



Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

Expanding Long-Term Care in the Community: Can it be Done?

*A. Paul Williams, PhD.
Full Professor, Health Policy*

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IRPP Study

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*Ideas
Analysis
Debate*
Since 1972

Integrating Long-Term Care into a Community-Based Continuum

Shifting from “Beds” to “Places”

A. Paul Williams, Janet Lum, Frances Morton-Chang,
Kerry Kuluski, Allie Peckham, Natalie Warrick, Alvin Ying

To address the growing long-term needs of Canada’s aging population, governments should expand community-based care instead of simply increasing the number of residential care beds.

Where We Are Now

Inadequate Community-Based Care: Default To Beds

Caring For Our Aging Population and Addressing Alternate Level of Care

**Report Submitted to the
Minister of Health and Long-Term Care**

Dr. David Walker, Provincial ALC Lead
June 30th, 2011

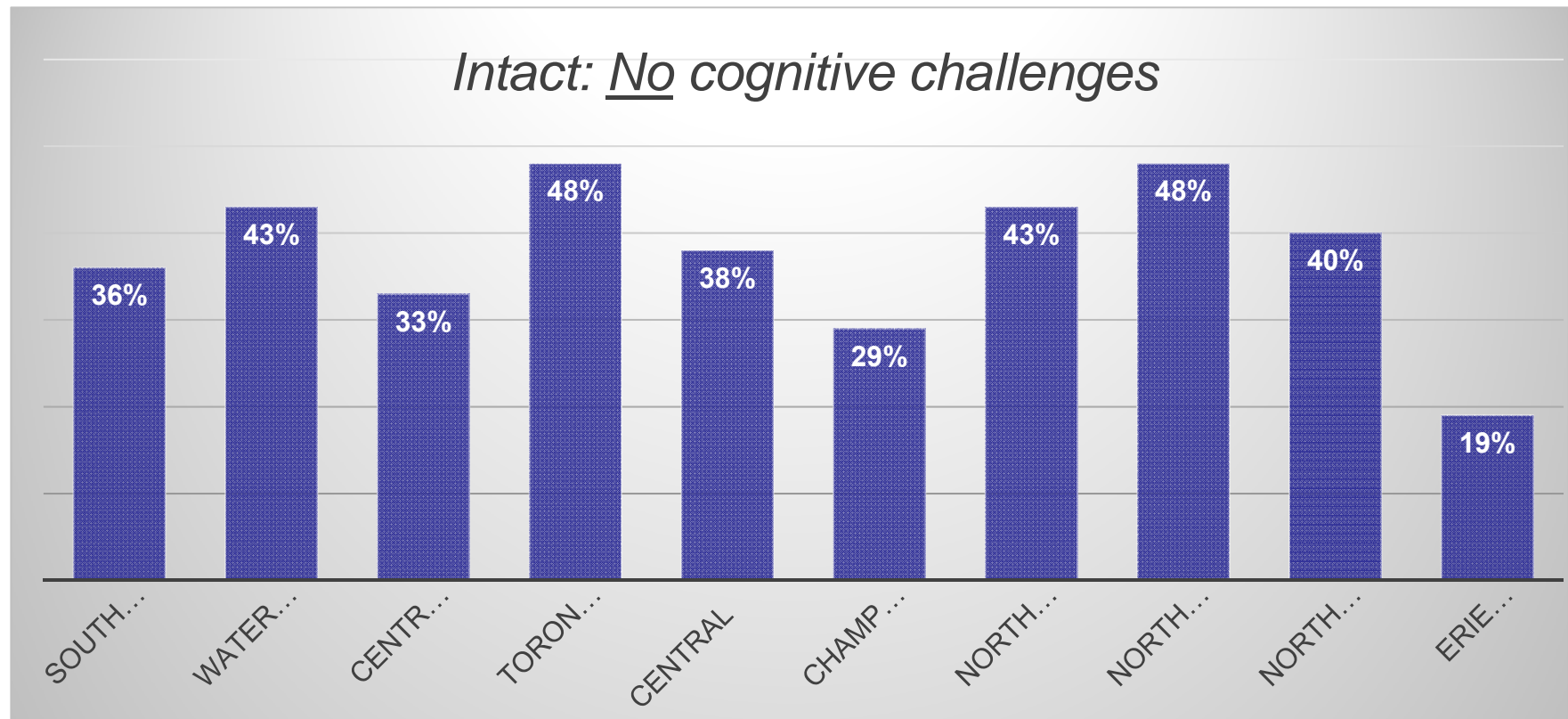


Ontario BoC Studies: The Big Question

- Why can many older persons age successfully in community settings while others with similar needs require residential LTC beds?

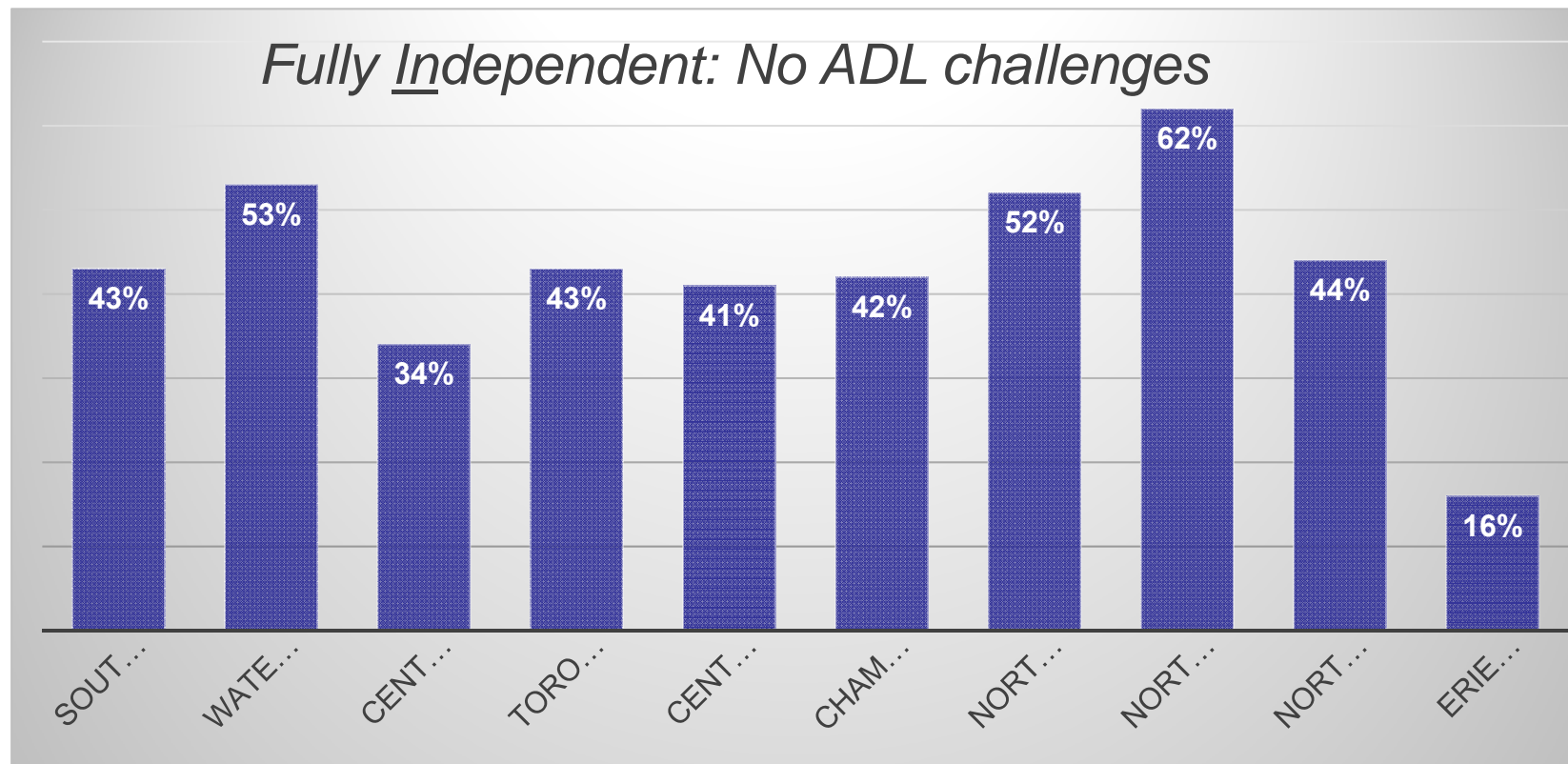
Waiting for LTC: Cognition

Cognitive Performance Scale: Short term memory, cognitive skills for decision-making, expressive communication, eating self performance.



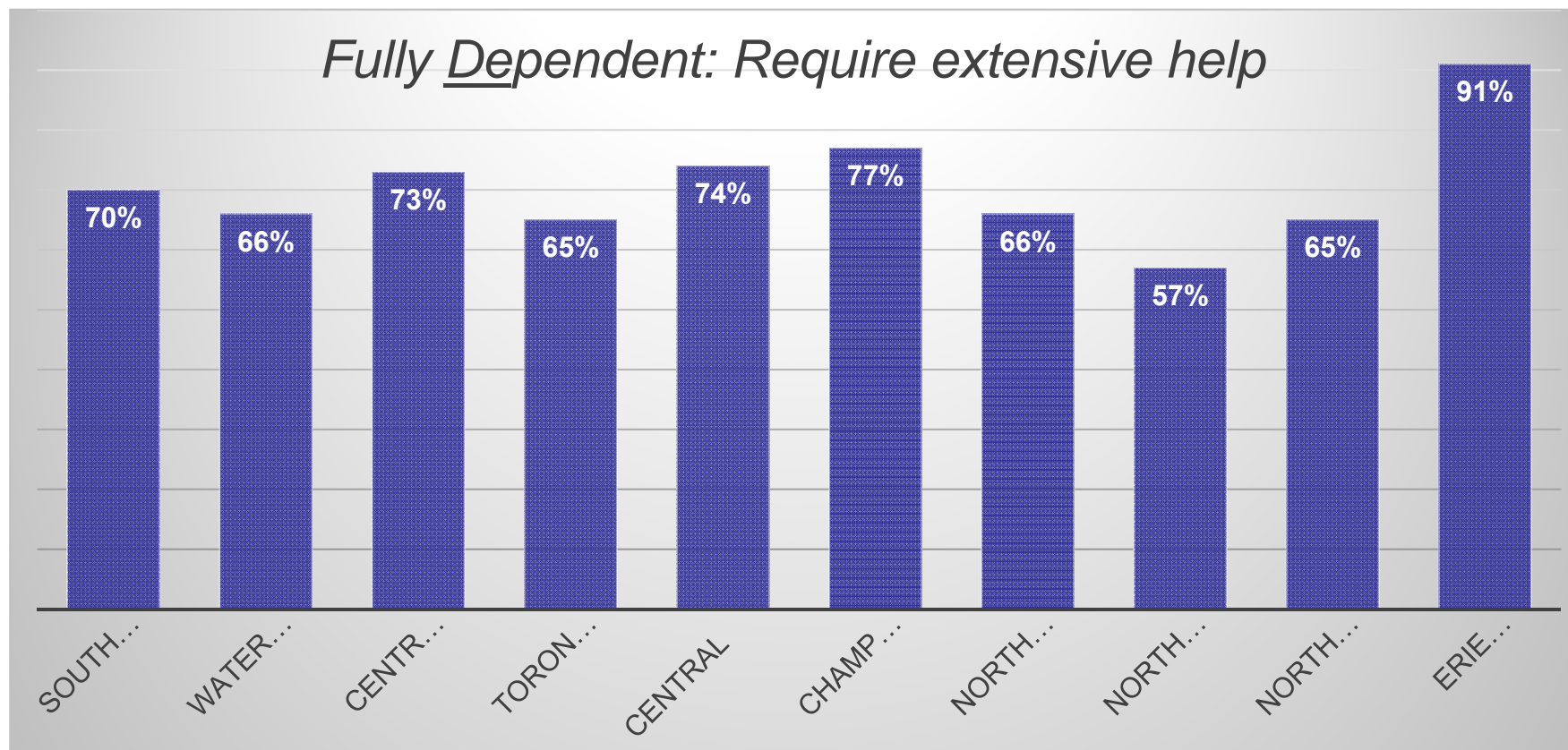
Waiting for LTC: ADL

Self-Performance Hierarchy Scale: eating, personal hygiene, locomotion, toilet use

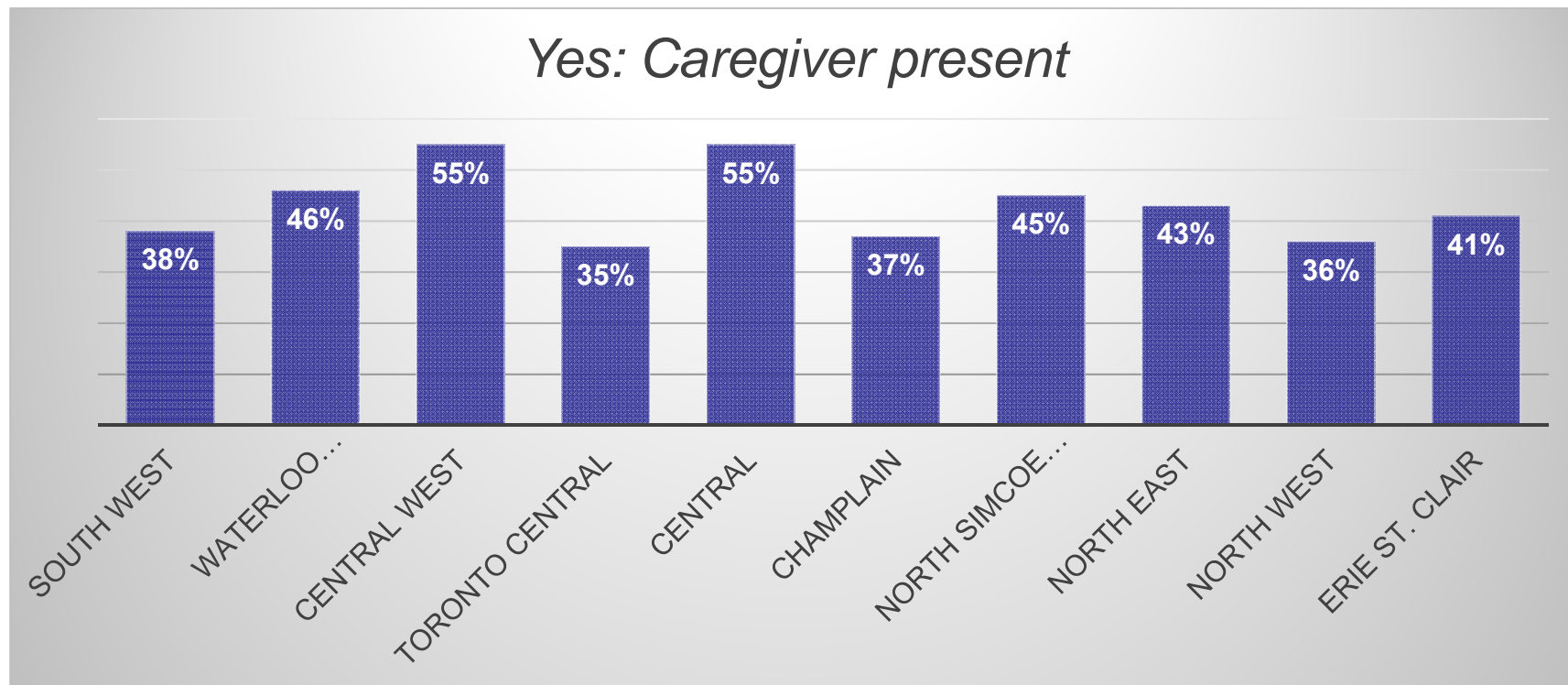


Waiting for LTC: IADL

IADL Difficulty Scale: meal preparation, housekeeping, phone use and medication management



Waiting for LTC: In-Home Caregiver?



Ontario BoC Studies: Key Observations

- Needs “tipping point” for residential LTC varies extensively across and within regions
 - Substantially lower – especially rural and remote areas – where there is limited community-based capacity
- Informal caregivers play an essential role
 - Continuing emotional, personal, instrumental support *and* care navigation
 - Particularly crucial for persons facing cognitive challenges

Ontario BoC Studies: Key Observations

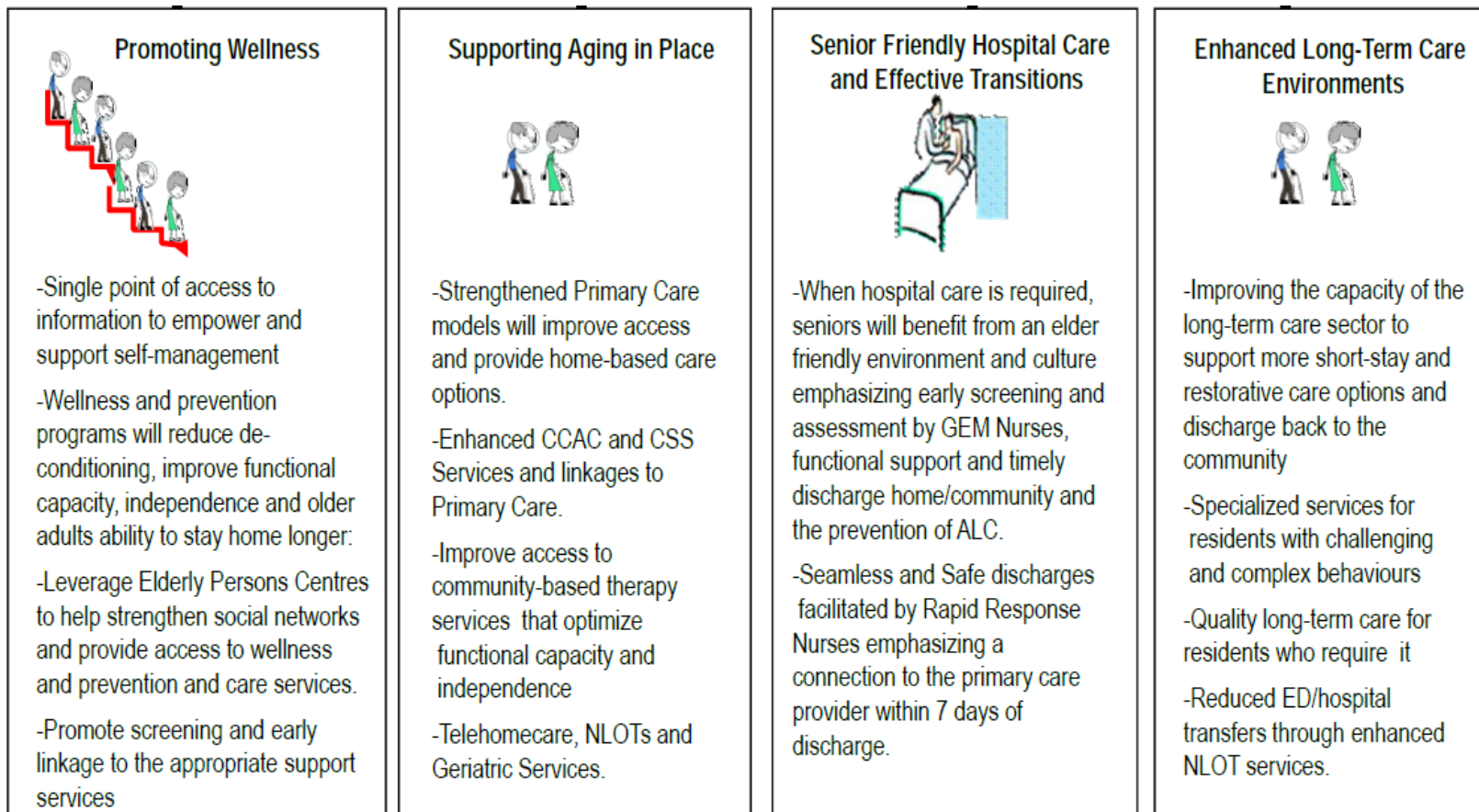
- “Small things” matter
 - Grocery shopping, banking, home maintenance, homemaking, transportation to medical appointments key (yet first to be cut)
- More integrated delivery models (e.g., enhanced day programs, supported housing, supportive neighbourhoods) offer considerable advantages
 - More seamless, client-centred care
 - Superior cost-effectiveness

Where We Want to Go

The Holy Grail: A Continuum of Places for Care Over the Longer Term

- Health Services Restructuring Commission (1996-2000)
 - Authority to close or merge hospitals
 - Advise (only) on community reinvestments
- Consultants concluded:
 - Ontario required an integrated continuum of care including residential “beds” as well as equivalent “places” in supportive housing, adult day programs, at home
 - “Downward substitution” to the “least restrictive, least intrusive setting possible”
 - Support families “in their role as caregivers”
 - “Funding levels ... determined in relation to the needs of the resident, not the location of care” (HayGroup 1997)

Ontario's Emerging Seniors' Strategy: A Community-Based Continuum



Source: Samir Sinha, Lead, Ontario Seniors Strategy http://www.crncc.ca/knowledge/events/pdf-IntegratingCareforOlderPersons/Symposium%20Dec10_Sinha.pdf

Ground-Up Innovations 1: Jasper Place, North West Ontario

- Seniors supportive housing model adjacent to LTC home
 - Social housing plus 24/7 on-site coordinated support services
 - NP works to maintain wellness to delay or avoid LTC, does tests on-site to avoid hospital visits, follows clients who require hospital care
 - Demonstrated capacity to support high needs -- 30% of Jasper clients now MAPLe 4 or 5's (comparable to LTC)

Ground-Up Innovations 2: SMILE (Seniors Managing Independent Living Easily), South East Ontario

- “Supported self-management” model
 - Focus on frail older persons with complex needs and caregivers living in community
 - Professional case managers use nominal budgets to work with informal caregivers and clients to identify challenges, co-create solutions, lever local resources, build comprehensive care packages
 - Applicable to urban and rural areas with vastly different needs, formal and informal support capacity

Ground-Up Innovations 3: Assisted Living in South Western Ontario (ALSO)

- “Hub & spoke” model
 - 9+ supportive housing buildings, plus mobile and outreach services to create “supportive neighborhoods”
 - Designed to support persons with disabilities (including ventilator dependent) – expanded to support frail seniors
 - Services include: In home personal support/independence training; client intervention; day services, ABI assisted living; VoN nursing; falls prevention
 - Transitioned 200 clients from ALC, CCC, ER and ICU demonstrating “proof of concept”

Spread and Scale?

- Ability to manage rising needs, or do outreach constrained by historically embedded funding (\$30/day for supportive housing) and politics of “market share”
- Preoccupation with getting people out of hospitals has eroded capacity to keep them out in the first place
- Numbers of client “hand offs” have multiplied as providers have narrowed their needs “band width”
- Since no agency is responsible for the entire client “care trajectory,” very difficult to demonstrate hard outcomes

How We Get There

Three Essential Steps:

Plan for a Continuum of “Places” for Care Over the Longer Term

- Stop thinking about LTC beds as the final destination for older persons
 - Start thinking about a continuum of care “places” most of which could be in the community (e.g., day programs, supported housing, supportive neighborhoods)
 - Embed principle of “downward substitution” to the least restrictive environment possible

Three Essential Steps:

Build Enabling Policy Frameworks

- New policy and funding mechanisms needed to break historical patterns and enable ground-up innovation
- Japan's 2015 Orange Plan
 - Seven “pillars” to guide the creation of dementia-friendly communities
 - Support family caregivers, encourage cooperation, remove institutional barriers within government and between providers, incent intergenerational projects, and give people with dementia a greater voice

Three Essential Steps:

Fund Based on Need, Not Location

- If we're willing to pay to keep people in beds, why not pay a similar amount to keep them in the community?
 - Basis of gold standard "PACE" (Program of All Inclusive Care for the Elderly) model in the US
 - PACE clients all nursing home eligible
 - Organization pays for all care including care in hospitals and nursing homes
 - Strong financial incentive to keep people well
 - Clear outcomes

*Expanding Long-Term Care in the
Community: Can it be Done?*

Glass Half Full: Reasons For Optimism

- Growing awareness in Ontario and beyond that “business as usual” is not sustainable
 - Rise of multiple chronic health and social needs
 - Decline of traditional social support networks
 - Persistence of costly system challenges (esp. ALC)

- Growing weight of evidence demonstrating the value of “ground-up” innovations
 - Internationally, in jurisdictions like Japan, England
 - “Closer to home” in Ontario with innovations like SMILE, ALSO – as well as Carefirst, Yee Hong, LOFT, Woodgreen, Peel -- which lever local resources to build supportive communities

Glass Half Full: Reasons For Optimism

- New willingness to think creatively about the role of residential “beds” within an integrated continuum of care “places”
 - According to OANHSS (April 2016), opportunities include community hubs, supported housing, campuses of care which can serve underserved populations in new ways



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