

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

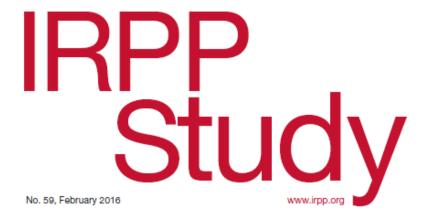
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IRPP/CRNCC Working Lunch Ryerson University, Toronto June 14<sup>th</sup>, 2016



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### **HPMF**





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

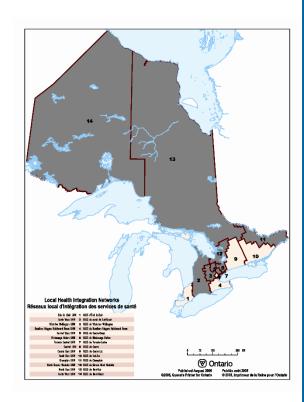


### Drilling Down to the Local Level:

Ontario Balance of Care (BoC) Studies

The BoC is a policy planning tool adapted from the UK and applied in 12 of 14 LHINs

- Erie St. Clair, South West, Waterloo Wellington, Central East, Central West, Toronto Central, Central, Champlain, North Simcoe Muskoka, North East, North West, South East and North Shore Tribal Council
- Best available data and most knowledgeable local experts across the continuum



Source: <a href="http://www.ryerson.ca/crncc/relatedreports.html#balance">http://www.ryerson.ca/crncc/relatedreports.html#balance</a>

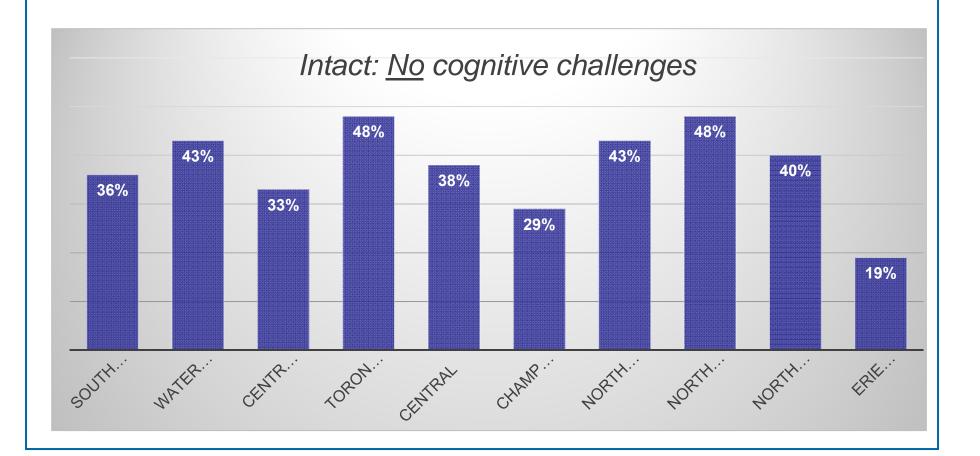
### **THPME**

### 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?

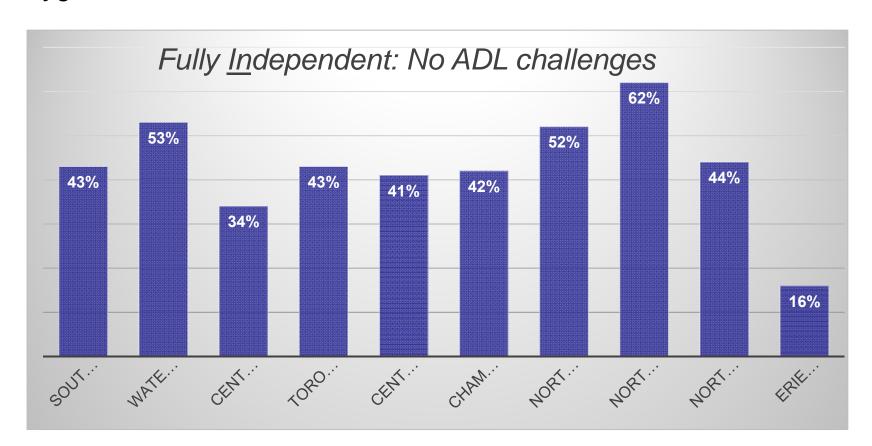
### Waiting for LTC: Cognition

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



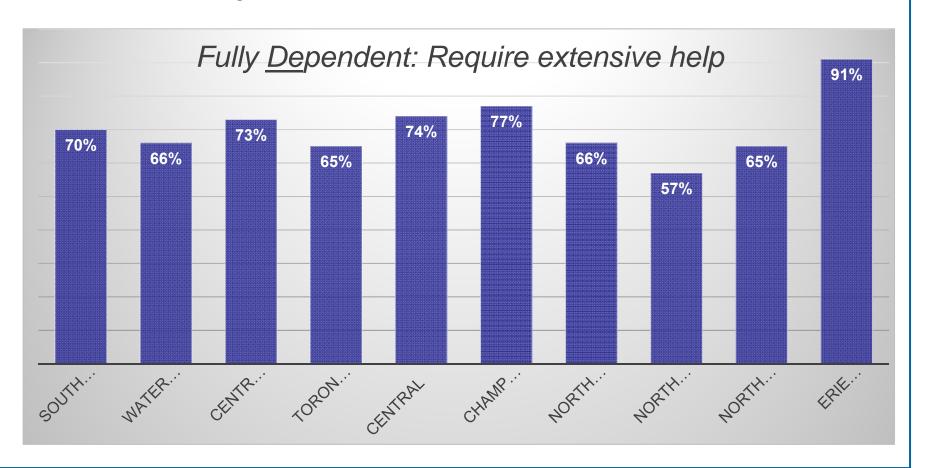
### Waiting for LTC: ADL

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

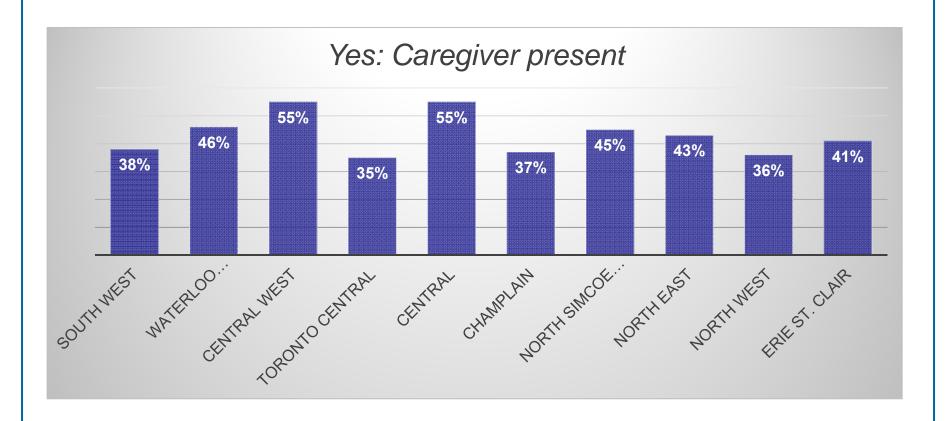


### Waiting for LTC: IADL

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



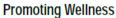
### Where We Want to Go

## 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





- -Single point of access to information to empower and support self-management
- -Wellness and prevention programs will reduce deconditioning, improve functional capacity, independence and older adults ability to stay home longer:
- -Leverage Elderly Persons Centres to help strengthen social networks and provide access to wellness and prevention and care services.
- -Promote screening and early linkage to the appropriate support services

Supporting Aging in Place



- -Strengthened Primary Care models will improve access and provide home-based care options.
- -Enhanced CCAC and CSS Services and linkages to Primary Care.
- -Improve access to community-based therapy services that optimize functional capacity and independence
- -Telehomecare, NLOTs and Geriatric Services.

Senior Friendly Hospital Care and Effective Transitions



- -When hospital care is required, seniors will benefit from an elder friendly environment and culture emphasizing early screening and assessment by GEM Nurses, functional support and timely discharge home/community and the prevention of ALC.
- -Seamless and Safe discharges facilitated by Rapid Response Nurses emphasizing a connection to the primary care provider within 7 days of discharge.

#### Enhanced Long-Term Care Environments





- -Improving the capacity of the long-term care sector to support more short-stay and restorative care options and discharge back to the community
- Specialized services for residents with challenging and complex behaviours
- -Quality long-term care for residents who require it
- -Reduced ED/hospital transfers through enhanced NLOT services.

Source: Samir Sinha, Lead, Ontario Seniors Strategy <a href="http://www.crncc.ca/knowledge/events/pdf-lntegratingCareforOlderPersons/Symposium%20Dec10">http://www.crncc.ca/knowledge/events/pdf-lntegratingCareforOlderPersons/Symposium%20Dec10</a> 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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