

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

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

Key Findings

- **Demographics and Aging:** The chance of a person residing in a LTC home increases by age and varies by gender. In addition, the oldest age groups will grow the fastest over the next twenty years. during this period Mississauga Halton LHIN's senior's population is expected to be 2.3 its current size, a growth rate larger than any other LHIN in the Province
- **Communities within the LHIN:** Health risks, assets and population characteristics vary within the LHIN so planning and outcomes measurement should often be done at a subLHIN level. There may be differences in service delivery within the LHIN that are better addressed at the Health Link level, in particular, municipal services, such as housing and transportation Mississauga Halton LHIN's seven Health Link regions are defined by population density, hospital, and physician referral patterns within the LHIN.
- **Diagnosis and Functional Status**: Age, specific functional limitations and diagnoses, and social health determinants can combine to predict risk of LTC admission for multiple years into the future. Once estimated, planners can use this trajectory to target early interventions to reduce risk of LTC admission and other adverse health events.
- **Social Determinants of Health:** Social determinants of health are important for community based service planning. Among measures reviewed, the Ontario Marginalization Index was most promising. This was adapted to construct a Socio-Economic and Cultural (SEC) index. Seniors from the highest SEC Group are at a greater risk for institutionalization and socio-cultural risk varies enough within the LHIN's Health Links and neighbourhoods to make SEC an important segmentation factor.

Know Your Neighbourhoods and Their Assets

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

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

Key Findings

Including neighbourhood assets in the overall capacity plan requires mapping assets and neighbourhood assessments. Existing assets in the Mississauga Halton LHIN could be used immediately to develop senior hubs, and can be enhanced to a Campus of Care model if redevelopment is possible.

As the Mississauga Halton LHIN increases its Supports for Daily Living services and identifies long-term care beds for redevelopment, it should consider developing sites as hubs, and undertake site-planning analysis that incorporates existing capacity, population growth, and resident activity.

Care Coordination Can Reduce Health Risk

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

- Smooth transitions between services and sectors;
- Quick and accurate patient information sharing between providers;
- Interdisciplinary teams that determine what services seniors should receive and how those services should be coordinated among providers;
- Linking frail seniors and caregivers with the services they need.

Seniors and caregivers are often unaware of the programs and service available and fear they are not accessing all the right resources.

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

Key Findings

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

Long-Term Care Homes are for the Highest Needs Seniors

Transforming, not expanding the long-term care sector, is the strategy seniors and planners want. The long-term care home acuity trend is rising, but the LHIN should further accelerate its efforts to keep people at risk of long-term care admission in the community. Currently, the Mississauga Halton LHIN has 25 per cent fewer beds per senior than the provincial average. Long Term Care days per senior are lower in the Mississauga Halton than in other LHINs because their seniors are less likely to be admitted, not because length of stay per resident is different. Most of Mississauga Halton's LTC home expenses are spent on seniors in high care groups, and residents with aggressive behaviours and severe cognitive impairment.

Key Findings

Current practice, without changes to admission criteria, would require bed increases to 5,720 in 10 years, a 55% increase. Under better practice, long-term care beds would grow by only 50 percent of the demographic forecast resulting in a growth to 4,705 (over 1,000 less beds). See exhibit 16.1 pg. 11 of summary or pg. 88 of the Study.

A two-part strategy:

1) Improve transitions from LTC back to community within 90 days (enable lower need clients to remain in the community – implement specific low care initiatives).
2) Develop community-based *High Risk Seniors Can Live at Home with Supports for Daily Living* supports to change preferences for institutional care.

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

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

Key Findings

- Congregate living and residential service delivery models are preferable to LTC homes according to research, policy and senior advocates
- Sound community care redesign will expand Supports for Daily Living services to provide care to more clients with varying needs.
- Using a tiered supports based on MAPLe scores for Supports for Daily Living system.

Community Care and Clients with Frailty

Community Care Access Centre (CCAC) services all concentrate on the frailest clients. The CCAC's most prominent functions are currently: LTC home admission assessment and placement; and purchaser of personal support, nursing and allied health services for sub-acute and functionally dependents seniors. Within two years of CCAC assessment, 25% of all seniors in the LHIN will be in a LTC home, 32% will have an emergency department visit, and 31% will be admitted to hospital. Of Mississauga Halton CCAC's 2013/14 budget, 17% is spent on care coordination and case management, and 72% is spent on purchased services.

Key Findings

- Well-coordinated population-specific CCAC services reduce LTC home admission and hospital use
- Using health care and community data in new ways can greatly improve case finding and service design
- CCAC should make best use of information available to tailor its services to those that can benefit most
- In the Mississauga Halton LHIN, the oldest seniors (85+) receive CCAC services more intensely that other LHINs

Expand and Consolidate Adult Day Services

Adult day programs offer physical, recreational, and therapeutic group activities to stimulate physically frail or cognitively impaired seniors. Day programs also provide respite for caregivers. Currently Mississauga Halton LHIN has an estimated 330 ADP spaces. In order to achieve the better practice in LTC the LHIN would need to provide 850 ADP spaces in ten years, an increase of 520 ADP spaces.

Key Findings

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

Invest in Transportation

The Mississauga Halton LHIN's seniors have the lowest access to CSS transportation services. Only three per cent of the LHINs 75+ population is served by CSS transportation services, much less than the 11 per cent provincial median, and the highest served LHIN at 15 per cent. The Mississauga Halton LHIN funded nearly 90,000 rides in 2012/13. At the current trips per senior, the LHIN's future seniors are projected to need 141,200 trips in ten years. Under better practice, the LHIN would provide an estimated 642, 600 trips in ten years to improve seniors' ability to remain in the community.

Key Findings

- Increase number of adult day programs locations.
- Improve transportation across provider service boundaries. Work with municipalities and health service providers to ensure efforts are not duplicated and organizations can benefit from the strengths of the other

Informal Care: Seniors and Carers are the Most Important

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

Without initiatives that make it easier for caregivers to support seniors at home, the demand for formal health care services may increase substantially. On average, in the Mississauga Halton LHIN, home care clients received 2.6 hours of informal care for every hour of PSW care provided by the CCAC. In ten years, the Mississauga Halton LHIN's seniors will need 5.7 million informal care hours to main today's informal care supports. Today's per capita and hours per caregiver, implies a future gap of 0.7 million informal care hours in the LHIN. In the Mississauga Halton LHIN:

- Children provide 48% of all informal care
- Spouses provide 41% of all informal care
- Number of seniors will growth faster than the number of their children
- Demand for informal care will grow faster than the supply needed

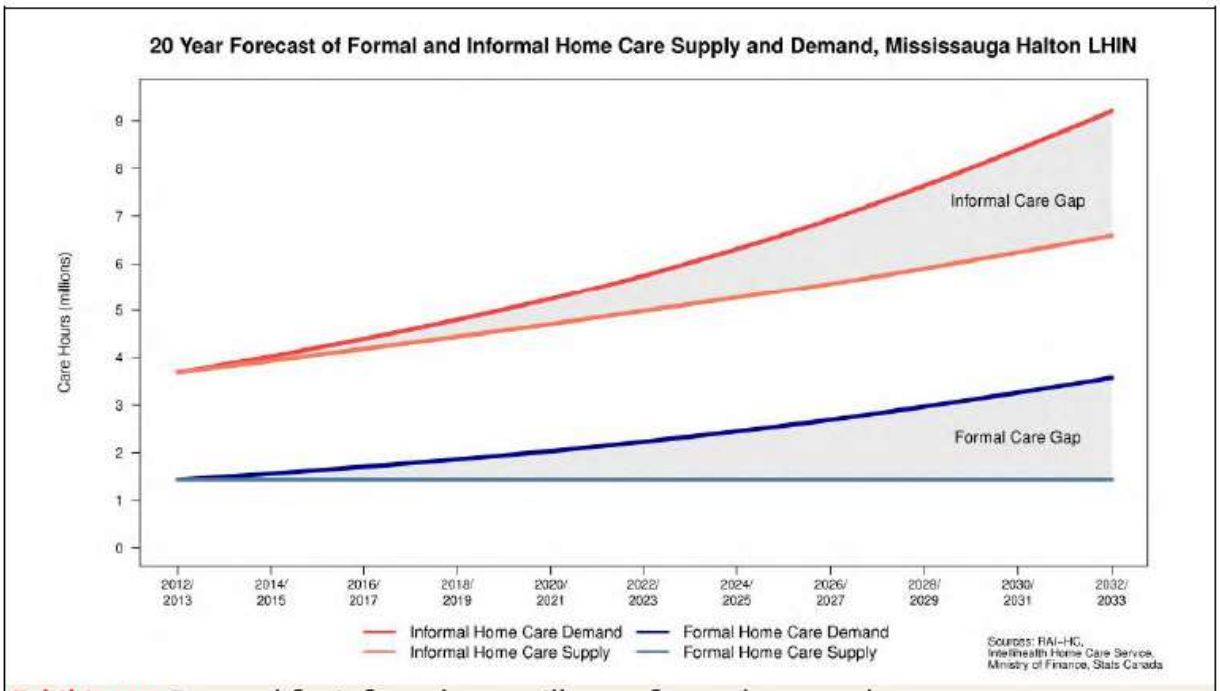

Exhibit 15.3 Demand for informal care will grow faster than supply
Source: RAI-HC 2012/13; Homecare Client Database; Ministry of Finance; Statistics Canada

Forecast demand for carers will exceed supply by 700,000 hours by 2032/33

Key Findings

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

Increase supply of informal care hours by:
- Provide services and initiative that reduce caregiver burnout, improve care competency, and support working caregivers

Care Planning at the End of Life

The Mississauga Halton LHIN has the fastest expected growth in the number of deaths, twice the rate of the slowest growing LHIN and 42 per cent higher than the provincial median. Since most deaths will need palliative care, the LHIN will need substantial expansion of end of life services in the coming years. Findings imply that there are opportunities in the Mississauga Halton LHIN to improve the mix of institutional and community palliative care and hospice services.

Key Findings

- There are currently 16 residential hospice beds in the Mississauga Halton LHIN. Under the better practice forecast, the Mississauga Halton LHIN would need 36 residential hospice beds in ten years.
- Increase supports for palliative/end of life care at home/ community, including nursing care, pain management, respite, education and social supports.
- Expand provision of respite care in the community; enhance education, hospital bereavement support, homemaking support for patients and families; develop wellness, psychological and workplace support for family members.

Quantifying the Gaps

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

Exhibit 16.1 below summarizes gap analysis, showing resource use today and in 5, 10 and 20 years under better practice. Under better practice, LTC beds would grow by 50 percent of the demographic forecast – other services would increase substantially. For example, CSS would increase from $34 million today to $194 million in 20 years.

		Actual	Better Practice Forecast		
Service	*Unit*	*2012/13*	*2017/18*	*2022/23*	*2032/33*
Long Term Care	Bed	3,690	4,145	4,705	6,565
Home Care	Expenses ($M)	$83	$110	$147	$275
Community Support Services	Expenses ($M)	$34	$57	$88	$194
End of Life					
Hospice	Bed	16	24	36	75
Palliative Care Physicians	FTE	15	23	36	79
Palliative Care Nurses	FTE	9	17	31	79
Specialized Geriatric Services					
Nurse-led Outreach NP	FTE	10	12	15	24
BSO RPN	FTE	14	17	22	36
BSO PSW	FTE	25	31	40	66
BSO Psychogeriatric Resource Consultant	FTE	6	7	9	15
Psychogeriatric Clinics and Programs	Expenses ($M)	$2.2	$2.7	$3.4	$5.1
Informal Care	Hours (M)	3.7	4.6	5.7	9.2

Exhibit 16.1 Under better practice, LTC beds will grow by 50% and other programs would increase substantially

Key Findings

- The Mississauga Halton LHIN can use the gap analysis to inform investment and reallocation decisions.
- Allocation of new funding can be provided to the programs with the highest projected gaps, or across programs in proportion to their projected gaps.
- In particular, for funding decisions, an incremental funding amount can be allocated across programs proportional to the relative magnitude of the gap and incremental dollars allocated to a particular program can be used to calculate how much of the current and culture gap the additional funds would address.

Senior Health Outcomes and Quality Improvement

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

Key Findings

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

Implementing the Capacity Planning Study

This report describes Mississauga Halton LHIN seniors' growing health care needs and how to plan community-based care to meet those needs. Available resources for seniors in the LHIN should increase, and those resources used in different ways. Changing the Mississauga Halton LHIN's senior care model is complex and long term; the initial stage alone of implementing the Study is substantial. Stakeholders will vary in their need to understand and collaborate on methods, processes and program specific plans.

The report findings suggest that using current assets and anticipated funding increases, progress could be hampered without a provincial senior community and institutional care resource allocation strategy.

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

Long-term care home capacity planning is a key area where a province wide plan is needed. Currently, the age-adjusted LTC bed rate per senior of the highest served LHIN is 34 percent more than the Mississauga Halton LHIN. Without any changes in LTC bed capacity, in twenty years the rate of the highest served LHIN would be 80 percent more than the Mississauga Halton LHIN.

If the Ministry continues its plan to redevelop but not increase the total number of provincial LTC home beds, then the Study's results suggest two fundamental mitigating factors. First, that beds move within the LHIN towards areas that will have few beds per seniors in the coming years because of population aging. Second, that the Ministry move beds from LHINs with relatively high bed rates, to high growth LHINs with low bed rates, such as the Mississauga Halton LHIN.

The Ontario Ministry of Health and Long Term Care has recognized that the funding growth in the community sectors should be faster than that in the institutional sectors. Additional funding flexibility for high growth LHINs, like Mississauga Halton, to allow more rapid expansions of home care, Supports for Daily Living services, and other community support services, might be considered by the Ministry.

Study Implementation Plan

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

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

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

Community Capacity Planning Steering Committee Membership

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