Leading System Integration for Adults with Physical Disabilities

A strategic evaluation of the Bellwoods' Community Connect Program

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Executive Summary

Bellwoods Centres for Community Living (Bellwoods) is funded by the Toronto Central LHIN (TC LHIN) and provides "support for adults with physical disabilities to live as independently as possible"[1] in the community. Founded in 1957, Bellwoods has developed programs that respond to an identified need in the community of people with physical disabilities in Toronto. Most recently (in April 2009) Bellwoods used its LHIN-base budget to develop, implement and operate the Community Connect Program (CC).

The aim of the Community Connect Program is to transition Alternate Level of Care (ALC) clients with disabilities from health facilities to independent community living. This program is targeted at individuals designated as "ALC" in hospitals and people who are living in LTC homes with the potential to live in the community with appropriate supports. The Community Connect Program provides a transitional stay (short or longer term) in Bellwoods Park Housewhere intensive training, education, support and planning prepares clients for discharge to the community.

In December 2010, Bellwoods issued a Request for Proposals (RFP) for an external consultant to conduct an evaluation of the CC Program. Key aims of this evaluation were to determine:

- The extent to which CC Program has met the needs of clients and stakeholder
- Key lessons learned to date
- Potential changes to continue to improve the quality and value of the CC Program.

This report presents results from a multi-stage evaluation of the CC Program conducted by Fern Teplitsky and Associates, in collaboration with the Balance of Care Research Group, University of Toronto.

Environmental Scan:
Results of the environmental scan suggest that the stated aims of the CC Program align closely with a number of key health system performance initiatives. At the provincial level the CC Program is well aligned with the Wait Times, ALC, Excellent Care for All, Aging at Home, and Assisted Living for Seniors initiatives, and at the LHIN level the Program is in sync with the TC LHIN Integrated Health Services Plan 2010 to 2013, the ALC Resource Matching and Referral (RM&R), and the Community Navigation and Access Program (CNAP) initiatives.

Program Statistics:
The CC Program occupies 14 private apartment units at Bellwoods Park House that is owned and operated by Bellwoods Centres. Clients have 24/7 access to client-directed support services including hygiene, assistance with eating and toileting, and housekeeping. Focus of the program is on education and reinforcement of: safety at home and in the community; increased independence in Activities of Daily Living (ADLs) e.g. managing bowel and bladder routines; and increased independence in Instrumental Activities of Daily Living (IADLs) e.g. managing finances, directing care and accessing community resources.

Over the past two years the CC Program has admitted 33 individuals from 4 rehab hospitals, 1 acute care hospital, 1 long term care home and 3 complex continuing care hospitals. To date the program has discharged 13 clients from its short stay program (with an average length of stay of 5 months) and 9

[1] Bellwoods Centres for Community Living. Community Report 2009 – 2010, page 2-3.

clients from its long stay program (with an average length of stay of 10 months.) The majority of clients have been male, under 65 years of age and victims of a stroke or a spinal cord injury. Of the 22 clients discharged from the program 6 went home without personal support worker (PSW) assistance, 5 went home with assistance, 6 went to permanent supportive housing, 2 went to long term care homes, 2 returned to the organizations that referred them due to deterioration, and 1 died. Fifteen of these continue to receive some support from Bellwoods.

Evaluation/Key Informant Interviews

The two clients and one family caregiver interviewed for the evaluation overwhelmingly endorsed the value of the CC Program. They emphasized the desirable outcomes of the program including the development of skills, the building of confidence and the program's contribution to an enhanced quality of life. Other stakeholders that were interviewed praised the program and highlighted the important skills and knowledge that it imparts to its clients. At a focus group of providers of attendant services in TC LHIN, participants stated that it would be beneficial to all individuals with physical disabilities who want to live independently in the community to have the kind of education and training that is provided by the CC Program.

The program evaluation also demonstrated the program's value to the health care delivery system in Toronto Central LHIN: the program allows people to move out of costly care locations, reduces unnecessary or avoidable system utilization, reduces pressure on LTC homes, reduces ALC statistics and reduces lengths of stay in hospitals.

Cost comparisons

A cost comparison of the CC Program with other transitional programs like Convalescent Care and Stepping Stones found that the costs of the CC Program are in line with these programs. This is admirable considering that CC Program clients have high physical care needs and many require nightly assistance. (At approximately $153 per day, the CC Program is of course much more cost effective than ALC, acute care, rehab or complex continuing care.)

Analysis

The CC Program is addressing a persistent system problem. Because of high care needs it is difficult to discharge people with physical disabilities from acute, rehabilitation or LTC settings. People with physical disabilities can wait months or years for an accessible apartment or supportive housing unit in the community. System pressures often result in temporary or permanent placement in a LTC home that is often an inappropriate or undesirable choice for a younger person with a physical disability.

Think Tank / Recommendations

The evaluation culminated with an invitational Think Tank involving key stakeholders and Bellwoods staff. Participants were charged with developing a "business case" for the CC Program and developed a series of recommendations aimed at enhancing the CC Program at both the system and operational levels. Recommendations address: the need to establish formal relationships with partners; the need to demonstrate a broader impact on ALC; and the opportunity to seek out alternative sources of funding. Think Tank participants expressed admiration for the CC Program and recognized that Bellwoods had used its existing resources to link the hospital system to the community support sector, thereby creating an integrated model of care for adults with physical disabilities in TC LHIN.

The Report includes the following recommendations:

Think Tank Recommendations - Strategic

- The CC Program has demonstrated value for its clients, who constitute a small but particularly vulnerable and hard-to-serve segment of the population with potentially high costs for the health care system and families. The CC Program should continue and possibly expand to serve more individuals.
- Bellwoods has demonstrated considerable success in creating value for the health care system by transitioning high needs individuals from costly hospital and institutional beds to independent community living. In the process it has built strong relationships with providers along the care continuum and established a model for system integration. These successes should be clearly communicated to potential funders, including the TC LHIN.
- The range of individual and system level benefits created by the CC Program, including its ability to integrate client care across the continuum, need to be clearly communicated to funders and partners both as a justification for additional resources and as a model for caring for other high needs client groups (e.g., high needs seniors).
- The CC Program should seek more formalized partnerships with rehabilitation hospitals, the TC LHIN, CCAC and the other providers in order to further consolidate care pathways for clients and find new opportunities for integration. E-technologies could assist the establishment of virtual teams or virtual rounds to improve planning, service delivery and discharge.
- The CC Program, in collaboration with partners and the TC LHIN, should identify an appropriate set of performance measures that demonstrate success at system, organization and individual levels.

Key Informant Recommendations - Operational

- To maximize impact, Bellwoods may want to target its outreach to specific organizations with higher numbers of potential CC Program clients (e.g., rehabilitation hospitals), or to specific client groups, for example, males under 65 years of age, who now constitute the majority of Program clients.
- Further, to raise its profile with other providers and funders including the TC LHIN, Bellwoods might consider creating a CC Program Advisory Committee that involves key stakeholders and client organizations from across the care continuum.
- Bellwoods should consider streamlining its application process. The new 2-page PIC application form to be introduced shortly will assist.
- Bellwoods can consider developing succinct information packages which clearly set out selection criteria, processes and timelines.
- Bellwoods staff members may want to meet with hospital staff on a regular basis to review admission decisions and clarify the reasons for refusals, possibly as an element of virtual rounds or team meetings
- Demonstrating its leadership and the high quality of its teaching approach, Bellwoods could consider sharing material used in the CC and MILE programs with other providers across the system, possibly through the TC LHIN.
- Bellwoods might also engage in collaborations aimed at developing best practices.
- Stakeholders suggested the development of an integrated up-to-the minute inventory of available supportive housing, accessible housing and/or RGI units in TC LHIN. This anticipates the roll-out of the TC LHIN RM&R initiative as well as redevelopment of the PIC system.
- Bellwoods can make discharge process and protocol more transparent to partners, stakeholders and clients.

Strategic Recommendations (Consultants)

- **Strategic Recommendation 1**: Position the CC Program not just as a very valuable service for a small number of deserving high needs individuals, caregivers and families, but as an innovative and cost-effective model of system integration for high needs groups more generally. *We note that the TC CCAC is now piloting a similar model for high needs seniors.*

- **Strategic Recommendation 2**: Develop new mechanisms to strengthen working partnerships with other providers both "upstream" and "downstream" across the care continuum.
    - At a strategic level, the establishment of a CC Program Advisory Panel including senior leaders from provider organizations, the TC LHIN, provincial ministries, City of Toronto housing, and the disability community, could increase Bellwoods visibility and leadership, build awareness of the Program's value and relevance as a viable care option, and create opportunities for resources, either though dedicated funding from the LHIN, or through resource sharing with partners particularly under new provincial performance-driven funding arrangements.
    - At an operational level, the establishment of multi-disciplinary, multi-organization "rounds" including experienced care managers, discharge planners, and front-line care providers, who would consider actual client cases, identify opportunities for improving "flow," and make CC Program decisions more transparent.

- **Strategic Recommendation 3**: In collaboration with partners, elaborate a set of CC Program "metrics" to demonstrate success under the provincial ECFA strategy at individual, organization and system levels. Such metrics would, for example, document client and caregiver satisfaction since these are mandated in the legislation and since clients and caregivers are at the centre of the CC Program. Subsequently, these metrics might identify "benchmarks" for client flow between organizations and through the care continuum, building on the experience of the provincial wait times strategy.

- **Strategic Recommendation 4**: Consider targeting the CC Program more tightly at least on an interim basis to optimize the use of available resources. A growing international literature on integrating care for high needs populations emphasizes that integrating care is time and resource intensive with potentially high dividends, but not all the time. Two different approaches to targeting were surfaced during the evaluation: focusing on relatively homogeneous groups of potential clients (such as younger adults with acquired disabilities who now make up the bulk of the Program client base); or targeting particular institutional partners (such as rehabilitation hospitals) to strengthen working relationships, minimize transaction costs, and build valuable experience.

A Strategic Evaluation of the Bellwoods' Community Connect Program

1.0 Introduction

Established in 1957, Bellwoods Centres for Community Living Inc. is a charitable, not-for-profit organization providing a range of community services, programs and affordable and accessible housing to people with physical disabilitiesinToronto.This mandate is embodied in its mission statement: "Bellwoods Centres enables community support for adults with physical disabilities to live as independently as possible."[2]

In April 2009, Bellwoods initiated its Community Connect (CC) Program. The Program facilitates the discharge of adults and seniors with physical disabilities from hospitals and long-term care homes (LTCH) to community living. It targets individuals who have been designated as "alternate level of care" (ALC) in hospitals -- those who have the potential to transition safely back to the community but who cannot be discharged because of a lack of appropriate community-based care options -- as well as individuals living in LTCHwho could potentially live independently. The CC Program was established within existing LHIN service funding; it re-deploys existing Bellwoods' resources to serve these high needs individuals.

In December 2010, Bellwoods issued a Request for Proposals (RFP) for an external consultant to conduct an evaluation of the CC Program "regarding program efficacy and efficiency in order to provide seamless and effective access to service delivery to clients." The RFP emphasized that Bellwoods is committed to "being accountable and making changes to meet the changing needs of the community in order to achieve a successful and sustainable program."

This report presents results from a multi-stage evaluation of the CC Program conducted by Fern Teplitsky and Associates, in collaboration with the Balance of Care Research Group, University of Toronto, led by Professor A. Paul Williams. Key aims of the evaluation were to determine:

- The extent to which CC Program has met the needs of clients and stakeholders;
- Key lessons learned to date;
- Potential changes to continue to improve the quality and value of the CC Program.

In the sections below we begin by providing background information about Bellwoods and the CC Program. We then present our evaluation strategy and key findings. We conclude by offering recommendations to support the continuing development of the CC Program.

[2] Ibid.

2.0 Background

2.1 Bellwoods Centres for Community Living

Bellwoods is located in the Toronto Central Local Health Integration Network (TC LHIN). It offers persons with physical disabilities a range of community-based services and supports including:

- Outreach services: pre-scheduled support services for individuals already living in the community.These services are provided in the client's residence, place of employment, or at educational facilities (if they are students or pursuing some form of degree/certificate/diploma);
- Supportive housing services: transitional or permanent accommodations, with 24-hour access to support services;
- Transition and independent living programs: to improve independence and quality of life. There is a strong focus on safety and well being, to improve communication, budgeting, mobility and stress management.

Among its resources, Bellwoods owns and/or operates 75 accessible, affordable supportive housing unitsat three sites:

- Bellwoods Park House(ownedand operated by Bellwoods);
- Mimico Apartment Project (operated by Bellwoods);
- Bellwoods Dundas Project (owned and operated by Bellwoods).

In addition, Bellwoods provides a range of services including:

- Supportive services to the 75 clients living in Bellwoods' housing units, on a pre-booked and ad hoc basis, 24 hours a day, seven days a week;
- Pre-booked attendant care outreach services to about 100 people in the community from 6 AM to midnight daily;
- Educational programs to support independent living to 90 individuals in the community (clients and others) through its MILE (Mobile Independent Living Education) program.

2.2 Bellwoods' Community Connect (CC) Program

Bellwoods created and implemented the Community Connect (CC) Program in 2009. The Program goes beyond Bellwoods traditional focus on people with physical disabilities already living in the community to include people with physical disabilities requiring help to transition safely and appropriately back to community from institutional settings.

The CC Program targets adults and seniors with physical disabilities who occupy ALC beds in hospitals as well as individuals in LTCH with the potential for independent community living. The CC Program thus responds to a particularly high needs, but underserviced population group, while also addressing a persistent and costly system challenge: hospital and institutional beds occupied by individuals who cannot be discharged because of a lack of suitable discharge options.

The CC Program has both individual and system level goals. These are:

- Individual-level goals**:** to ensure that individuals have accessible and safe home environments; that they can live safely in their own homes; and that they set and achieve objectives based on their own needs;
- System-level goals: to reduce the number of costly ALC bed days in hospitals and other health care facilities, and moderate demand for hospital emergency services and in-patient beds.

The CC Program consists of 14 dedicated private, rent-geared-to-income apartment units with access to support services on a 24/7 basis. In addition to this housing, individuals receive a mix of:

- Personal supportservices: client-directed services including hygiene, assistance with eating and toileting and housekeeping, delivered by personal support workers (PSWs) and other on-site staff;
- Education and training: a mix of teaching, skills development and practice under supervision delivered by independent living educators and facilitators, focusing on safety, increased independence with ADLs (e.g., bowel and bladder routines), and increased independence with IADLs (e.g., financial management, ability to direct own care, and ability to access community resources).

The education and training aspect of the CC Program is of particular note since it looks beyond the individual's transitional stay in the supportive environment of Bellwoods, to equipping individuals with the skills and knowledge needed to manage as independently as possible in the community over their life course.

Reflecting the fact that individuals come to the CC Program with different needs, resources and abilities, CC incorporates two distinct program elements:

- A short-stay program (1-6 months) for up to 7 individuals with an identified home to return to;
- A long-stay program (1-14 months) for up to 7 individuals who need to be relocated in the community or on the LTCH wait list.

To be eligible for the Program, individuals must:

- Be adults over 16 years of age, and/or seniors (over 55), with physical disabilities including neurological and musculoskeletal conditions;
- No longer require facility-level care, but still require a transition period from ALC to living in their own homes;
- Require 24/7 access to personal care services during transition;
- Be able to be left alone safely, call for assistance when required, and have their medical needs met in the community;
- Be insured under the Ontario Health Insurance Act.

3.0 Evaluation Approach

The evaluation aimed to assess the CC Program's strengths and weaknesses, as well as opportunities for growth and improvement, following its first two years of operation.

Noting that the Program was established and has operated in a volatile policy environment, that it spans multiple services and providers, and has multiple stakeholders, the evaluation was conducted using a multi-stage, mixed-methods approach. Each stage is summarized briefly below.

Stage 1: Steering Committee

In the first stage we met with a Steering Committee including Bellwoods' senior staff and representatives of other provider organizations. (For a list of Steering Committee members please see Appendix A.) In its initial meeting on February 3, 2011, the Steering Committee:

- Reviewed and confirmed the evaluation approach;
- Provided CC Program documentation;
- Identified key informants;
- Discussed available health assessment data and established steps for data sharing.

Stage 2: Environmental Scan

In the evaluation's second stage we conducted an environmental scan of relevant policies and priorities at local and provincial levels potentially impacting on the CC Program. As part of this scan we:

- Analyzed relevant Toronto Central Local Health Integration Network (TC LHIN) and Ministry of Health and Long-Term Care (MOHLTC) policies and priorities;
- Conducted semi-structured qualitative interviews with 6 key informants identified by the Steering Committee representing the TCLHIN, Ministry of Health and Long-Term Care (MOHLTC), City of Toronto, and the Toronto Central Community Care Access Centre (TC CCAC).

Stage 3: Document Analysis

In the third stage we reviewed available CC Program documentation to analyze key program characteristics including eligibility criteria, assessment protocols, patterns of service allocation and utilization, and discharge planning processes as well as assessment data for CC Program clients. Documents included:

- Community Connect Program Report 2009-2010, November 2010;
- Service Delivery Report 2009-2020, September 2010;
- Community Connect Program Summary Update, September 2010;
- Community Connect Program Outline, April 2009.

Stage 4: Client Assessment Data Analysis

In stage four, we analyzed anonymous assessment data for individuals referred to, or accepted into the CC Program. This included data collected by Bellwoods' staff using protocol such as the Resident Assessment Instrument – Community Health Assessment (RAI-CHA). Data were available for 32 of the 33 clients accepted into the CC Program as of February 2011, and for an additional 51 individuals referred but not accepted into the Program.

Stage 5: Stakeholder Perspectives

In stage five, we documented the perspectives of CC Program funders, partners, staff and clients. We conducted semi-structured in-depth interviews with 12 key informants – individuals identified by the Steering Committee as having key knowledge of, or insight into the Program design and operation. This included representatives of Bellwoods, TC LHIN, TC CCAC, MOHLTC, City of Toronto Affordable Housing

Program, Canadian Paraplegic Association Ontario, Ontario March of Dimes, Bridgepoint Health Centre, Providence Centre, Toronto Rehab Institute (TRI), and St. Clare's Multifaith Housing Society. Interviews typically lasted 30 to 45 minutes, with some lasting more than an hour. For a list of interviewees please see Appendix B. A list of interview questions can be found in Appendix C.

To ensure that client voices were heard, we also interviewed two CC Program clients (one male and one female) and one personal support worker.

In addition, we conducted a 90-minute focus group with representatives of TCASN (Toronto Central Attendant Services Network), a network of attendant service providers funded by TC LHIN. Nine individual organizations participated. For a list of organizations represented please see Appendix D.

Stage 6: Cost Comparisons

In this stage, we analyzed available TC LHIN and MOHLTC data to estimate the per diem and total costs for typical CC Program clients, in comparison to the costs of care in other settings including:

- Acute care hospital Alternative Level of Care (ALC) beds;
- Complex Continuing Care (CCC);
- Convalescent Care (CC);
- Long-Term Care (LTC);
- Another transitional care program.

Stage 7: Think Tank

In the evaluation's final stage we conducted a half-day Think Tank to summarize and present the evaluation findings to date, and elicit feedback from partners and stakeholders including:

- Bellwoods senior staff;
- City of Toronto, Affordable Housing Program;
- MOHLTC;
- Ministry of Municipal Affairs and Housing;
- TC CCAC;
- Downsview Services for Seniors;
- Gage Centre for Community Living, West Park Healthcare Centre;
- Providence Centre;
- Lyndhurst Centre, Toronto Rehabilitation Institute;
- CastleviewWychwood Towers;
- Ontario Community Support Association.

For a list of Think Tank participants please see Appendix E.

4.0 Findings

4.1 Environmental Scan

The results of our environmental scan suggest a close alignment between that the aims of the CC Program and key health system policy directions and initiatives at provincial and LHIN levels.

4.1.1 Alignment with Wait Times and Alternate Level of Care (ALC) Initiatives

First among these are ongoing efforts to address persistently high numbers of Alternate Level of Care (ALC) beds in hospitals and other institutional care settings.

By definition, ALC beds are "system errors"; they have costs, but no benefits. They are beds occupied by individuals who no longer require them and who would be more appropriately, safely, and cost-effectively served in other care settings. According to Ontario's Wait Times Strategy, ALC occurs:

> *When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).*[3]

In addition to the direct costs of ALC beds (which range up to several hundred dollars per day in hospitals – see cost estimates below), they drive up wait times across the health care system, since patients who need beds cannot access them, and they erode public and political perceptions of health system sustainability.

ALC beds are also bad for individuals who "decompensate" or lose functional capacity each day they are bed-ridden, who may be at risk of contacting a hospital-borne illness, and who are isolated from family and friends. Key informants also noted that persons with disabilities due to recent trauma may also progressively lose confidence in their ability to return to independent living the longer they stay in a hospital bed.

The number of ALC bed/days across Ontario is substantial. According to the Ontario Health Quality Council (OHQC) 2010 report, ALC patients occupy one sixth of hospital beds in Ontario, and close to 20% of hospital beds in some LHIN regions.[4] In the TC LHIN, 13% of ALC patients were deemed ALC for more than 30 days.[5] Compounding the costs and consequences for patients and system, the 2009 CIHI

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[3] Guerriero L and Nord P. (2009). "Provincial alternate level of care (ALC) definition adoption and application." Downloaded from: www.oha.com/CurrentIssues/Alternate%20Level%20of%20Care/Lynn%Guerriero%20Peter%20Nord%20Handouts.pdf.

[4] Ontario Health Quality Council (OHQC). (2010). 2010 Report on Ontario's Health System.

[5] Greco J, Williams D, Sakelaris V, Daub S. (2011). The Long Stay Alternative Level of Care (ALC) Review & Intensive Case Management Project in the Toronto Central LHIN: Final Report. Toronto Central Community Care Access Centre.

Alternate Level of Care in Canada reports that in 2007-08, 27% of Ontario ALC patients who were discharged home visited an emergency department within 30 days of discharge.Dementia is the most common diagnosis for ALC patients, accounting for more than one third of all ALC days. However, trauma, which includes injuries, accounts for approximately 11% of ALC days and stroke accounts for 7%[6] -- as noted later, injuries and stroke are two leading reasons for entry to the CC Program.

While CIHI data show that the most common discharge destination for ALC patients across Canada in 2007/08 was LTCH (43%), Ontario's MOHLTC emphasizes that a mix of institutional and community-based alternatives is needed to relieve ALC pressures. This mix includes:

- Increased home care and community supports;
- Community programs and outreach services.

By targeting high needs individuals with physical disabilities occupying ALC beds, and by providing them with training and community-based supports to transition and maintain them in the community and prevent their re-admission to hospital, the CC Program thus clearly aligns with key provincial and LHIN-level priorities.

4.1.2 Alignment with Other Initiatives

The CC Program also addresses and anticipates other key priorities.

Provincial Initiatives

Excellent Care for All (2010)

At the provincial level, Excellent Care for All (ECFA) is now at the centre of the government's pre-election health care agenda.

ECFA was announced in 2010. It includes four components (described in more detail in an appendix):

- The *Excellent Care for All Act, 2010;*
- Expansion of the role of the Ontario Health Quality Council (OHQC);
- Patient-based payment (PBP);
- Evidence-based practice.

Of particular relevance is the PBP component, which shifts hospital funding from a purely global budget structure to one that links funding more closely to performance. This new approach provides financial incentives to hospitals that achieve reductions in ALC days, average length of stay (ALOS) and readmissions. Also included are incentives for hospitals to implement evidence-based discharge practices and to establish better linkages with the community.

Since funding will increasingly be tied to performance in areas including reductions in unnecessary or avoidable bed utilization, and patient/client satisfaction, there will be growing financial incentives for hospitals and other institutions to find appropriate community-based discharge options which respond to client needs on a timely basis. In turn, this suggests new opportunities for providers such as Bellwoods not only to provide such options, but to lever a share of financial rewards which will accrue to

[6] Guerriero L and Nord P. (2009). "Provincial alternate level of care (ALC) definition adoption and application." Downloaded from: www.oha.com/CurrentIssues/Alternate%20Level%20of%20Care/Lynn%Guerriero%20Peter%20Nord%20Handouts.pdf; Canadian Institute for Health Information (CIHI). (2009). Alternate levels of care in Canada. Ottawa: CIHI.

high performing hospitals.

Aging at Home (2007)

The rollout of Ontario's Aging at Home (A@H) strategy further emphasizes the growing opportunities for community-based providers to contribute to solutions for hospital and institutional problems.

In August 2007, the government of Ontario launched its $1.1 billion, four-year strategy to provide community living options for seniors. While initially designed "…to enable people to continue leading healthy and independent lives in their own homes" through expanded community living options, the focus of A@H has progressively shifted toward moving patients through and out of hospitals as quickly as possible. In 2009-2010, the MOHLTC directed that 50% of Aging at Home money be used to reduce emergency room (ER) wait times and ALC bed/days; in 2010-2011, 25% of Aging at Home money was retained by the province to support its ER/ALC initiatives, with the remaining 75% to be used to address ER/ALC problems at LHIN level.

While seniors currently comprise only a small proportion of CC Program clients (as we will see below, younger adults comprise the majority), the Program pioneers a pathway for flowing difficult-to-discharge persons from institutional beds to community settings. Not only is this of high value for the individuals and institutions directly involved, but the Program can also contribute to generating evidence and best practices to inform the design and operation of similar initiatives to improve system flow. Such initiatives will become increasingly important as the general population ages, and particularly as people with physical disabilities live longer and themselves become seniors with progressively higher levels of need.

Assisted Living Services for Seniors Policy (2011)

While also aimed at seniors, this policy is of interest since, like the CC Program, it emphasizes the value of combinations of housing and community-based services to support "high risk" individuals in the community. Not only is appropriate housing seen as a fundamental requirement for health and wellbeing, but supportive housing in particular is seen as a way of coordinating and delivering needed ADL and IADL supports on a flexible and cost-effective basis.

The definition of "high risk" under this policy clearly pertains to many individuals living with a physical disability. Characteristics include:

- High to very high levels of difficulty with Instrumental Activities of Daily Living (e.g. housekeeping);
- Mild to moderate levels of difficulty with Activities of Daily Living (e.g., personal hygiene);
- High to very high levels of caregiver burden;
- Multiple chronic conditions (e.g., hypertension, arthritis, diabetes);
- Falls;
- Complicated medical management.

TC LHIN Initiatives

Toronto Central LHIN 2010-2013 Integrated Health Service Plan (IHSP)

In 2006, Ontario established 14 Local Health Integration Networks (LHINs), regional entities responsible for planning, funding and monitoring a range of providers including hospitals, CCACs, community support agencies, community-based mental-health-and-addictions services and LTC. According to the Ministry of Health and Long-Term Care (MOHLTC), "LHINs are a critical part of the evolution of

healthcare in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated, and sustainable" (Ministry of Health and Long-Term Care, 2008).

This idea of moving from fragmented "non-systems" of care,to more coordinated, integrated care systems where individuals can access the most-appropriate, cost-effective care on a timely basis, is at the centre of the TC LHIN's IHSP. It is also at the centre of TC LHIN initiatives, which aim to improve the flow of individuals with multiple needs, requiring multiple services, and providers across care "silos" so that they get the most appropriate, cost-effective care, on a timely basis. Two ongoing initiatives deserve special mention since they closely align with the CC Program.

ALC Resource Matching & Referral (RM&R)

This first ongoing initiative aims to standardize business and clinical processes between acute and post-acute providers to discharge patients more quickly and effectively out of hospitals in order to use in-patient hospital resources more effectively. RM&R is an electronic information and referral system that matches clients to the earliest available service that best meets their individual needs. It is currently being rolled-out to move people. According to the TC LHIN website, "RM&R is a powerful tool to reduce Alternate Level of Care (ALC) days and contribute to lower ER wait times. RM&R identifies people who are waiting too long or unnecessarily in a hospital bed and helps them to transition to another care setting to continue their care."

Community Navigation and Access Program (CNAP)

This initiative involves 34 community support service agencies that collaborate to improve access and coordination of community support services for seniors, in effect, to build an integrated continuum of care from existing services and providers. According to the CNAP website, "the CNAP Network aims to ensure that 'every door leads to service' so that seniors can reach the care they need." To date, CNAP had developed standardized assessment and intake protocol, and mechanisms to ensure that individuals receive a "warm transfer" when they are referred to CNAP agencies.

TC CCAC Initiatives

Integrated Client Care Project (ICCP)

In March 2011, the Toronto Central CCAC initiated this new initiative that has aims and approaches very similar to the CC Program.

According to the CCAC, the ICCP adopts "a shared model of integrated care for complex populations that spans across primary care, acute, CCAC, rehab and community service providers has the potential to deliver meaningful cost savings by reducing dependence on acute care and optimizing system resources to free up the capacity needed to meet future demand." It targets frail seniors with complex medical, physical, cognitive and social conditions who have a recent history of hospital admissions, receive care from multiple providers, and are at risk of further hospitalization or long-term care.

Like the CC Program, the ICCP focuses on "ensuring successful transitions" by using a team approach which will involve providers across the continuum, and clarify roles and accountabilities at key transition points in the individual's "care journey." In addition to providing individuals with more appropriate, cost-effective care, ICCP anticipates reduced ALC days, reduced hospital re-admissions, and improved client and caregiver satisfaction and experience.

Perhaps most importantly, the ICCP places great emphasis on the benefits of building stronger relationships between different providers across the care continuum. Rather than working in "silos,"

providers will now work together as a team to "wrap care around the client" through regular case conferences and rounds "to assess and review client and caregiver needs and progress."

4.1.3 Environmental Scan Summary

In sum, the Bellwoods' CC Program closely aligns with the aims and approaches of key provincial and LHIN-level policy initiatives. The CC Program meticulously assesses the needs of individuals with physical disabilities who are "stuck" or likely to become stuck in ALC beds or in LTC; it matches individual needs to available resources with the aim of equipping these individuals to return to the community; and it actively manages the entire client flow process so that individuals move seamlessly from hospital/institutional intake to eventual discharge and independent living.

In doing so, Bellwoods also contributes to greater system integration by building strong relationships among multiple providers. In effect Bellwoods CC Program established a new model of integrated care, very similar to the ICCP just initiated by the TC CCAC.

For additional information on the Environmental Scan Please refer to Appendix G.

4.2 CC Program Pathway

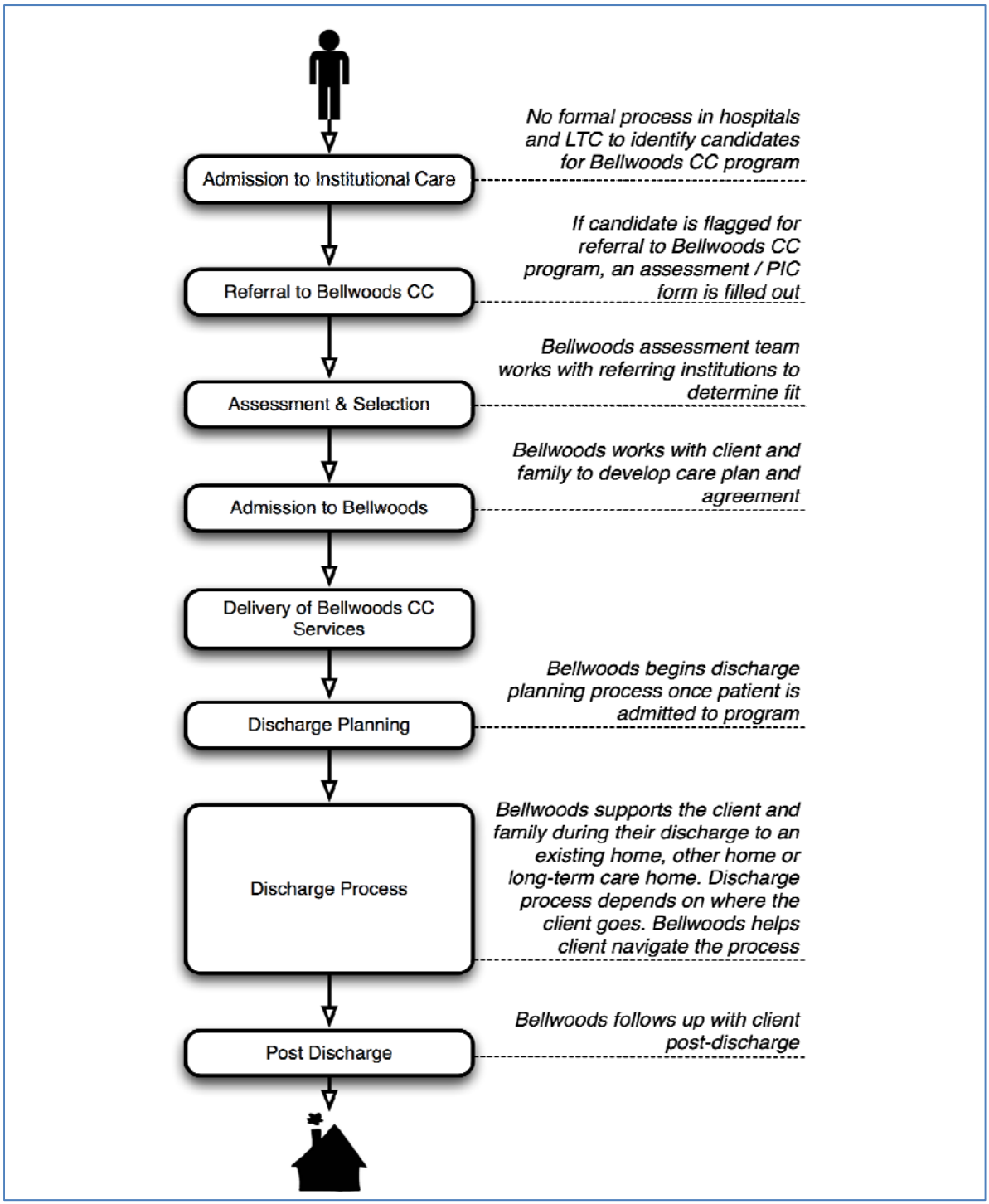
4.2.1 Client Flow Map

The diagram below provides an overview of how clients flow through the CC Program.

This diagram clarifies that the CC Program extends well beyond Bellwoods itself: it reaches back along the care continuum to work with providers at the point at which individuals enter institutional care; it reaches forward to assist individuals not only to find suitable housing, but to develop the skills and knowledge needed to maintain their independence and wellbeing over the long term. In effect, the CC Program integrates care for high needs individuals across multiple providers and care transitions. Key transitions are as follows:

- In partnership with hospital staff, Bellwoods' staff work to identify individuals with physical disabilities, often admitted to a rehabilitation hospital, often post-trauma, who are likely to require extensive education and support to transition successfully back to the community; the CC Program works proactively to anticipate and avoid ALC status;
- Working with hospital staff, Bellwoods conducts an extensive client needs assessment, including, but not limited to the RAI-CHA (Resident Assessment Instrument – Community Health Assessment); if individuals meet CC Program criteria (e.g., they can be left alone safely) staff assist with completion of a PIC (Project Information Centre) application required for individuals needing attendant care services in Toronto (the PIC application process can take several weeks but did not hold up the admission process);
- Working with hospital staff, Bellwoods staff use assessment results to help determine the "fit" between an individual's needs and available CC Program resources (e.g., open places in short and long-stay programs); as we will see below, a third to a half of individuals assessed in hospitals are actually admitted to the CC Program;
- If a good "fit" is determined, and an individual wishes to proceed, a detailed care plan and agreement is negotiated with the individual, and family where appropriate;
- In Bellwoods' supportive housing, CC Program clients receive a coordinated mix of education and personal support services aimed at improving their functional status and safety and building their skills, knowledge and confidence to live independently in the community;

- Anticipating discharge, Bellwoods staff work with clients and providers to find supportive housing, to modify the client's existing home to make it accessible and safe, or to find an appropriate placement in a LTCH;
- Post-discharge, Bellwoods continues to provide education and support to ensure a successful transition back to community living.



4.2.2 Client Journeys

The brief vignettes below give a more personal sense of what typical clients experience as they move through the CC Program; these vignettes are based on actual individuals. The first vignette ("Mike"), describes the experience of short-stay program client; the second vignette ("Bob") is about a client in the long-stay program.

Mike: A Short-Stay Program Client

Mike is a young male who suffered a spinal cord injury. Following treatment in an acute care hospital, Mike was transferred to a rehabilitation hospital where he received therapy aimed at improving his function and mobility, as well as basic skills needed to safely return home.

After being flagged by rehab hospital staff, and assessed by Bellwoods, Mike was identified as a candidate for the 6-month CC Program. With Bellwoods staff he identified the following goals:

- To develop skills to live safely at home, including independence with transfers, meal prep, equipment use;
- To reduce service needs to three hours per day with no overnight care;
- To develop links to needed community support services;
- To develop psycho-social coping with his new disability;
- To return home.

As a part of the CC Program, Mike was able to have trial visits home. These visits identified that Mike was in need of overnight care and therefore that Mike's home was no longer appropriate due to lack of available overnight services. The CC Program was able to locate supportive housing with 24/7 care coverage for Mike from another provider. Mike also received teaching and reinforcement on a day-to-day basis around how best to manage his ADL and IADL needs. As a result Mike can now:

- Direct his own care safely and efficiently;
- Access all the equipment he needs to live safely;
- Maintain a high level of independence with transfers and some personal care;
- Maintain his relationships with family;
- Cope with his disability;
- Live independently.

Bob: A Long-Stay Program Client

Bob is a middle-age male disabled after a stroke; Bob also suffered from mental health issues. After acute care, Bob moved to a rehabilitation hospital where he received a range of services aimed at restoring his function and independence. However, Bob had no home to return to.

Working closely with the rehabilitation facility, Bellwoods' staff identified Bob as a long-stay CC Program client. They assisted Bob in developing the following goals at intake:

- To increase independence and safety in transfers, in the kitchen, bathroom and with medication management;
- To increase skills related to managing finances, and acquiring funding;
- To develop links to community services;
- To develop psycho-social coping skills with disability and mental health;
- To find a family physician;
- To find a home.

In addition to providing Bob with a transitional home in Bellwoods' supportive housing with 24 hour access to care, CC Program staff worked intensively with Bob to develop skills and knowledge needed to identify and manage his own care needs and access the funding he would require to remain independent. CC Program staff also found Bob a permanent place in supportive housing. As a result, Bob now:

- Can transfer independently and assess high risk transfer situations (e.g. wet surfaces)
- Can manage medication maintenance
- Is independent in the kitchen
- Can direct personal care and support services efficiently
- Has needed funding and a solid knowledge base to maintain this funding
- Has a suitable home with attendant outreach services.

4.3 CC Program Client Metrics

4.3.1 Admissions

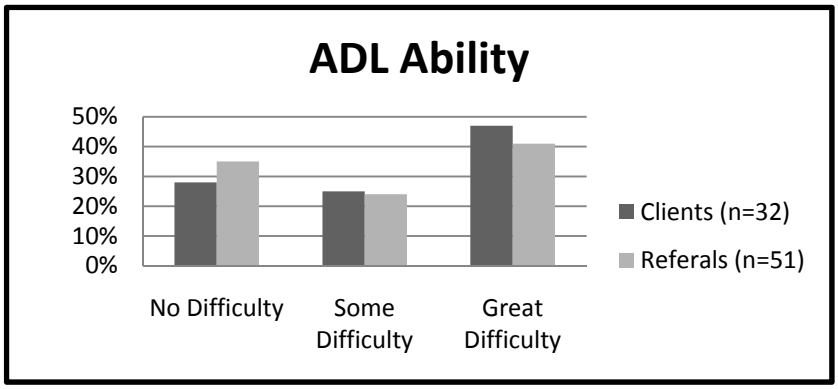
As of February 2011, 33 clients had been admitted to the CC Program. As shown in the table below:

- Most (26 or 79%) were male;
- The majority (82%) were under age 65;
- More than three quarters (26 or 79%) were admitted from rehabilitation hospitals (e.g., the Toronto Rehab Institute, Providence Healthcare, Bridgepoint Health, and West Park Healthcare Centre), with others admitted from complex continuing care facilities, acute care and LTCH;
- The majority (29 or 88%) had experienced an adverse event including a stroke, spinal cord injury, or acquired brain injury.

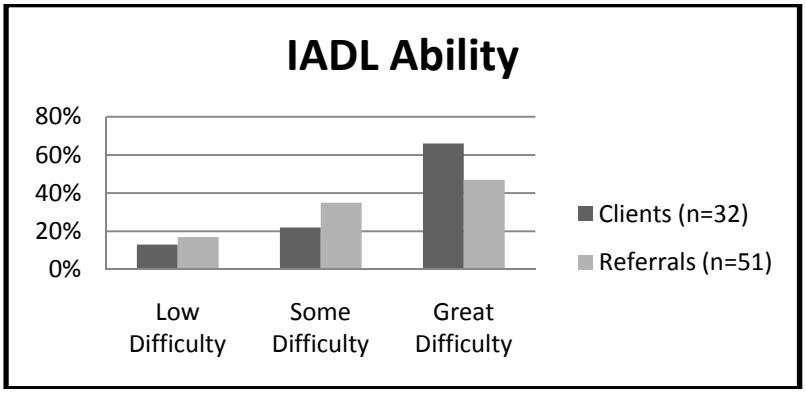
CC Client Metrics	
Total Number of Clients Admitted	**33**
Client Demographics*	
Male	26 (79%)
Under the age of 65	27 (82%)
Referring Organization	
Rehabilitation hospital	26 (79%)
Complex continuing care	5 (15%)
Long-term care home	1 (3%)
Acute care hospital	1 (3%)
Total	33 (100%)
Adverse Event Prior to Admission	
Stroke	13 (39%)
Spinal cord injury	13 (39%)
Acquired brain injury	3 (10%)
Other	4 (12%)
Total	33 (100%)

* Percentages do not add to 100%.

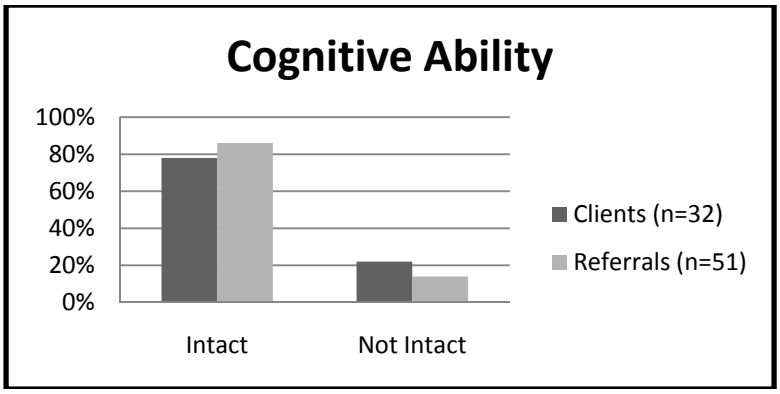
The three graphs below summarize data from RAI-CHA assessments conducted by Bellwoods' staff at the time of initial referral. These data are for 32 (of 33) clients admitted to the CC Program, as well for 51 clients not admitted because they did not meet eligibility criteria or because space was not available at the time of referral.



This first table shows how CC clients scored according to their ability to perform ADL (activities of daily living) including personal hygiene, toileting, movement – locomotion, and eating. While just less than a third could perform these activities without any help, almost half (47%) experienced great difficulty, meaning that they depended on others to perform these activities for them. Overall, clients accepted into the CC Program experienced greater difficulty with ADLs than those not accepted.



The second table measures ability with IADL (instrumental activities of daily living), everyday but crucial activities such as meal preparation, ordinary housework, managing finances, managing medications, phone use, shopping and transportation. As with ADL, a large majority (about two thirds) of those accepted into the CC Program experienced great difficulty with IADL. Clients accepted into the Program were somewhat more likely to experience difficulty than those not accepted.



The third table presents data from the RAI-CHA Cognitive Performance Scale. The scale measures short-term memory, cognitive skills for daily decision making, expressive communication and eating self-performance. The majority (78%) of CC Program clients were cognitively intact; these clients were less likely to experience cognitive impairment than individuals referred but not accepted into the Program.

In sum, typical CC Program clients were adult males who had suffered a stroke or injury, requiring intensive rehabilitation in a specialized rehabilitation facility. Most experienced moderate to high levels of difficulty with ADL, and great difficulty with IADL. Consistent with the requirement that CC clients should be capable of managing safely on their own, most were cognitively intact.

Suggesting the extent of existing but unmet need, of the 83 clients assessed as possible candidates for the CC Program, less than half (32 or 39%) were actually admitted. While key informants indicated that some were refused because they did not meet eligibility criteria, it was observed that others could not access the Program because of resource limitations – space was not available.

It is worth noting that these data provide no evidence of "cream-skimming" on the part of the CC Program, that is, selecting lower needs, and presumably lower cost and easier-to-care-for individuals, while leaving higher needs, higher cost clients to other providers. While the Program is not designed for individuals with cognitive limitations that impact on their ability to manage by themselves, Bellwoods tended to accept those with higher ADL and IADL needs.

4.3.2 Discharges

As of February 2011, the CC Program had discharged a total of 22 clients. Of these:

- 13 (60%) were discharged from the 6 month program with an average length of stay (ALOS) of 5 months;
- 9 (40%) were discharged from the 14month program with an ALOS of 10 months.

The following chart describes the destinations of the 22 clients discharged from the CC Program up to February 2011. Note that the majority (77%) of these high needs individuals were able to transition back to the community.

Discharge Destination	Number of Clients (percentage)
Home with no service requirements	6 (27%)
Home with services (e.g. PSW services)	5 (23%)
Supportive housing	6 (27%)
Long term care home	2 (9%)
Returned to referring institution (due to change in condition)	2 (9%)
Died	1 (5%)
Total Number of Clients	22 (100%)

4.4 CC Program Cost-Effectiveness

In addition to direct benefits to individuals, a key justification for the CC Program lies in its ability to provide a cost-effective alternative to care in a hospital or institutional setting. To test this, we calculated the cost of the CC Program in comparison to the cost of care in other settings.

Before presenting these comparisons, we note that Bellwoods does not receive additional funding for the CC Program from the LHIN; rather, it redeploys resources from internal sources. More specifically, it funds CC Programmatic and educational aspects out of its TC LHIN-funded base budget, while the housing component is covered by a combination of subsidies (Ministry of Health and LTC, Canada Mortgage and Housing Corporation) for eligible clients, and rents (rent geared to income or low end of market rate) paid by clients.[7] In and of itself, this suggests the Program has offered considerable value to the system by supporting some of the highest needs clients in the health care system, without drawing on additional system resources.

As a comparative base, Bellwoods provided the following cost data for the CC Program for the period April 1 to December 31, 2011. These data show that the per diem cost per client was $153, excluding the costs of any additional services provided by external agencies such as the CCAC, and also excluding rent-geared-to-income co-payments charged to the client for housing.

[7] Market rent for a CC unit is $985 per month, while rents for those on Ontario Disability Support Program (ODSP) pay $145 per month. In the 9 month period of April 1 to December 31, 2010 12 of the 16 Community Connect clients were on ODSP.

CC Program Stay	Service	Program[8]	Housing[9]	Total	Per diem cost[10]
6 month	$18, 364	$2,566	$4,226	$25,156	$153
14 month	$42,848	$5,988	$9,860	$58,697	$153

4.4.1Health Care Facility and ALC Costs

Acute care hospitals provide intensive medical and nursing support, as well as drugs and medical devices for individuals in the acute phases of an illness or following a traumatic event. Once the condition of the individual is stabilized and they no longer require such intensive care, efforts are made to discharge to a more appropriate and less costly care setting.

As indicated above, if an individual no longer requires the level of care provided, but cannot be discharged because of a lack of appropriate discharge options, they are "designated" as "alternate level of care" (ALC); subsequently they receive less intensive care. Similarly, patients who no longer require active treatment in rehab hospitals or CCC facilities may also be designated as "ALC."

The following table presents estimates of the costs of acute care and ALC beds in hospitals and other facilities. While standard estimates are difficult to obtain, we obtained two such estimates – one from a hospital in the TC LHIN (the "High Estimate") and one from the MOHLTC ("Low Estimate").

Level of Care	In-Patient Per Diem Cost -- TC LHIN[11]	ALC Per Diem Cost -- High Estimate[12]	ALC Per Diem Cost -- Low Estimate
Acute Care – medical	$1,493	Not Available (NA)	$493 (Ontario)[13]
Acute Care - surgical	$2,662	NA	$493 (Ontario)[14]
Rehab[15]	$703	$985 ($1350 – WSIB clients)	NA
Complex Continuing Care[16]	$485	NA	NA

[8] Vacancy adjusted – assumes client in residence 164 days of 6 month cycle and 383.6 days of 14 month cycle.
[9] Excludes net client share of housing costs, which varies depending on income.
[10] Vacancy adjusted – assumes client in residence 164 days of 6 month cycle and 383.6 days of 14 month cycle.
[11] Average Total Cost per inpatient day (calculated). Source: TC LHIN March 2011.
[12] Information provided by a TC LHIN Rehab facility.
[13] Source: Ministry of Health and LTC, March 2011.
[14] Source: Ministry of Health and LTC, March 2011.
[15] Net direct and overhead costs per day. Source: TC LHIN
[16] Net direct and overhead costs per day. Source: TC LHIN

These data show that the per diem cost of the CC Program ($153) is only a fraction of the cost of an in-patient hospital bed (ranging up to $2600). However, because the CC Program does not provide intensive medical and nursing care, we believe that this is not the best comparison.

A more appropriate comparison may be made between ALC beds and the CC Program since both provide 24/7 supports to clients: ALC costs range from $493 in an acute care hospital to $985 in a rehabilitation hospital (ignoring the reported higher charge of $1350 for WSIB clients). While, as noted, CC Program clients pay an additional amount, based on income, for housing which they do not pay in hospital, the per diem CC Program cost is still less than half of the lowest cost of an ALC bed.

This raises an issue which we return to later: although, for a system perspective, the CC Program appears to be a cost-effective alternative to an ALC bed ($153 vs. $493 per day), from a client perspective, there may be an economic disincentive for clients to move to the CC Program where they will contribute to their rent.

Reasonable comparisons may also be made between the CC Program and Complex Continuing Care (CCC), both of which provide high levels of physical support for high needs clients including persons with physical disabilities. The per diem cost of a CCC bed is approximately three times higher than the per diem cost of the CC Program ($485 vs. $153). However, while in CCC, clients pay no fees for accommodation.

4.4.2 Long-Term Care Homes (LTCH) and Convalescent Care

Ontario LTCHs receive a total of about $148 per resident day (assuming a Case Mix Index of 100).[17] Part of this cost is born by the resident (ranging from $34.63 to $53.23 per day depending on rate reduction eligibilities); the Ontario government through the LHIN pays the balance ($94.54 to $113.14).

Thus, the per diem cost for the CC Program (excluding rent) is comparable to the full cost of a LTCH bed (i.e., $153 versus $147); however, it is higher than the public share of the cost of a LTCH bed (i.e., $153 vs.$113). For clients, costs are similar since they pay for accommodation in both settings.

We believe an additional metric should be considered. The ALOS in a LTCH bed is approximately 28 months;[18] this compares to an ALOS in the CC Program, which, even for long-stay clients, does not exceed 10 months. Thus the total public cost of an average stay in a LTCH may be estimated at just under $95,000 (i.e., 840 days @ $113); this compares to a total cost for a CC client of just under $46,000 (i.e., 300 days @$153), a considerable cost savings. This comparison ignores the fact that the majority of CC Program clients are young or middle-aged adults, whose ALOS if admitted to LTCH would likely exceed the average length of stay for older persons by a very considerable margin; by avoiding early placement to LTCH, the CC Program promises considerable cost savings over the life of an individual.

The following table shows the cost comparison of an episode of care in LTCH and in the CC Program. It also estimates the cost of a longer length of stay for a younger adult with a disability who, if placed in a

[17] MOHLTC 2010 rates.

[18] Ontario LTC Association presentation.http://74.6.239.84/search/srpcache?ei=UTF-8&p=average+length+stay+ltc+ontario&fr=yfp-t-715&u=http://cc.bingj.com/cache.aspx?q=average+length+stay+ltc+ontario&d=4935660629527689&mkt=en-CA&setlang=en-CA&w=b45b73bc,f74a3806&icp=1&.intl=ca&sig=qnn1hG0FIH2w6dC04pZ50w--

LTCH, would likely be there for 20 or more years. The real advantage of the CC Program, therefore, lies in its ability to minimize care requirements over the long term.

	Per Diem Cost	Average Length of Stay	Cost of average length of stay (or a typical "episode" of care)
Client in CC Program – short stay	$153	5 months	$22,950
Client in CC Program – long stay	$153	10 months	$46,000
Typical Client in LTCH	$113	28 months	$95,000
Younger Client with disability in LTCH	$113	20 years (minimum)	$824,900

Comparisons can also be made to Convalescent Care. This relatively new care designation entails 24-hour care mostly to post-acute care patients, mostly in LTCH. According to TC CCAC documentation, individuals in Convalescent Care no longer require hospital-level care but do "require specific medical and therapeutic services in a supportive environment before returning home."[19] The per diem cost for this program is the same as for LTCH (approximately $147 per day) although one government key informant estimated an actual per diem cost of $200. Average length of stay is two months and there are no client fees. However, Convalescent Care assumes a return home upon "recovery;" this does not seem to apply to persons with disabilities who require extensive education and skills development, as well as ongoing personal support, not required by many post-acute care patients. While Convalescent Care may appear less costly than the CC Program on this basis, it may not be a suitable option for CC Program clients.

4.4.3 Stepping Stones (LOFT)

We believe on additional comparison is valuable since it pertains to a transitional program which, on the face of it, looks much like CC.

Stepping Stones is a transitional program for seniors with mental health challenges who have been hospitalized (in Emergency Departments or ALC in acute care) and require support before they can return to a home environment. The program is provided by LOFT (Leap of Faith Together), a leading community services provider in Toronto.

Like the CC Program, Stepping Stones is based in a supportive housing setting. It provides supportive care and case management services to identify appropriate housing and supports for individuals upon discharge from the program. Average length of stay in this program is 4 months and average costs for the program is $143 per day[20]. There are no client fees or rent for this program, which is fully funded by the TC LHIN.

[19] Toronto Central CCAC brochure.

[20] Source: Stepping Stones program.

Stepping Stones is like the CC Program in that it helps take people out of ER or ALC and transition them to community living. But that is where the similarities end. Clients of the Stepping Stones program do not require the level of 24/7 supports that clients of the CC Program require. Stepping Stones clients are seniors with mental health challenges who need case management and supervision and assistance with finding a home in the community. CC clients on the other hand, require round the clock physical care and assistance with all activities of daily living. The staff to client complement, and the level of support provided is much higher in the CC Program than the Stepping Stones program.

4.4.4 Cost Comparison Summary

The table below summarizes the results of our cost analysis. It highlights key comparisons between the CC Program and other settings.

Overall, we conclude from a system perspective, that Bellwood's CC Program:

- Presents a considerable cost savings compared to the per diem costs of ALC beds in acute care or rehab hospitals;
- Presents a cost-effective alternative to CCC;
- Is more costly from a system perspective than LTCH on a per diem basis over the short run, but likely considerably less costly over the long run, since candidates for Bellwood's CC Program can be expected to live in LTCH for decades.

From a client's perspective:

- Co-payments for accommodation in the CC Program and LTCH are comparable;
- However, client co-payments in the CC Program may be an incentive for individuals to remain longer in acute care or rehab hospital ALC beds, since the latter charge no co-payments; this constitutes a considerable liability for the system. TC LHIN funding of the Stepping Stones offers a precedent for eliminating client co-payments.

Program or Level of Care	Per diem costs	Per diem costs paid by	Client co-payment or rent required	Average length of stay	Level of support provided
Community Connect	$153	LHIN/Bellwoods	Yes	150 - 300 days	Medium - high
Acute care ALC	$493	LHIN	No	6.9 days*	Medium
Rehab ALC	$985 to 1350	LHIN	No	13-30 days*	Medium
CCC	$485	LHIN	Yes	161 days	Medium – High
Convalescent Care	$148 - $200	LHIN	No	2 months	Medium
LTC	$148	LHIN	Yes	2 years	Medium
Stepping Stones	$143	LHIN	No	4 months	Medium

*ALOS for all patients, not ALC

4.5 Key Issues and Recommendations

Our in-depth interviews with key informants and stakeholders, as well as the focus group and Think Tank session, surfaced a range of strategic (big picture) and operational (program level) issues that elaborate these findings and suggest future directions for the CC Program.

4.5.1 Strategic (Big Picture) Issues

This first set of issues speaks broadly to the opportunities and challenges experienced by the CC Program. Key informants and stakeholders recommendations are included in text boxes below.

The CC Program creates value for clients

Key informants and stakeholders were virtually unanimous in their agreement that the CC Programprovides a range of benefits to clients, families and caregivers.

They commented that clients have an improved quality of life due to more appropriate living arrangements (e.g. home-like environment versus institutional environment). Moreover clients typically leave the program with crucial knowledge and skills based on individualized goals that are set by the client, family and CC staff; these skills equip them not just to go home, but to remain at home, as independently as possible over the long term. Key knowledge and skills include: independence and safety in ADLs (e.g. transfers, toileting, bathing); development of IADL skills (e.g. financial management, meal preparation, shopping); and development of pyscho-social coping skills (e.g. mental health issues, depression related to new disability).

Clients also receive extensive assistance to find appropriate, accessible, affordable housing, a daunting task at the best of times, and a particularly difficult task for individuals who have recently experienced a life changing trauma or illness. CC staff members start discharge planning early and to date they have been successful at securing places for all clients in a timely way. Most clients in the CC Programs have been discharged in a shorter time frame than the program initially anticipated.

Clients were particularly positive about the CC Program, which they felt had allowed them to regain their independence. For example, clients stated that:

- "CC was fantastic – it helped me get out of the hospital and now I can live alone in my own apartment"
- "CC staff are terrific – they have shown me how to manage my own care in the community, and they have made sure that I can do this well by visiting me in my home even after I have left the program."
- "CC has been tremendous for me – it allowed me to get out and live my life even after such a life-changing event."

Other stakeholders echoed these views suggesting that:

- The CC Program addresses the needs of a small population of high needs individuals who might otherwise end up in inappropriate care settings (e.g., young adults in LTCH);
- CC Program clients learn valuable skills which enable them not only to live independently in the community, but to contribute to their communities;
- The Program also reduces caregiver stress, and supports families who may not have the skills or resources to provide appropriate care to individuals experiencing the costs and consequences of severe trauma or illness.

Respondent Recommendations: The CC Program has demonstrated value for its clients, who constitute a small but particularly vulnerable and hard-to-serve segment of the population with potentially high costs for the health care system and families. The CC Program should continue and possibly expand to serve more individuals.

The CC Program creates value for the health care system

Virtually all key informants and stakeholders recognized the value of the CC Program at a system level.

Key informants and stakeholders observed that the CC Program:

- Provides a cost-effective alternative to care in hospitals;
- Assists in moderating hospital ALOS, number of ALC beds, and LTCH wait lists, by working proactively to transition high needs, difficult-to-discharge clients to safe and appropriate community settings;
- Maximizes the use of available health care resources over the long term, since individuals who might have required permanent placement in institutional settings can be successfully transitioned to independent community living with minimal supports;
- Reduces the likelihood of hospital emergency department visits and re-admissions, since the CC Program provides clients with a full range of personal supports and connections to primary care on a continuing basis in the community;
- Contributes to system integration by raising awareness among hospital discharge coordinators of safe discharge options in the community and by building strong working relationships among providers across the care continuum;
- Improves client flow by transitioning individuals smoothly between hospitals, Bellwoods, supportive housing, and independent living, thus improving client satisfaction, and making the best use of system resources.

Respondent Recommendations: Bellwoods has demonstrated considerable success in creating value for the health care system by transitioning high needs individuals from costly hospital and institutional beds to independent community living. In the process it has built strong relationships with providers along the care continuum and established a model for system integration. These successes should be clearly communicated to potential funders including the TC LHIN.

The CC Program takes on persistent system problems with limited resources

The relatively small CC Program takes on "big" system problems.

As noted, it bridges existing gaps between multiple providers so that high needs individuals with disabilities can transition along a continuum of care and successfully return to independent community living.

However, in doing so, Bellwoods expends considerable resources, not just through its direct support of individuals once they are in the CC Program, but through the time and resources committed to building relationships with other providers, communicating with them on an on-going basis, conducting assessments of Program candidates and finding them appropriate discharge locations once they have completed the Program. Note that by finding discharge locations for clients, it has had to overcome the same problems which caused individuals to become ALC in the first place. In effect, therefore,

Bellwoods takes on the costs of system problems such as ALC beds, but without the ability to share any resulting savings.

Moreover, even though it can clearly transition high needs individuals back to community living, thus benefitting these individuals and the health care system, system outcomes can be difficult to demonstrate, since freed-up hospital beds will be quickly filled by individuals "backed-up" further down the line. The Program's constrained resources and capacity limit its impact and visibility. For example, since the Program can serve no more than 14 individuals at any point, there is little "surge" capacity if multiple candidates appear at any point in time; as a result, some good candidates may be turned away. In addition to being a sub-optimal situation for these individuals, it may cause uncertainty for referring institutions which may be less willing to make the effort to identify and refer potential program candidates if they cannot be sure the Program will take them. Ironically, as the value of the CC Program becomes better known among providers and the disability community, this capacity issue may become more problematic as more referrals are made.

Lack of integrated care for people with disabilities is a major problem not only for the TC LHIN but across the province. People with physical disabilities are particularly hard to discharge from acute care and rehab facilities as many of them require assistance overnight as well as during the day. Such individuals may become "stuck" in institutional care beds because of a lack of safe, appropriate community care options. This can precipitate admission to facility-based long-term care homes (LTCH) as a default option, even for relatively young individuals who will then spend decades in these facilities at considerable personal and system cost.

Nevertheless, by transitioning high needs people with disabilities from hospitals to independent community living, the CC Program provides a powerful working example of how care can effectively be integrated across existing organizational "silos" through strong partnerships.

Respondent Recommendations: The range of individual and system level benefits created by the CC Program, including its ability to integrate client care across the continuum, need to be clearly communicated to funders and partners both as a justification for additional resources and as a model for caring for other high needs client groups (e.g., high needs seniors).

The CC Program builds creative and mutually beneficial arrangements with partners

There are untapped opportunities to develop strong partnerships with other providers.

For example, it might be possible for Bellwoods to be identified as "preferred" referral site for people with disabilities from a particular hospital. Alternatively, the CC Program could consider co-locating staff in referring organizations, and working more directly with the CCAC around the design and delivery of community service packages. It might also be possible to use e-technology to conduct "virtual rounds" with other providers which would allow early identification of CC Program candidates, and facilitate integrated multi-disciplinary, multi-organization team approaches to planning, delivery and discharge.

Respondent Recommendations: The CC Program should seek more formalized partnerships with rehabilitation hospitals, the TC LHIN, CCAC and the other providers in order to further consolidate care pathways for clients and find new opportunities for integration. E-technologies could assist the establishment of virtual teams or virtual rounds to improve planning, service delivery and discharge.

The CC Program must be able to demonstrate success

The Excellent Care for All (ECFA) strategy will require hospitals, and then other providers, to demonstrate high performance as a condition of funding.

Particularly at its current capacity, the CC Program has limited ability to demonstrate a significant impact on ALC rates overall; vacated hospital bed are likely to be filled unless community capacity increases. Also, while undoubtedly impacting positively on the quality of life and independence of individuals, such "soft" outcomes are inherently difficult to demonstrate.

Nevertheless, key informants and stakeholder emphasized that to ensure its continued success, and justify requests for resources to external funders and partners, appropriate performance measures must be "designed in" to the Program and documented on an ongoing basis.

In addition to considering system-level measures such as ALOS and ALC bed numbers, it may be constructive to look at organization and individual-level indicators. For example, ECFA emphasizes client satisfaction as a key performance indicator; this can be measured through interviews and surveys. Cost-effectiveness, another key performance indicator, can be measured by continuing to carefully document the per diem costs of the CC Program for individuals at comparable levels of need, and the comparative costs of their care in other care settings such as hospitals and LTCH. It was noted that Program staff have already moved in this direction, for example, by implementing standard assessment protocol for all referred clients.

Also, Bellwoods, along with its partners, should consider documenting additional benefits of the integration achieved by the CC Program. These may include measures of improved client "flow" (e.g., times from initial hospital intake to final community discharge).

Respondent Recommendations: The CC Program, in collaboration with partners and the TC LHIN, should identify an appropriate set of performance measures that demonstrate success at system, organization and individual levels.

4.5.2 Operational (Program-Level) Issues

The evaluation also identified a number of issues and opportunities related to the CC Program's day-to-day operation. For ease of presentation, we have arranged them below to follow the client pathway. We have again summarized respondents' recommendations in text boxes.

CC Program Information and Referral

Respondents noted that in spite of CC Program staff efforts, and clear successes with some hospital partners, there continues to be a lack of awareness among hospital discharge staff more broadly about the CC Program and about community care options.

Stakeholdersobserved that there are growing pressures on hospital staff to discharge clients as quickly as possible in order to reduce ALOS as well as ALC. These pressures often limit the ability of staff to explore the full range of options that may be appropriate for each client even when they are aware of them; this increases the likelihood that individuals with high needs including seniors and adults with disabilities, will "default" to LTCH or other institutional settings. Hospital discharge staff also tend to be "risk adverse" and unwilling to consider community care options particularly when they require extensive efforts to coordinate with multiple providers. Increasing pressure to avoid hospital

readmissions also reduces risk tolerance. Moreover, client and families may also be uneasy about transferring clients to environments with which they are not familiar.

While a dedicated, but small number of Bellwoods' staff has worked very hard to communicate with providers, and potential clients, there are many providers, and many potential clients, making effective communication an uphill battle.

Respondent Recommendations: To maximize impact, Bellwoods may want to target its outreach to specific organizations with higher numbers of potential CC Program clients (e.g., rehabilitation hospitals), or to specific client groups, for example, males under 65 years of age, who now constitute the majority of Program clients.

Further, to raise its profile with other providers and funders including the TC LHIN, Bellwoods might consider creating a CC Program Advisory Committee that involves key stakeholders and client organizations from across the care continuum.

Intake

It was noted that the current intake and application process is complex and that it demands considerable time and effort to complete; streamlining could encourage referring organizations and clients to access the Program.

For example, Bellwoods'comprehensive assessment (of services and housing needs) of the client is lengthy and can take over a month to complete; similarly, the 15-page PIC housing application process can take up to several weeks. This can slow the movement of clients out of hospitals, and it may discourage clients who are not sure if their applications will be accepted. The CC program has attempted to develop a timely intake process.

Timelines can be further extended by the fact that hospital staff do not always begin planning discharges until well into a patient's stay, as they cannot predict the patient's capacity at the end of the course of treatment. So when the client has reached his/her potential staff members may then be seeking a quick discharge for that client that is not, at this point in time, feasible for the CC Program.

Supportive housing co-payments can encourage clients to stay in hospital.

An additional issue impacting on clients' willingness to move into the Program is the need to pay rent while in Bellwoods supportive housing. Also, for individuals who have homes, the CC Program poses a double economic burden since they continued to pay mortgages and utilities, even as they pay rent at Bellwoods. As noted earlier, this may create a perverse incentive for individuals to delay discharge from hospital or avoid the Program altogether.

Only a minority of referrals to the CC Programare actually admitted.

Stakeholders observed that less than half of those identified as candidates for CC Program are actually get admitted; this low probability of success may discourage providers and clients from considering the Program. Bellwoods staff explained that some applicants are not admitted because they do not require the level of care provided, or they cannot manage on their own. However, a failure to admit may also be due to the fact that there is simply no available place at that point in time. Indeed, to the extent that

Bellwoods is successful in "marketing" the CC Program, the likelihood of admission is likely to fall even further.

Key informants observed that the reasons for admission decisions may not always be understood by referring organizations leading to confusion about eligibility, and creating the perception that the Program is difficult to access. This may further reduce the willingness of referring organizations to engage in the application process, and just as importantly, to see the CC Program as a solution.

Respondent Recommendations: Bellwoods should consider streamlining its application process. The new 2-page PIC application form to be introduced shortly will assist.

Bellwoods can consider developing succinct information packages which clearly set out selection criteria, processes and timelines.

Bellwoods staff members may want to meet with hospital staff on a regular basis to review admission decisions and clarify the reasons for refusals, possibly as an element of virtual rounds or team meetings.

Service Delivery

Bellwoods consistently received high marks for the high quality of its educational and personal support services. However, it was noted that there do not appear to be consistent quality standards across the system as a whole for services to adults with physical disabilities.

For example, it was noted that Bellwoods does an excellent job of designing education to prepare clients for community living. Beyond what Bellwoods delivers, however, there is a knowledge gap in the area of training people with disabilities to live independently in the community. Several key informants recognized that all clients with physical disabilities who live independently in the community would benefit from more standardized approaches to client education. Bellwoods can provide leadership in this area.

Respondent Recommendations: Demonstrating its leadership and the high quality of its teaching approach, Bellwoods could consider sharing material used in the CC and MILE programs with other providers across the system, possibly through the TC LHIN.

Bellwoods might also engage in collaborations aimed at developing best practices.

Discharge

Timely discharge from the CC program may be negatively impacted by a lack of accessible and affordable housing units and by long waitlists for both social and supportive housing

Once again pointing to factors beyond Bellwoods' direct control, stakeholders observed that it is challenging for CC Program staff to find appropriate housing for clients once they have completed the program. In fact, CC clients are actually "in competition" for a limited number of spaces not only with other people with disabilities, but with other providers wishing to discharge (e.g., rehabilitation hospitals).

Stakeholders also recognized that planned discharge destinations for clients in the 6-month program have not always proven appropriate forcing CC staff to scramble to find alternatives.

The CC Program could be seen as a mechanisms for "jumping the queue" for available housing spaces in the community.

Several stakeholders recognized that because the CC Programenhances access into existing community supportive housing or attendant outreach spaces, it could be seen as a way of "gaming" the system. However, other stakeholder disagreed, suggesting instead that the CC Program, through its close partnerships with housing providers, is a good alternative to "hit and miss" approaches. They emphasized that it would be good to apply the lessons learned by the CC Program to guide resource matching on a broader scale.

Respondent Recommendations:
Stakeholders suggested the development of an integrated up-to-the minute inventory of available supportive housing, accessible housing and/or RGI units in TC LHIN. This anticipates the roll-out of the TC LHIN RM&R initiative as well as redevelopment of the PIC system.

Bellwoods can make discharge process and protocol more transparent to partners, stakeholders and clients.

5.0 Conclusions and Strategic Recommendations

This evaluation used multiple methods and data sources to evaluate Bellwoods' CC Program two years after its inception. This included an environmental scan; analysis of key policy documents; comparative analysis of costing data; key informant and stakeholder interviews; and a Think Tank which elicited feedback from partners and stakeholders.

A first conclusion is that Bellwoods' staff and its partners have done a commendable job of putting a very complex and visionary program on the ground. The strength of commitment among all those associated with the CC Program is exceptional.

A second conclusion is that the CC Program has achieved many important successes in its relatively short time in operation, particularly given its limited resources, and the magnitude of the problems it addresses. The CC Program:

- Is well aligned with provincial and LHIN-level priorities and initiatives including the wait times and ALC strategies;
- Creates value for individuals by enhancing the independence, functional capacity and quality of life of clients, caregivers and families;
- Creates value for the health care system by transitioning high needs, difficult-to-discharge people with disabilities (often young males who might otherwise live the rest of their lives in institutional settings) from costly beds to independent community living with minimal supports;
- Makes good use of resources since CC Program costs are considerably lower than the per diem costs of hospital ALC beds, and since the Program avoids the cumulative costs of caring for adults with disabilities in LTCH over the course of decades;
- Has demonstrated the ability to integrate care across an extended continuum by investing in strong partnerships with other provider organizations; in the process, it has established a model for care integration for high needs groups.

Third, the CC Program faces important challenges moving forward. These include:

- Small scale and limited capacity even as pressure to discharge increases;
- Extended referral and intake processes;
- Housing co-payments which may discourage eligible clients;
- Limited availability of community housing for discharge from the CC Program.

As detailed above, our key informants, stakeholders and Think Tank participants, made many valuable recommendations about what could be done to strengthen the CC Program. In addition, we add the following "high level" strategic recommendations based on these suggestions and our other data sources:

- **Strategic Recommendation 1**: Position the CC Program not just as a very valuable service for a small number of deserving high needs individuals, caregivers and families, but as an innovative and cost-effective model of system integration for high needs groups more generally. *We note that the TC CCAC is now piloting a similar model for high needs seniors.*

- **Strategic Recommendation 2**: Develop new mechanisms to strengthen working partnerships with other providers both "upstream" and "downstream" across the care continuum.
    - At a strategic level, the establishment of a CC Program Advisory Panel including senior leaders from provider organizations, the TC LHIN, provincial ministries, City of Toronto housing, and the disability community, could increase Bellwoods visibility and leadership,

build awareness of the Program's value and relevance as a viable care option, and create opportunities for resources, either though dedicated funding from the LHIN, or through resource sharing with partners particularly under new provincial performance-driven funding arrangements.

- At an operational level, the establishment of multi-disciplinary, multi-organization "rounds" including experienced care managers, discharge planners, and front-line care providers, who would consider actual client cases, identify opportunities for improving "flow," and make CC Program decisions more transparent.

- **Strategic Recommendation 3**: In collaboration with partners, elaborate a set of CC Program "metrics" to demonstrate success under the provincial ECFA strategy at individual, organization and system levels. Such metrics would, for example, document client and caregiver satisfaction since these are mandated in the legislation and since clients and caregivers are at the centre of the CC Program. Subsequently, these metrics might identify "benchmarks" for client flow between organizations and through the care continuum, building on the experience of the provincial wait times strategy.

- **Strategic Recommendation 4**: Consider targeting the CC Program more tightly at least on an interim basis to optimize the use of available resources. A growing international literature on integrating care for high needs populations emphasizes that integrating care is time and resource intensive with potentially high dividends, but not all the time. Two different approaches to targeting were surfaced during the evaluation: focusing on relatively homogeneous groups of potential clients (such as younger adults with acquired disabilities who now make up the bulk of the Program client base); or targeting particular institutional partners (such as rehabilitation hospitals) to strengthen working relationships, minimize transaction costs, and build valuable experience.

Appendices

Appendix A: Steering Committee Members

Name	Organization
Claire Bryden	Bellwoods Centres
Ed Montojo	Bellwoods Centres
Susan Andrew	Bellwoods Centres
Harriet Jamieson	Bellwoods Centres
Karen Woo	Bellwoods Centres
Janice Hayden	Bellwoods Centres
Dave Gibson	Bellwoods Centres
Anne Wojtak	TC CCAC
Paul Williams	Consultant
Fern Teplitsky	Consultant
Gillian Watkins	Consultant

Appendix B: Interviewees

Interviewees Name	Organization
Vania Sakelaris	Toronto Central LHIN
Angelika Gollnow	Toronto Central LHIN
Nello Del Rizzo	Toronto Central LHIN
Joanne Greco	Toronto Central CCAC
Anne Wojtak	Toronto Central CCAC
Vera Iwanow	Ministry of Health and Long Term Care, Housing
Richard Marshall	City of Toronto Affordable Housing
Linda Gordon	Ministry of Health and Long Term Care
Claire Bryden	Bellwoods Centres
Ed Montojo	Bellwoods Centres
Susan Andrew	Bellwoods Centres
Harriet Jamieson	Bellwoods Centres
Gloria Danielle	Bellwoods Centres
Therese Anne Sidler	Canadian Paraplegic Association
Sandra McGregor	Ontario March of Dimes
Wendy Cameron	Bridgepoint Health
Maggie Bruneau	Providence Centre
Patricia Bain	Toronto Rehab Institute - Lyndhurst
Kathryn Wise	Toronto Central CCAC
Jon Harstone	St Clare's Multifaith Housing Society
2 clients	
1 caregiver	

Appendix C: Interview Questions

1. Please describe your role in connection with the CC program.
    a. What is your interest in the program

2. What is your understanding of the goals of the CC program?
    a. Reduce demand for ALC?
    b. Reduce inappropriate placements for adults with disabilities
    c. Improve quality of life for adults living with disabilities

3. Please describe the major opportunities for the CC program.
    a. Optimal outcomes- system level, individual level
    b. What impact has it had to date? System level, individual level?

4. What might some of the challenges faced by the CC program?
    a. System level challenges impacting on the success of the program?
    b. What might need to be changed about the program
    c. How might we address these challenges?
        i. Consider client flow
        ii. Consider what key group we are targeting
        iii. Where is the demand coming from?

5. What are the opportunities for the future of the CC program?
    a. To meet current and future needs of the TC LHIN?
    b. Business case for continuing/expanding the program?
    c. What are barriers to effective discharge planning?
    d. Where are clients transitioning to?

Appendix D: TCASN Focus Group Participants

Participant Name	Organization
Claire Bryden	Bellwoods
Karen Woo	Bellwoods
FidelmaSerediuk	Canadian Paraplegic Association Ontario
ArijanaMarovic	Canadian Red Cross Community Services
Frank Hamilton	Ontario March of Dimes
Fran Boyce	Three Trilliums Community Place
Tania Thomas	West Park, The Gage
Sarah Kravetz	Clarendon Foundation

Appendix E: Think Tank Participants

Participant	Organization
Vera Iwanow	Ministry of Health and Long Term Care, Housing
Anne Wojtak	Toronto Central CCAC
Kathryn Wise	Toronto Central CCAC
Maggie Bruneau	Providence Centre
Richard Marshall	City of Toronto Affordable Housing
Ymelda Chua	CastleviewWychwood
Joanne Jasper	Downsview Services to Seniors
Lori Murphy	Toronto Rehab Institute
Tania Thomas	West Park Health, The Gage
TaruVirkamaki	Ontario Community Support Association
Claire Bryden	Bellwoods Centres
Ed Montojo	Bellwoods Centres
Susan Andrew	Bellwoods Centres
Karen Woo	Bellwoods Centres
Harriet Jamieson	Bellwoods Centres
Janice Hayden	Bellwoods Centres
Dave Gibson	Bellwoods Centres
Paul Williams	Consultant
Fern Teplitsky	Consultant
Jillian Watkins	Consultant
David Rudoler	Consultant
Allie Peckham	Consultant

Appendix G: Detailed Environmental Scan

Profile of ALC Patients:

- The majority of ALC patients in Canada are female (58.1% in 2004/05) and over the age of 65 (82.5% in 2004/05).[21]

- In 2009/10, in the TC LHIN, patients waiting in ALC under 14 days accounted for approximately 70% of all ALC discharges and 25% of ALC days; patients waiting in ALC for 15 to 30 days accounted for approximately 17% of ALC discharges and 21% of ALC days; and patients waiting for longer than 30 days accounted for approximately 13% of ALC discharges and 54% of ALC days.[22]

- According to the Canadian Institute for Health Information, 7% of hospitalizations in Ontario were ALC in 2007-2008 (tied with Newfoundland for the highest in Canada). The median ALC length of stay in 2007-2008 was 10 days, with 59% of ALC patients had stays of a week and 20% had stays of more than a month. 4% had stays of more than 100 days. The long stay patients were more likely to be in the hospital for reasons related to dementia.[23]

- ALC patients are older than non-ALC patients (on average) and are more likely to being their hospital experience in an emergency department than non-ALC patients. ALC patients are more likely to have co-morbid conditions, and longer lengths of stay. The groups that account for the most ALC days include the frail elderly, those with cognitive/behavioural problems and neurological disease or stroke. In 2007-2008, dementia accounted for almost one-quarter of ALC hospitalizations and more than one-third of ALC days. Stroke patients also had high ALC use. Stroke-related hospitalizations accounted for 7% of ALC hospitalizations and ALC days. 14% of ALC patients had a diagnosis of trauma, which accounted for 11% of ALC days.[24]

- In 2007-2008 ALC patients across Canada were most likely to be discharged from hospital to long-term care (43%), home (with or without support) (27%), or to a rehabilitation facility (13%).[25]

- 17% of ALC hospitalizations were followed by at least one 30-day readmission to hospital (compared to 12% for non-ALC patients). In Ontario, 27% of ALC patients who were discharged home visited an ED within 30 days. However, 22% of non-ALC patients also visited the ED within 30 days of discharge from hospital.[26]

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[21] Jokovic, A., Baibergenova, A., Baldota, K., Leeb, K. (2006). Alternatives to Acute Care?*Healthcare Quarterly*, 9(2), 22-24.

[22] Greco J., Williams D., Sakelaris V. et al. (2011). The Long Stay Alternative Level of Care (ALC) Review & Intensive Case Management Project in the Toronto Central LHIN: Final Report. Toronto Central CCAC: Toronto.

[23] Canadian Institute for Health Information (CIHI). (2009). Alternate levels of care in Canada. Ottawa: CIHI.

[24] Canadian Institute for Health Information (CIHI). (2009). Alternate levels of care in Canada. Ottawa: CIHI.

[25] Canadian Institute for Health Information (CIHI). (2009). Alternate levels of care in Canada. Ottawa: CIHI.

[26] Canadian Institute for Health Information (CIHI). (2009). Alternate levels of care in Canada. Ottawa: CIHI.

- In Ontario, the percentage of inpatient days accounted for by ALC patients was 23% in 2008/09. This percentage was highest among those aged 85 and older (33%) and lowest among those aged 65-74 (14%).[27]

- The number of ALC patients waiting for LTC placement in Ontario almost doubled between 2005/06 and 2008/09. Priority levels remained relatively stable, although the proportion of moderate-priority ALC patients waiting for LTC increased by more than 5%.[28]

- Ontario seniors waited a median of 103 days for a LTC placement in 2008/09. In 2008/09 crisis applicants waited a median of 79 days, high need patients waited a median of 104 days, and remaining applicants waited a median of 169 days.[29]

- In 2008/09 individuals admitted from hospital waited a median of 55 days, those admitted from the community waited a median of 153 days and individuals transferring between LTC homes waited a median of 203 days.[30]

Profile of Target Conditions:

a. Brain and Spinal Injury

- According to the Toronto Acquired Brain Injury Network, brain injury is damage to the brain that results from external force such as a collision, fall, assault, or sports injury (i.e., traumatic brain injury); or through a medical problem or disease process, which causes damage to the brain. Brain injury can result in physical, cognitive, emotional and/or behavioural disabilities in varying degrees depending on the location and severity of the injury.[31] Spinal cord injury is damage to the spinal cord that results in a loss of function such as mobility or feeling.
- In 2006/07 there were 18,033 (traumatic brain injury episodes (hospitalizations and emergency department visits) in Ontario. This number was higher for males (N=11,558, 190.2 per 100,000) than for females (N=6,475, 99.5 per 100,000). The major causes of traumatic brain injury in 2006/07 were as follows: Falls (41.6%), struck by and against (31.1%) and motor vehicle collisions (11.9%).[32] There are no definitive numbers for the Toronto area. However, the Toronto Acquired Brain Injury Network has projected that the incidence of acquired brain injury in Toronto will be between 4,393 and 9,794 in 2012, and the prevalence will be between 3,642

[27]Bronskill SE, Carter MW, Costa AP, et al. (2010). Aging in Ontario: An ICES chartbook of health service use by older adults. Toronto: ICES.
[28]Bronskill SE, Carter MW, Costa AP, et al. (2010). Aging in Ontario: An ICES chartbook of health service use by older adults. Toronto: ICES.
[29]Bronskill SE, Carter MW, Costa AP, et al. (2010). Aging in Ontario: An ICES chartbook of health service use by older adults. Toronto: ICES.
[30]Bronskill SE, Carter MW, Costa AP, et al. (2010). Aging in Ontario: An ICES chartbook of health service use by older adults. Toronto: ICES.
[31] Toronto Acquired Brain Injury Network. (2006). A framework for the future planning of publicly funded acquired brain injury services in Toronto.
[32]Colatonio A, Saverino C, Zagorski B, et al. (2010). Hospitalizations and emergency department visits for TBI in Ontario. *Can. J. Neurol. Sci*37: 783-790.

and 12,284 in 2012.[33] Research suggests that a disproportionate number of head injuries occur in males between 15 and 24.[34]

- In 2005-2006, 732 patients with head injury received inpatient rehabilitation services in Ontario. The median length of stay was 35 days (versus 17 for all patients). The mean total functional score at admission was lower for patients with head injury (80.2) when compared to all rehabilitation inpatients (85.9). At discharge, the mean Total Function Score for patients with head injury was 103.5. 44.4% of patients with head injury discharged from complex continuing care were transferred to acute care hospitals and 23% to residential care in 2005-2006. 16% per discharged home, compared to 29% for all complex continuing care patients.[35]

- In 2005-2006, 333 patients with spinal injuries received inpatient rehabilitation services in Ontario. The median length of stay for patients with spinal injuries was 56 days (compared to 17 days for all patients). The mean total functional score at admission was 70.1 and 93.7 at discharge. [36]

- According to the Toronto Acquired Brain Injury Network, in 2002/03 there were a total of 19,102 days of services provided by the community support services in Toronto (includes supported housing, community-based therapy and case management) sector to 54 clients. These services amounted to a total expenditure of $4,653,794 for the Ministry of Health and Long-Term Care.[37]

- The incidence of traumatic spinal cord injury has remained stable between 2003 (24.2 per million) and 2006 (23.1 per million). These rates were different for men (36.3 per million) and women (12.1 per million). The major causes of injury were as follows: falls (47.8% for men, 54.1% for women) and motor vehicle accidents (23.0% for men, 28.5% for women).[38] The Canadian Paraplegic Association estimates that 80% of those who suffer a spinal cord injury each year are male between the ages of 15 an 34 years.[39]

[33] Toronto Acquired Brain Injury Network. (2006). A framework for the future planning of publicly funded acquired brain injury services in Toronto.
[34] Canadian Institute for Health Information. (2007). The burden of neurological diseases, disorders and injuries in Canada. Ottawa: Canadian Institute for Health Information.
[35] Canadian Institute for Health Information. (2007). The burden of neurological diseases, disorders and injuries in Canada. Ottawa: Canadian Institute for Health Information.
[36] Canadian Institute for Health Information. (2007). The burden of neurological diseases, disorders and injuries in Canada. Ottawa: Canadian Institute for Health Information.
[37] Toronto Acquired Brain Injury Network. (2006). A framework for the future planning of publicly funded acquired brain injury services in Toronto.
[38]Couris CM, Guilcher SJT, Munce SEP, et al. (2010).Characteristics of adults with incident traumatic spinal chord injury in Ontario, Canada.*Spinal Cord* 48: 39-44.
[39] Canadian Institute for Health Information. (2007). The burden of neurological diseases, disorders and injuries in Canada. Ottawa: Canadian Institute for Health Information.

b. Stroke

- A stroke is a sudden loss of brain function caused by the interruption of flow of blood to the brain or the rupture of blood vessels in the brain. The effects of stroke depend on where the brain was injured and how much damage occurred. A stroke can impair movement, sight, memory, speech, reason and the ability to read and write.[40]

- The annual age- and sex-adjusted first-hospital visit rate for stroke was 1.4 per 1,000 population 2007/08 – a 7% decrease from 2003/04. Province-wide incidence of hospitalization for stroke was 1 per 1,000 population in 2007/07 – a 23% drop from 2003/04.[41]

- There was an increase in the proportion of stroke patients discharged to inpatient rehabilitation following an acute stroke hospitalization between 2003/04 and 2007/07 (from 20% to 23%), and a decrease in long-term care (from 8.5% to 7%). There was a 27% increase in the number of discharges of stroke patients to home with services (from 11% in 2003/04 to 14% in 2007/08) and a decrease in discharging to home without service (from 45% in 2003/04 to 41% in 2007/08).[42]

- The Toronto Central LHIN is third amongst all LHINs for high Functional Independence Measure (FIM) scores – a scale used to assess physical and cognitive disability in terms of the burden of care – for stroke at discharge (Average FIM at discharge in the Toronto Central LHIN = 102.2, Average FIM at discharge in Ontario = 98.3). The Toronto Central LHIN hospital Stroke discharge FIM varies from 98.6 at Providence to 106.5 at Bridgepoint.[43]

c. Alzheimer's and Dementia:

- Dementia refers to a large class of disorders characterized by the progressive deterioration of thinking ability and memory as the brain becomes damaged. Dementias can be reversible or irreversible. The latter category includes diseases like Alzheimer's disease and Vascular dementia. Alzheimer's disease is the most common form of dementia. It is a progressive, degenerative and fatal brain disease. The rate of decline in Alzheimer's disease is variable from person to person.[44]

- According to the Alzheimer Society of Canada in 2008 there were over 100,000 new cases of dementia. They predict this will increase to nearly 260,000 new cases per year by 2038.

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[40] Heart and Stroke Foundation of Ontario. (2011). What is stroke? Downloaded from: http://www.heartandstroke.com/site/c.ikIQLcMWJtE/b.3483935/k.736A/Stroke__What_is_Stroke.htm.

[41] Hall R, O'Callaghan C, Bayley M, et al. (2010). Ontario Stroke Evaluation Report 2010: Technical Report. Institute for Clinical Evaluative Sciences.

[42] Hall R, O'Callaghan C, Bayley M, et al. (2010). Ontario Stroke Evaluation Report 2010: Technical Report. Institute for Clinical Evaluative Sciences.

[43] HayGroup. (2010). CCC/rehab working group analysis. TC LHIN Value and Affordability Task Force.

[44] Alzheimer Society. Rising time: The impact of dementia on Canadian society. Downloaded from: http://www.mybrainmatters.ca/sites/default/files/Rising%20Tide_Full%20Report_Eng_FINAL_Secured%20version.pdf.

Currently, approximately 480,000 Canadians are living with dementia. It is predicted that this will increase to over 1 million by 2038. [45]

- In 2008, 55% of Canadians (over the age of 65) with dementia were living in their own homes. The Alzheimer's society predicts that the number of those living with dementia receiving community care services will increase from 33.3% in 2008 to 42.7% in 2038. [46]

- In 2005-2006, 39% of patients with Alzheimer's disease were discharged from complex continuing care to residential care, 15% were transferred to acute care hospitals, and 16% were discharged home. [47]

d. Other Neurological Disease:

- According to a Canadian Institute for Health Information (CIHI) report, neurological diseases, disorders and injuries represent one of the leading causes of disability in Canada. Very few are curable and most worsen over time. They lead to a range of functional limitations and challenges to daily living.[48]

- Six of the 11 conditions highlighted in the CIHI report accounted for 10.6% of the total disability-adjusted life years in Canada in 2000-2001. Just over 9% of acute care hospitalizations and 19% of patient days in acute care hospitals in Canada in 2004-2005 were for patients with one of the highlighted neurological conditions. 20% of patients receiving inpatient rehabilitation in 2005-2006 had a head injury, multiple sclerosis, Parkinson's disease, spinal injury or stroke. 50% of complex continuing care stays and 65.1% of complex continuing care days in Ontario in 2005-2006 were for patients with Alzheimer's disease, ALS, cerebral palsy, epilepsy, head injury, multiple sclerosis, Parkinson's disease or stroke.[49]

[45] Alzheimer Society. Rising time: The impact of dementia on Canadian society. Downloaded from: http://www.mybrainmatters.ca/sites/default/files/Rising%20Tide_Full%20Report_Eng_FINAL_Secured%20version.pdf.
[46] Alzheimer Society. Rising time: The impact of dementia on Canadian society. Downloaded from: http://www.mybrainmatters.ca/sites/default/files/Rising%20Tide_Full%20Report_Eng_FINAL_Secured%20version.pdf.
[47] Canadian Institute for Health Information. (2007). The burden of neurological diseases, disorders and injuries in Canada. Ottawa: Canadian Institute for Health Information.
[48] Canadian Institute for Health Information. (2007). The burden of neurological diseases, disorders and injuries in Canada. Ottawa: Canadian Institute for Health Information.
[49] Canadian Institute for Health Information. (2007). The burden of neurological diseases, disorders and injuries in Canada. Ottawa: Canadian Institute for Health Information.

Ministry of Health and Long-Term Care Priorities:

a. Aging at Home Strategy:

- On August 28, 2007, the government of Ontario launched a $1.1 billion (over four years) Aging at Home Strategy. The Aging at Home Strategy provides community living options for seniors. It includes a range of home care and community care support services that will enable people to continue leading healthy independent lives. The Aging at Home Strategy is now in its third fourth year (2010/11).

- Five principles guided the implementation of the Aging at Home Strategy: 1) the Strategy was to be senior-centred; 2) the Strategy was to be community-based and integrated with the broader system; 3) the Strategy was to recognize the demographic and geographical challenges that seniors face; 4) the Strategy was to clearly define and measure client and system outcomes; and 5) the Strategy was to rely on the capacity of local neighbourhoods and communities.[50]

- The Aging at Home Strategy is delivered through the LHINs and is expected to relieve pressure on hospitals and long-term care homes by moving alternative level of care patients to more appropriate settings. It is the expectation of the Ministry that funding under the Aging at Home Strategy will be allocated to initiatives that address reductions in emergency department wait times and ALC days.[51]

- Aging at Home is part of the Toronto Central LHIN's strategy to reduce emergency room wait times and ALC days. The Toronto Central LHIN invested $6.2 million in 2008/09, $15.4 million in 2009/10 and $24.2 million in 2010/11 in local agencies to delivery Aging at Home initiatives.[52]

b. Excellent Care for All (ECFA) Strategy:

i. The *Excellent Care for All Act* received Royal Assent on June 8, 2010. The Act is intended to "improve quality, value and promote evidence-based health care." The hospital sector has been charged with implementing the legislative changes, which includes:

   - Quality committees, which would report to the hospital board of directors on quality issues; annual quality improvement plans where each hospital would be required to create and publicly post a plan; executive compensation which would be required to be linked to achieving improvements set out in the annual improvement plan; patient

[50] AAH Project Management Office. (January 19, 2010). Aging at Home Strategy Evaluation RFP: LHIN-Level Evaluation Guidelines & Application. Downloaded from: http://www.ices.on.ca/file/LHIN-level%20Evaluation%20RFP.pdf.

[51] Toronto Central LHIN.(Undated). Aging at Home Year 3 Call for Proposals. Downloaded from: http://torontocentrallhin.on.ca/uploadedFiles/Public_Community/Aging_at_Home/FINAL%20Call%20for%20proposals%20FINAL%2004-NOV-09.pdf

[52] Toronto Central LHIN. (2011). Aging at Home. Downloaded from: http://torontocentrallhin.on.ca/Page.aspx?id=2838.

relations processes to address patient and caregiver relations; patient/client/caregiver surveys to assess satisfaction with services; staff surveys to assess employment experience and views about the quality of care provided; and declarations of values.

ii. Expansion of the Ontario Health Quality Council

- The ECFA Strategy is also expanding the role of the Ontario Health Quality Council. Through the *Excellent Care for All Act*, the Ontario Health Quality Council will: make recommendations to health care and other relevant organizations on standards of care in the health system; and make recommendations to the Minister of Health and Long-Term care for the funding of health care services and medical devices.[53]

- Every health care organization in Ontario will be required to provide a copy of its annual quality improvement plan to the Ontario Health Quality Council to allow for comparison and reporting on quality indicators.[54]

iii. Patient-Based Payment

- The Patient-Based Payment strategy will shift hospital funding from a purely global budget structure to one that links hospital funding with the level of services and quality of care that is being delivered.[55]

- Patient-Based Payment uses Ontario's Health-based Allocation Model (HBAM) to determine the expected costs of delivering high quality, evidence-based care. HBAM draws on clinical and demographic information collected across Ontario to model the expected demand and expenditures for health services. The model develops a cost profile for every patient based on their clinical diagnosis, type of treatment received and the characteristics of the hospital they received their care from.[56]

- The Patient-Based Payment approach provides incentives for providers that promote ALC reduction by providing incentives to reduce length-of-stay through improve efficiencies (e.g., reducing in non-acute days) and quality (e.g., reducing in complications). In addition, case-mix adjusted funding rewards admission of highly complex patients, and funding for reductions in readmission encourages appropriate discharge.

- In general, funding under ECFA will be based on patient complexity, which aligns the incentives to provide care in the right place. Incentives will help encourage hospitals to

[53]Ministry of Health and Long-Term Care. "Excellent Care for All: The Ontario Health Quality Council." Downloaded from: www.health.gov.on.ca/en/ms/ecfa/pro/ecfa_hqc.aspx
[54]Ministry of Health and Long-Term Care. "Excellent Care for All: The Ontario Health Quality Council." Downloaded from: www.health.gov.on.ca/en/ms/ecfa/pro/ecfa_hqc.aspx
[55]Ministry of Health and Long-Term Care. "Excellent Care for All: Patient-Based Payment." Downloaded from: www.health.gov.on.ca/en/ms/ecfa/pro/ecfa_pbp.aspx
[56]Ministry of Health and Long-Term Care. "Excellent Care for All: Patient-Based Payment." Downloaded from: www.health.gov.on.ca/en/ms/ecfa/pro/ecfa_pbp.aspx

discharge low complexity patients (e.g., unilateral hip and knee patients) to their homes in order to free up beds for more complex patients (hip fracture and stroke patients).

iv. Evidence-Based Care:

- This component of the ECFA Strategy "focuses on using the very best current evidence to support decision-making about the care of individual patients, and supports better use of health care resources by focusing on delivery of care that is known to be effective". Early initiatives under this component of the Strategy will focus on making changes to select OHIP codes to emphasize the implementation of evidence and to reduce expenditure on unnecessary procedures. And, it will also focus on implementing improvements that will reduce avoidable hospitalizations (e.g. discharge planning processes, virtual ward programs, etc.).

c. Mental Health and Addictions Strategy:

- The Government of Ontario is developing a 10-year strategy for mental health and addictions. The Minister of Health and Long-Term Care has established a Minister's Advisory Group of consumers, families, providers and researchers to provide advice on the development of the strategy. The two main focuses of the Strategy include: redesigning the mental health and addictions services to best meet the needs of individuals; and how to create the conditions in communities to reach optimal mental health and well-being.

- In December 2010, the members of the Minister's Advisory Group submitted their final report and recommendations for a 10-Year Mental health and Addictions Strategy for Ontario to the Minister of Health and Long-Term Care.[57] The key recommendations of the report include:

  - Making better use of existing resources by integrating services across education, justice, housing and social services;

  - Shifting towards community-based mental health and addictions supports and services; and

  - Promoting wellness and mental health supports throughout the lives of patients.

- Many of the report's recommendations focus on housing policy issues. For instance, the Advisory Group recommended that:

  - Health, housing, employment and income support policies be aligned, which included the recommendations that government:

[57] Minister's Advisory Group. (2010. Respect, Recovery Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy. Report to the Minister of Heath and Long-Term Care. Downloaded from: www.health.gov.on.ca/en/public/publications/ministry_reports/mental_health/mentalhealth_rep.pdf.

- Support programs that promote and develop affordable, accessible, safe and high quality housing, including transitional housing; develop and implement a policy to match existing health, housing and employment resources to need; and harmonize income support and housing policies and regulations so that they are client-centred, recovery-focused, and do not create disincentives to work.

- In addition, it was recommended that the needs of key populations be address by:

  - Increasing access to stable housing; and provide supportive housing opportunities for people with mental health addiction needs, focusing particularly on people with complex psychiatric needs in long stay, ALC beds, seniors who do not need the level of care provided in LTC homes but who can no longer manage in their homes with home care, and people who are homeless.

d. Ontario Wait Times Strategy / Emergency Room (ER) Wait Times Strategy

- In November 2004, the Ministry of Health and Long-Term Care announced Ontario's Wait Time Strategy, which initially focused on wait times for five priority areas: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacement and MRI and CT scans.[58] In September 2006, the Strategy was expanded to capture wait times for all adult and paediatric surgical areas by March 2008.

- In the fall of 2008 ER wait times were added with the announcement of the $109 million ER Wait Times Strategy. As part of this Strategy the LHINs were asked to target funding incentives to improve performance at Ontario hospitals.

- The Pay-for-Results program is part of the ER Wait Times Strategy and aims to help hospitals meet specific ER wait time reduction targets. In July 2010, the Ontario government claimed that in the previous two years the program helped hospitals lower overall wait times by 4.7 hours (28%) for patients who require complex care or admission to hospital and by 1.4 hours (22%) for patients with minor conditions.[59]

- Hospitals across Ontario received $100 million in funding through the Pay-for-Results program: $60 million to fund ER reduction initiatives and $40 as incentives for achieving targets. In 2010/11 the Toronto Central LHIN received $6.5 million.[60]

[58]Ministry of Health and Long-Term Care. (2010). "Ontario wait times." Downloaded from: www.health.gov.on.ca/en/public/programs/waittimes/strategy.aspx
[59]Government of Ontario. (July 29, 2010). "Pay for results program."Downloaded from: news.ontario.ca/mohltc/2010/07/pay-for-results-program.html.
[60]Government of Ontario. (July 29, 2010). "Pay for results program."Downloaded from: news.ontario.ca/mohltc/2010/07/pay-for-results-program.html.

- On July 29, 2010 the Ontario government announced the expansion of the Pay-for-Results program to 25 additional hospitals across the province, bringing the total number of participating hospitals to 71.[61]

- Addressing ALC was considered an important part of the overall strategy as ALC directly contributes to reductions in ER Wait Times.[62] As part of the ER/ALC component of the Strategy, a standard definition of ALC was developed. This definition is as follows:

  > When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).[63]

- The initial ER Wait Times Strategy included funding for "home care services and enhanced integration between hospitals and the community."[64] Funded initiatives included:

  - Increasing the upper limits on hours of personal support/homemaking services by 50%.

  - Removing home care maximums on personal support and homemaking for patients waiting for long-term-care or receiving palliative care at home.

  - Improve the use of community care case managers in hospital ERs to help patients find the appropriate level of care.

  - Reduce wait times by electronically linking hospitals to CCACs.

[61] Government of Ontario. (July 29, 2010). "Pay for results program."Downloaded from: news.ontario.ca/mohltc/2010/07/pay-for-results-program.html.

[62] Government of Ontario. (May 30, 2008). Ontario's $190 million investment to reduce wait times in the emergency room: Backgrounder. Downloaded from: www.health.gov.on.ca/english/media/news_releases/archives/nr_08/may/er_alc_strategy_combined_bg_04_20080529.pdf.

[63] Guerriero L and Nord P. (2009). "Provincial alternate level of care (ALC) definition adoption and application." Downloaded from: www.oha.com/CurrentIssues/Alternate%20Level%20of%20Care/Lynn%Guerriero%20Peter%20Nord%20Handouts.pdf

[64] Government of Ontario. (May 30, 2008). Ontario's $190 million investment to reduce wait times in the emergency room: Backgrounder. Downloaded from: www.health.gov.on.ca/english/media/news_releases/archives/nr_08/may/er_alc_strategy_combined_bg_04_20080529.pdf.

a. Assisted Living Services for High Risk Seniors, 2011

- In 2010, the Ministry of Health and Long-Term Care updated the Assisted Living Services for High Risk Seniors Policy. The key objectives of this update were to: 1) improve community alternatives to institutional care for frail and cognitively impaired seniors; 2) reduce unnecessary or avoidable emergency room visits for this population; 3) reduce the length of stay for this population after they have been designated ALC, and 4) improve the continuum of care for this population. [65]

- The policy provides provisions regarding the eligibility, care locations, design components, governance and performance management of assisted living services for high-risk seniors. These criteria were developed to "optimize" $180 million (2009/10) of provincial assisted living infrastructure.

    - In order to be eligible, "clients must be 'high risk seniors' who reside at home and require the availability of personal support and homemaking services on a 24-hour basis."

    - With only a few exceptions for some care homes, eligible clients will access assisted living services in their homes if they reside within a designated geographic service area (known as a "hub"). Clients can reside in a number of settings including: private sector or non-profit housing, housing co-operatives or traditional social housing. Under the policy, each LHIN is responsible for defining the "hubs" within their geographical jurisdiction.

- Assisted living services include: personal support services (i.e. dressing, personal hygiene, assisting with mobility, medication monitoring, etc.), homemaking (i.e. house clearning, meal preparation, etc.), security checks, and care co-ordination.

Toronto Central LHIN Priorities:

a. 2010 – 2013 Toronto Central Integration Health Service Plan

- According to the Toronto Central LHIN's 2010-2013 Integrated Health Service Plan, the LHIN's top priorities include the following:[66]

    1. **Reduce emergency room wait times and reduce alternative level of care days.** To accomplish these priorities the Toronto Central LHIN plans to: 1) Standardize referral

[65]Ministry of Health and Long-Term Care. (2010). Questions and Answers: Assisted Living Services for High Risk Seniors Policy Update. MOHLTC: Toronto.
[66]Toronto Central LHIN. (2009). Integrated health service plan 2010-2013. Downloaded from: www.torontocentrallhin.on.ca/uploadedFiles/Public_Community/IHSP-2/TC-LHIN_2010-13IHSP-2_full_report.pdf.

and intake processes to improve the flow of patients to and within community programs; 2) Enhance community based programs and services to support patients at home; 3) Improve hospital processes to increase capacity in the emergency department.

2. **Improve the prevention, management and treatment of diabetes.** To accomplish this the Toronto Central LHIN proposes to: 1) Expand outreach and screening programs starting with high-needs neighbourhoods; 2) Increase access to primary care teams starting with high-needs neighbourhoods and high-risk groups; 3) Improve the quality, consistency and comprehensiveness of diabetes services in the primary care or physician clinic setting;

3. **Improve prevention, management and treatment of mental illness and addiction.** To accomplish this the Toronto Central LHIN proposes to: 1) Develop and implement initiatives to target the needs of the most complex and vulnerable community in the Toronto Central LHIN; 2) Implement standardized assessment process in Community Mental Health programs; 3) Develop and implement standardized intake and referral process in Mental Health and Addictions programs; 4) Enhance data collection and utilization in mental health and addictions programs and services to support evidence-informed decision-making.

4. **Improve the value and affordability of health care services.** To accomplish this the Toronto Central LHIN proposes to: 1) Integrate value and affordability collaboration in the annual cycles of all health service providers; 2) Increase the proportion of supplies purchased through joint buying groups; 3) Improve data quality relating to value and affordability.

b. ALC Resource Matching and Referral

- The ALC Resource Matching and Referral (ALC RM&R) program will standardize business and clinical processes between acute and post-acute providers to increase capacity in the acute setting by discharging ALC patients more quickly and effectively. This project is focused on patient referrals from hospital to rehabilitation facility; hospital to complex continuing care facility; hospital to in-home services and hospital to LTC.

- RM&R is an electronic information and referral system that matches patient/clients to the earliest available services that best meets their individual needs. RM&R identifies people who are waiting too long or unnecessarily in a hospital bed and helps them to transition to another care setting to continue their care.[67]

[67]Toronto Central LHIN. (2011). eHealth. Downloaded from: http://www.torontocentrallhin.on.ca/Page.aspx?id=3164.

- In the Toronto Central LHIN, the RM&R program is currently supporting referrals from acute (medical/surgical units) to rehabilitation/complex continuing care; acute (medical/surgical units) and rehabilitation/complex continuing care to Toronto Central Community Care Access Centre (in-home services); acute to LTC (via the Toronto Central Community Care Access Centre).[68]

- The Toronto Central LHIN is currently exploring opportunities to expand the RM&R program to other sectors. Work began in 2010 to roll the program out to the Community Support Services and Community Mental Health and Addictions sectors.[69] The first phase of this work began with the implementation of RM&R software in agencies who are part of the Community Navigation and Access Project network, which is comprised of 34 community support service agencies.[70]

- The project attempts to help reduce ER wait times, improve access to ALC, improve referral efficiency, improve patient care and increase satisfaction.

- In 2009, a Provincial Reference Model for ALC RM&R was developed. This set guidelines that will assist LHINs and health services providers with implementing RM&R and is intended to promote standardization processes and practices for referral across the health care system. It is also the basis for funding future LHIN-based ALC RM&R initiatives.

c. Community Navigation and Access Program (CNAP)

- The CNAP is supported by the Toronto Central LHIN through the Aging at Home Strategy. The CNAP involves 34 community support services agencies in the Toronto area that collaborate to improve access and coordination of community support services for seniors. The CNAP network of service providers aims to ensure seniors reach appropriate care settings.

- In collaboration, the 34 community support services agencies have developed 29 community service definitions (e.g., caregiver support, foot care, supportive housing, etc.) and updates the Toronto Central CCAC's Community Care Resource database to include these definitions, as well as mapping of these community support services in the region. The project partners also developed and implemented a standardized intake and assessment form to ensure data collection is consistent across all participating agencies, and to improve referrals between agencies.

- The CNAP includes a toll-free phone number that provides a single access point for anyone unsure of where to receive community support services (e.g., adult day programs).

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[68]Toronto Central LHIN. (2011). Toronto Central LHIN Resource Matching and Referral Program. Downloaded from: http://www.torontocentrallhin.on.ca/Page.aspx?id=3178.
[69]Toronto Central LHIN. (2011). Toronto Central LHIN Resource Matching and Referral Program. Downloaded from: http://www.torontocentrallhin.on.ca/Page.aspx?id=3178.
[70]Toronto Central LHIN. (September 2010). eHealth Bulletin. Downloaded from: www.torontocentrallhin.on.ca/uploadedfiles/eHealth/TC%20LHIN%20eHealth%20Bulletin%20September%202010%20FINAL.pdf

d. Home At Last Program

- The Home At Last Program is funded by the Toronto Central LHIN through the Aging at Home Strategy. The program is led by St. Christopher House in partnership with the Toronto Community Care Access Centre, several community support service agencies and several Toronto hospitals (both acute and sub-acute hospitals). The program aims to assist seniors in transitioning from hospital to home safely and comfortably. Patients who are 55 years of age or older, are without support from a caregiver (family or friend) at discharge, and are unable to direct their own care are eligible for the program.

- The program partners include:

    - *Community Support Service Agencies:* St. Christopher House, Community Care East York, Mid Toronto Community Services, Neighbourhood Link Support Services, SPRINT, St. Clair West Services, WoodGreen Community Services and Les Centres d'Accueil Heritage.

    - *Acute Hospitals:* Mount Sinai Hospital, Princess Margaret Hospital, St. Joseph's Health Centre, St. Michael's Hospital, Sunnybrook General Hospital, Toronto General Hospital, and Toronto Western Hospital.

    - *Sub Acute Hospitals:* Bickle Centre, TRI: Hillcrest Centre, TRI: University Site, TRI; Baycrest, Bridgepoint Healthcare, Providence Healthcare, Toronto Grace Centre and Westpark Healthcare Centre.