Caring For Our Aging Population and Addressing Alternate Level of Care

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

Dr. David Walker, Provincial ALC Lead
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Acknowledgements

I am pleased to be submitting my report to the Minister of Health and Long-Term Care regarding Alternate Level of Care (ALC) in Ontario. Upon taking this assignment, I quickly came to realize that the challenge is not limited to those who are occupying acute care beds when their needs could be better served in other care settings, but that our health care system needs to undergo a broader transformation in order to meet the care needs of an aging population; the title and content of this report is reflective of this. For system change to occur, many of the institutional and organizational components of our current system will need to re-orient themselves to a priority of caring for seniors in ways not accomplished to date. Without such change, we will experience a wave of frail older Ontarians receiving poor care in the wrong environment amongst those ill equipped to provide it, with resultant disruption of the engines of health care designed for other purposes.

The Ministry of Health and Long-Term Care has made strides in implementing programs and policies to address the ALC challenge and support seniors to live in their homes (for example, the province-wide rollout of "Home First"). The focus on the primacy of home and supports in the community should continue, but there is a timely opportunity to move forward with a more comprehensive system transformation. My recommendations are but the first step – from here, it is up to the ministry and more specifically, the individual and team who are accountable to address these issues, to develop an implementation plan for this system redesign. It is also essential that in the next two years, an evaluation be undertaken of the actions proposed in this report. The ministry team will not be starting from nothing. From my travels visiting many LHINs, my discussions with stakeholders, and my research, I know there are many best practices in existence that can be adopted and adapted across the province.

I could not have researched, contemplated, developed, or confirmed these recommendations without a great deal of support from those both within and outside of the ministry to whom I'd like to thank for their guidance and expertise during my appointment.

The ALC Action Team Steering Committee has been invaluable in bringing senior-level leadership and experience to this file. Thank you to Dr. Kevin Smith, Camille Orridge, Donna Cripps, Mark Rochon, Dr. Ben Chan, Sandra Coleman, and Andrée Robichaud.

To the ALC Action Team, I would like to thank you for taking a break from your full-time positions to travel across the province with me on many LHIN site visits, to meet with local providers, assess local challenges and share best practices. I encourage this cross-pollination to continue and hope that your learnings from these visits have also been beneficial. Thank you to Dr. Barry Nathanson, Dr. Gilles Lanteigne, Laurie Fox, Dale Clement, Dr. Samir Sinha, Marianne Walker, Maureen Shantz, and Sally Davis.

A sincere and well deserved thank you to the management, staff and health service providers of the South East, Toronto Central, Central East, Hamilton Niagara Haldimand Brant, Champlain, Erie St. Clair and North East LHINs for organizing and leading my site visits. I know that each took a great deal of planning, and I appreciate your sharing of local system expertise. Our discussions informed many of the recommendations in this report and I'd encourage you to reach out to your counterparts to continue these discussions.

Lastly, thank you to the Deputy Minister of Health and Long-Term Care and ministry staff for their support throughout this appointment. More specifically, to Alex Bezzina, Melissa Farrell, Ann Schrager, Soma Mondal, Iphigenia Mikroyiannakis, Gazelle D'Souza, Jamie Watts, and Lorraine De Braganca, for their daily dedication to the completion of this report. And lastly, to Lauren Ettin for bringing the many pieces of this report together, and for ensuring that all my ideas have been reflected.

Dr. David Walker

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Preface and Executive Summary

Our society now confronts a growing phenomenon – that of a burgeoning aging population of individuals living with frailty, and/or multiple co-morbidities, all of which may be confounded by the challenges of dementia. As this changing demographic becomes the reality, and the health care system's ability to manage the diseases of aging improves, there is a pressing and urgent necessity to address the needs of this population in new ways.

Current models of care still rely too heavily on acute care hospital resources and a culture that emphasizes "permanent" placement of seniors in Long-Term Care Homes (LTCHs), without appropriate consideration of the patient's potential to improve or recover and be cared for at home with support. An outcome of this delivery system is that far too often the hospital Emergency Department (ED) becomes the default, which leads to acute care hospital admission. From there, in the absence of alternatives, too many seniors remain in the hospital while waiting to be transferred to an alternate level of care (ALC). Some wait excessively long periods of time, which is detrimental to their overall health and well-being. The acute care hospital is not designed to meet a patient's restorative, supportive or rehabilitative needs, but has conversely been shown to advance functional deterioration and place patients at significant risk of hospital-related infections, falls and other adverse events. The end result of this patient journey is often permanent placement in a Long-Term Care Home (LTCH) – an outcome that could often have been avoided.

This pattern of care for a large cohort of the population is inadequate and inappropriate, and its effect on the capacity of the acute care system is significant. When such capacity is occupied by patients who no longer require the services of the acute care sector, substantial resources are misdirected and misapplied. Hospital units are crowded, patients requiring admission languish in EDs, surgeries are cancelled, and patient, family and staff morale is reduced.

The government, working in collaboration with the Local Health Integration Networks (LHINs), has attempted to tackle this problem through community investments such as Aging at Home and the commitment to reducing ED backlogs. Although pockets of success and improvement exist, these strategies alone will not meet the ever-growing demand nor solve this problem. A fundamental system redesign is required – from changing the design of LTCH programs to shifting more resources in the community, to holding primary care physicians accountable – to ensure the frail elderly are proactively identified and their needs addressed.

An opportunity, and in fact, a duty, exists to transform our health care system to meet the needs of this increasingly aged population who will live longer, in states of both health and illness. Seniors want to live in their homes for as long as possible and receive dependable and reliable community supports to meet their social, physical, emotional, nutritional, health professional and caregiver needs. To meet these needs, the system must shift to address six transformational pillars of care by realigning, refocusing and targeting investments which will ultimately improve access to the right care through community investments, improve patient flow across the system and optimize and differentiate capacity.

Improve Access to the Right Care Through Community Investments

Primary Care:

Primary care providers must make care for the elderly a priority, including the early identification of seniors at risk of frailty and proactive management of their multiple challenges.

The Community Care Continuum:

The continuum of community care must be supported through additional and sustained resources to integrate, coordinate and enhance Community Care Access Centres (CCACs), Community Support Service (CSS) agencies and assisted living arrangements while bridging gaps through new models of care that serve populations whose care needs exceed what is currently available.

Cross-System Responsiveness to Special Needs Populations:

Seniors and younger populations with special needs, particularly behavioural challenges, must be provided with knowledgeable, integrated care across the continuum, wherever they seek treatment, with equitable and timely transition to the right provider for the right service.

Improve Patient Flow Across the System

"Assess and Restore":

An "Assess and Restore" philosophy and function must be central to health care delivery. Programs aimed at restoring and reactivating an elderly patient's level of functioning, and creating opportunities for them to be transferred home with appropriate ongoing supports must be enhanced. For example, many frail seniors arriving at the ED could and should be directly transferred to "Assess and Restore" programs delivered either in Complex Continuing Care (CCC) or Rehabilitation (Rehab) hospitals or in short-term/transitional programs in LTCH. Similarly, patients designated as ALC in acute care hospitals should have an opportunity to receive immediate "Assess and Restore" services in CCC/Rehab or LTC settings, rather than waiting in hospital at risk of deterioration.

The Role of Acute Care Hospitals in Seniors' Care:

Considering that many frail elderly patients enter the acute care system through the ED, hospitals have an integral role to play in their care and thus must embrace "Senior Friendly" Care principles. Furthermore, given the burden of ALC on capacity, hospitals must become more effective in optimizing this capacity, while applying best practices as related to discharge planning.

Optimize and Differentiate Capacity
Specialized and Differentiated Long-Term Care Capacity:

LTCHs should focus a portion of their capacity on cyclical, restorative, transitional and respite care programs, while maintaining permanent placement for those with more complex needs. LTCHs should create the right care environment for seniors who have special needs that cannot be met elsewhere, particularly patients with challenging behaviours who often remain in acute care hospitals for excessively long times.

System Enablers

In order to support effective and sustained implementation of the six transformational pillars, key system enablers are essential. Of the utmost importance is strengthened governance and accountability. The ministry needs to identify goals, while LHINs must ensure accountability for meeting identified targets and objectives, aligning incentives with desired outcomes. In addition, a comprehensive needs-based service planning and forecasting model is necessary to inform decision making on the type and number of beds and services to be funded in each community, optimizing current and future investments.

Improve Access to the Right Care Through Community Investments	Improve Patient Flow Across the System	Optimize and Differentiate Capacity
Primary Care • Early identification and management of high-risk frail seniors • Integration of primary care sector • LHIN Primary Care Lead **Community Care Continuum** • Enhancement and alignment of CCACs and CSS • Group home models of care • "Virtual Wards" **Special Needs Populations** • Specialized units in community and LTC	**Acute Care Hospitals** • "Senior Friendly" principles • Capital modifications • Bed utilization management • Integrated discharge planning • Role of small, rural hospitals **"Assess and Restore"** • "Assess and Restore" in CCC/Rehab and LTCH • Best practice rehab care pathways • Community rehab services	**LTC Capacity** • Transitional, cyclical capacity • Enhanced capacity for high needs patients and complex care • Supply of basic and preferred beds • Geographic location of LTCH • Surge capacity
System Enablers: Governance and Accountability, HHR, IT, Health Professional and Public Education and Awareness, Process and Patient Flow Efficiency		

The Challenge

Alternate Level of Care in Ontario

Ontario has the highest Alternate Level of Care (ALC) rates in Canada, and data indicates that this has remained relatively unchanged between 2008 and the third quarter of 2010/2011.[1,2] ALC patients – those who have care needs that could be better addressed in other settings – are staying in acute care hospitals for prolonged and often excessive periods of time; the largest proportion of ALC days is for those waiting for Long-Term Care Homes (LTCHs) placement.[3] This is partially a result of the traditional culture in hospitals where patients wait because LTCHs have been considered to be the most appropriate destination for ALC patients.

Studies have shown that:

- 37 per cent of ALC patients waiting for LTCH placement have care needs no more urgent or complex than those of people being cared for at home.[4]
- ALC patients waiting in hospitals to be discharged to LTCH have the longest waits compared to other destinations.[5]
- To place all seniors on current LTCH waitlists in LTCH beds (i.e., all current demand for LTCH is met) would require over 130,000 beds by 2021 (assuming the same level of demand continues in future) or an approximate 75 per cent increase in bed capacity; it would also require additional investments in community services.[6]
- A significant investment in approximately 15,000 new LTCH beds between 2002 and 2004 did not have a sustained impact on ALC rates.[7]

Most ALC patients are over the age of 75, in a demographic that is estimated will grow by 32 per cent over the next 10 years.[8] This growth could place unsustainable demands on current program models which result in prolonged hospital stays while patients wait for LTCH placement. There is significant potential to divert demand from LTCHs to other care settings which would be more aligned with patient preference and potentially be more cost effective. Furthermore, seniors have indicated that they would prefer to remain in their own homes or in the community for as long as possible, rather than receiving premature or unnecessary institutional care.[9]

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[1] Canadian Institute for Health Information, January 14, 2009. Alternate level of care in Canada. Analysis in brief.
[2] Discharge Abstract Database, FY 2008/09-FY 2010/11 (interim), MOHLTC, Intellihealth Ontario.
[3] Discharge Abstract Database, FY 2008/09-FY 2010/11 (interim), MOHLTC, Intellihealth Ontario.
[4] The Change Foundation, February, 2011. Because this is the rainy day: a discussion paper on home care and informal caregiving for seniors with chronic health conditions.
[5] Cancer Care Ontario Interim Upload Tool Monthly Data, 2010/2011.
[6] Health Analytics Branch Analysis. MOHLTC. January, 2011.
[7] Health Capital Investment Branch Analysis, MOHLTC, June 2011.
[8] Population Projections LHIN [Ministry of Finance], 2010-2036, MOHTLC, Intellihealth Ontario.
[9] Ontario Seniors' Secretariat.

Concurrently, acute and post-acute care hospital systems are challenged by ALC patients whose clinical needs cannot be suitably met in the community and LTCH settings.[10] These ALC sub-populations are those with heavy care needs, dementia and responsive behaviours, ventilator-dependency and dialysis requirements, who often remain in hospital for excessively long periods of time – sometimes years – as no other care setting is available.

More specifically, in July 2010, there were 4,546 ALC patients in acute and post-acute care hospitals (and this number remained relatively unchanged every month throughout 2010 and the first quarter of 2011) while 47 per cent waited more than 40 days for alternate levels of care.[11] Of these long-stay patients, 943 were in acute care hospitals, and of this, 95 patients had been there for more than 318 days. 1,187 were in post-acute care hospitals with 120 of them in hospital for more than 550 days.[12]

As beds are occupied by ALC patients, acute care hospitals are losing much needed capacity for acutely ill patients, particularly those admitted through the ED. In 2009/10, an average of 1,060 patients admitted through the ED each day experienced delays in being transferred to an in-patient unit due to bed unavailability.[13] In addition, patient flow from acute care in-patient units to post-acute care hospitals is significantly delayed when post-acute care hospital beds are occupied by ALC patients.

The above data and other similar analyses indicate that existing system capacity and program models are not optimally configured to address current or future ALC population needs, particularly for complex elderly patients who make up much of the ALC population. Please refer to Appendix A for more information regarding ALC in Ontario.

As such, a Provincial ALC Lead was appointed to provide advice and recommendations to the Minister of Health and Long-Term Care based on experiences in other jurisdictions, previous reports submitted to the ministry outlining strategies to address ALC, LHIN initiatives and successes to date, and lessons learned by health system leaders.

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[10] Cancer Care Ontario, July 2010. Provincial ALC Long Wait Cases Project.
[11] Ibid.
[12] Ibid.
[13] Institute for Clinical Evaluative Sciences, September 2010. Rapid Response Regarding ED Bed Delays.

Approach

Provincial ALC Lead

The Minister of Health and Long-Term Care appointed Dr. David Walker as Provincial ALC Lead in January 2011, with a mandate to provide recommendations on actionable strategies to address systemic problems that cause or contribute to Ontario's ALC challenge. Dr. Walker is immediate past Dean of the Faculty of Health Sciences (Schools of Medicine, Nursing and Rehabilitation) at Queen's University, was Chair of the provincial Expert Panel on SARS and Infectious Disease Control and recent and inaugural Board Chair of the Ontario Agency for Health Protection and Promotion. He is a Professor of Emergency Medicine, Family Medicine and Policy Studies at Queen's University and a member of the Attending Staff at Kingston General and Hotel Dieu Hospitals in Kingston. Upon Dr. Walker's appointment, he recommended three immediate, short-term, high impact strategies. Please refer to Appendix B for more information regarding these strategies.

Information Gathering

Dr. Walker reviewed many inputs in his initial information and gathering, including data, reports and jurisdictional analyses. The review included data from the Ministry of Health and Long-Term Care (MOHLTC), Cancer Care Ontario, and the Ontario Hospital Association. Some relevant reports used as a foundation include Provincial ALC Long Wait Cases Project, the Two-Day ALC Designation Report, the ER/ALC Action Plan, and the Appropriate Level of Care Execution Plan to Reduce Emergency Room Wait Times.

Stakeholder Consultations

To inform his work, Dr. Walker selected a group of key stakeholders to act as the ALC Steering Committee. The members included Senior Management representatives from the MOHLTC, LHINs, acute and post-acute care hospitals, and Health Quality Ontario. The Steering Committee played a pivotal role in guiding the work of the Action Team and providing ongoing input regarding recommendations.

In addition, Dr. Walker met and forged relationships with a range of stakeholders, including the Ontario Hospital Association, Health Quality Ontario, the ER/ALC Expert Panel, LHIN Chief Executive Officers, the Ontario Association of Community Care Access Centres, and the Ontario Seniors' Secretariat. Dr. Walker also played a leadership role in a roundtable discussion with health care providers from across sectors, focusing on challenges and solutions to address the needs of ALC special needs populations.

Site Visits

Dr. Walker and the Action Team visited seven LHINs – those who had achieved some success with best practices to share, and those who were experiencing challenges in addressing ALC. The visits were held for one to two days, and included meetings with LHIN Board Chairs and CEOs, LHIN Emergency Room/ALC Advisory Committees, and key organizational leaders from hospitals, CCACs, and LTCHs. Dr. Walker and the Action Team assessed challenges on the ground, provided the LHINs and service providers with customized solutions to address local issues, and prepared an Action Plan for implementation within three to six months. Please refer to Appendix C for a site visit summary, and Appendix D for more information regarding LHIN Best Practices.

The criteria for selecting sites to be visited included both quantitative and qualitative information such as:

• ER wait times for admitted patients
• ALC days and length-of-stay of ALC patients in hospitals from designation to discharge
• Challenges with Long-Stay patients waiting in hospitals for LTC placement
• Challenges with increasing numbers of newly designated ALC patients
• Challenges with discharging ALC patients within 30 days or quicker
• Successful initiatives to reduce ALC that could be adopted by other LHINs

LHIN site visits include South East (March 18), Toronto Central (April 27), Central East (May 4-5), Hamilton Niagara Haldimand Brant (May 11), Champlain (May 16-17), Erie St. Clair (June 16) and North East (June 21).

The knowledge garnered through research, data and analysis, stakeholder consultations, the Action Team and Steering Committee, and LHIN site visits informed Dr. Walker's recommendations as outlined below.

Recommendations

Primary Care

The primary care system must improve its early intervention capability and case management to identify patients in the community at risk of frailty and deterioration. By doing so, the likelihood of a crisis situation that may require an ED visit and/or subsequent hospital admission may be significantly reduced. Proactive care and service plans could then be implemented that would ensure effective management of seniors' multiple challenges while living in the community. Currently, screening processes and programs that facilitate early risk identification are not well developed or sufficiently pervasive across the province.

Furthermore, advancing comprehensive assessments of seniors' care needs while in the community will require refocused and targeted investments to ensure assessment clinics and services are available and oriented towards geriatric, memory or dementia issues, and chronic disease. Experience from the field supports that clinics such as these prevent unnecessary hospitalizations.

Furthermore, the primary care system needs to ensure that access to primary care is made a priority for seniors living at home or housebound. One approach to achieve this is to support primary care physicians and other care professionals to visit frail seniors in their homes. Such a program is being implemented in the Toronto Central LHIN where an inter-professional team serves seniors for whom house calls are a necessity and not a convenience. Without this service these patients often go without primary care and access help via 911 or the ED.

Primary Care Reform has brought much needed multi-disciplinary effectiveness to primary care and resulted in improvements in access. Family Health Teams (FHTs), Nurse Practitioner Clinics, and Community Health Centres (CHCs) are models that lend themselves well to the comprehensive care of an aging population.

FHTs and CHCs are expected to collaborate with local health care partners, including hospitals, public health, community service agencies, CCACs and others to improve patient care and coordination. FHTs and CHCs will be held accountable for the delivery of these programs and must report regularly on progress and status.

Recommendations:

R1. The Ministry of Health and Long-Term Care and the Ontario Medical Association jointly create performance targets and other mechanisms that incent behaviours to emphasize primary prevention through community-based screening programs.

R2. Local Health Integration Networks and Community Care Access Centres jointly establish accountability agreements that establish CCACs' role and responsibility in service delivery through community-based screening programs.

R3. The Ministry of Health and Long-Term Care monitor seniors' access to primary care across community, Long-Term Care and other settings, and modify accountability, performance targets and other mechanisms to drive improvements where required.

R4. The Ministry of Health and Long-Term Care, in consultation with stakeholders, develop a Geriatric Assessment Clinic model that works with and supports family physicians, and takes into consideration the existing primary care models.

The inclusion of the primary care sector in local service planning is integral in ensuring the effective and pervasive integration of primary care in all community-based programs, including assisted living/ supportive housing, group homes, retirement homes, and LTCHs. As such, Primary Care Leads should be appointed as part of the LHIN senior administrative structure, as is modeled in the Hamilton Niagara Haldimand Brant LHIN.

Recommendation:

R5. Local Health Integration Networks appoint Primary Care Leads as part of their senior administrative structure.

The Community Care Continuum

To support the principle of caring for seniors and others with complex needs in their homes, investments must be realigned and refocused to build and sustain the capabilities of community-based providers and programs.

Enhanced and sustained investments in Community Care Access Centres (CCACs) and Community Support Services (CSS) are essential in supporting seniors in the community. Over the past two years, LHINs and CCACs have been working closely to embrace the "Home First" philosophy which aims to support patients in their homes, or to return home from hospital while awaiting their choice of LTCH. This program requires a greater intensity of community resources since the target patient population often exhibits more complex conditions and requires more specialized care.

As CCACs become increasingly responsible for the support of these sicker, frailer individuals, incentives and resources should be aligned and re-configured to allow CSS agencies to strengthen their role in the continuum of care and relieve some of the resource pressures on CCACs.

In addition, there is a need to introduce new models of care to address the needs of patients whose care needs exceed the current service maximums (i.e., CCAC and assisted living/supportive housing service maximums for personal support and homemaking services), but who do not require around-the-clock nursing services. For instance, a group home model is well positioned to bridge this gap in the continuum of care. Effective management of such new models will reduce the burden on LTCHs and liberate capacity for patients who need it most.

The Aging at Home Strategy and other targeted ministry investments have played a pivotal role in providing LHINs with funds to enhance their community-based programs and services. With these resources, LHINs have created or expanded "Home First" programming, assisted living/supportive housing capacity, homemaking services, caregiver support and respite programs, palliative care programs, day programs for seniors with dementia and other behavioural issues, outreach teams, and other similar services. These programs should continue to be supported and enhanced.

Recommendations:

R6. Local Health Integration Networks realign, refocus and enhance investments in:

    a. the Community Support Services sector to support seniors and caregivers in the community, to relieve the resource pressures on Community Care Access Centres. Such investments would focus on homemaking services, caregiver support and respite services, and adult day programs for frail seniors and those with cognitive impairments.

    b. Community Care Access Centres to further implement the "Home First" philosophy and resulting programs in a standardized, intensified, and prioritized manner.

R7. Local Health Integration Networks invest in new models of care that provide opportunities for high-risk seniors or seniors with complex needs to be cared for in group home models.

Community-based care should be an option for patients who require higher intensity care for a short period of time after a hospital discharge. A pilot study is underway in the Toronto Central LHIN that aims to create a "Virtual Ward" by bringing the hospital in-patient experience into the patient's home for those with complex clinical needs that have been assessed as high risk for acute care re-admission. A multi-disciplinary team consisting of a family physician, CCAC staff, specialists, and social support services combines the best aspects of hospital, primary and home care to deliver integrated care after hospital discharge. The pilot is being evaluated over two years with early evidence indicating that this model is appropriate to stabilize high-risk patients outside of acute care settings.

Recommendation:

R8. The Ministry of Health and Long-Term Care along with Local Health Integration Networks support through funding and/or policy changes the implementation of additional "Virtual Ward" models, where appropriate, advancing community discharge with professional and specialty supervision during the patient's recovery.

Cross-System Responsiveness to Special Needs Populations

Experience indicates that hospitalized seniors and other patients who exhibit challenging behaviours (e.g., due to mental health problems, addictions, dementia, or other neurological conditions), and those who require high intensity care (e.g., dialysis and ventilation assistance patients) remain in hospital for excessively long periods of time. These patients have long hospital stays waiting for placement because the post-acute care sector does not have sufficient programs to meet their needs. As a consequence, this cohort of patients has a very significant impact which resonates throughout the acute care system – for example, one person in the wrong bed for 300 days is equivalent to 30 patients in the wrong bed for 10 days, which prevents 100 patients from receiving a service that has an average length of stay of 3 days.

A considerable shift will have to occur in the LTC sector to be able to better provide support to this higher needs population. Such patients require units that can address significant behavioural issues, dialysis, bariatric, palliation, multiple medical conditions, and in small numbers, ventilation assistance.

Plans and resources to ensure that LTCHs become more specialized and differentiated in order to meet client needs must be undertaken. At the same time, comprehensive knowledge transfer – among LTCHs, across disciplines, and among sectors of the health system – is necessary to share knowledge regarding care pathways and clinical best practices for these populations. The goal is knowledgeable, integrated care wherever these patients seek treatment, with equitable and timely transitions to the right provider for the right service.

Recommendations:

R9. The Ministry of Health and Long-Term Care support creation of special units/programs in the community and Long-Term Care Homes for seniors with special needs. Targeted investments should focus on adding new human resources specialized in responsive and challenging behaviours in Long-Term Care Homes, developing and deploying Mobile Behaviour Teams, and expanding services in the community.

R10. Local Health Integration Networks support ongoing intensive assessment of long-stay ALC patients and investments to create the required resources and opportunities to place these patients in the right care settings.

The Role of Acute Care Hospitals in Seniors' Care

The principles of a "Senior Friendly" system are widely accepted. However, acute care hospitals are particularly challenged in adapting to this reality. It will be critical in the years ahead to consider the needs of this burgeoning population, from convenience of parking, through navigating the physical and care pathways inherent to complex organizations, to active prevention of de-conditioning.

Recommendations:

R11. Local Health Integration Networks embed "Senior Friendly" Hospital principles through accountability agreements with hospitals, which should be considered as an accreditation standard.

R12. The Ministry of Health and Long-Term Care ensure that capital processes are established to facilitate the implementation of "Senior Friendly" Hospital principles.

Given the constraints the ALC burden places on acute care capacity, acute care hospitals need to become far more effective in managing and optimizing the utilization of their existing capacity. There are known best practices, methods and tools hospitals could apply to manage admission, discharges and bed utilization. While hospital admissions can be modified to be more appropriate, they are otherwise inevitable and, in timing, immutable. In contrast, hospital discharges are more predictable and can be optimally managed. Using predictive models of estimated day and time of discharge, timed decision making, and removal of delaying obstacles, many institutions have achieved significant improvements in lengths of stay and thus released ineffectively used capacity.

Recommendation:

R13. Hospitals adopt best practices in bed utilization management to achieve improvements in lengths of stay and utilization of capacity.

Acute care hospitals also need to employ best practices relating to discharge planning and decision making regarding the patient's discharge destination. Experience indicates that in those hospitals that involve CCAC case managers in discharge planning as early as a patient arrives in the ED, patients are discharged in a timely manner and discharge destinations are effectively identified. Whereas physicians possess the skill sets to address the acute care needs of their patients and determine when that process is complete, CCAC case managers possess the skill sets to determine the appropriate discharge destination. By identifying an appropriate discharge destination, discharge pathways for seniors focused on Admit → ALC → LTCH placement will no longer be an available or predominant care pathway.

Recommendation:

R14. Hospitals shift the role and responsibility for discharge planning for this population to Community Care Access Centres to ensure identification of appropriate discharge destinations (interim and permanent) using system level, consistent admission criteria, facilitated by automated systems such as Resource Matching and Referral.

In many small, rural hospitals (often located in the north), very significant bed capacity is occupied by those patients who have been identified as ALC, sometimes in excess of 50 per cent of capacity. Many such hospitals have adapted their resources to meet the needs of the population with rehabilitation, behavioural, palliative and sometimes restorative capacity available in the hospital.

Upon examination, it is clear that for many of these patients, there is no alternate care setting available locally that could more appropriately meet the patients' needs.

It is also the case that if all ALC patients were to be successfully moved to another facility, the fiscal sustainability of the hospital would be severely challenged.

Recommendation:

R15. The Ministry of Health and Long-Term Care develop and apply criteria to determine small, rural hospitals that appropriately meet the needs of their ALC patients so that these patients are no longer considered ALC. Such hospitals should be considered critical in the care of the frail elderly, and should be supported in the continuation of this role through policy and funding changes as required.

"Assess and Restore"

Older patients often encounter a single destabilizing event complicating multiple other health challenges. Such an event, whether it be a fracture from a fall, a small stroke, or even caregiver exhaustion, often results in an ambulance ride to the ED and hospital admission. While seniors wait in an acute care bed for an appropriate placement de-conditioning occurs, sometimes to an irreversible degree, where they then require permanent support. Adding to the situation are the patient's unfamiliarity with the hospital environment, and the urgency of the decision-making process, which then leads to a premature determination that permanent placement in a LTCH is the only possible option.

LHINs and other jurisdictions have found that providing a period of assessment and restoration/ rehabilitation, preferably in a post-acute care environment, allows for a far more appropriate determination of the patient's needs and progress towards recovery. Many patients then improve sufficiently to return and remain home.

This "Assess and Restore" philosophy and function should be considered central to the care delivery for seniors, regardless of their point of entry into the health care system. Many frail patients arriving at the ED could, after immediate assessment, be transferred directly to such "Assess and Restore" programs, either through in-patient or out-patient services. As well, patients designated as ALC should first have an opportunity to receive timely "Assess and Restore" services, rather than wait in hospital for an alternate level of care and risk deterioration.

Ontario lacks a coherent approach to this "Assess and Restore" philosophy and programming. Many seniors with the same need profile are treated in different programs and settings that may or may not have the "Assess and Restore" approach central to their mandate. There is also a lack of clear program standards and admission criteria for post-acute care programs (such as convalescent beds, transitional beds, interim beds, etc.). Opportunities should be provided in CCC/Rehab hospitals and LTCHs for "Assess and Restore" programming. Lastly, LHINs and CCACs should continue to work towards ensuring that CCACs are the single point of access for transitioning patients to the appropriate care settings including, "Assess and Restore" programs.

Many LHINs have used Aging at Home and other ministry funds to develop "Assess and Restore" programs locally. Qualitative evaluations underscore that such programs are effective and the LHINs advice has been that such programs should be enhanced and expanded. Furthermore, the LHINs, along with ministry partners, have established a Complex Continuing Care/Rehabilitation Expert Panel that includes organizational leaders from the CCC and Rehab sectors. The Panel has developed several recommendations that support the "Assess and Restore" principle, and their work will inform program details and implementation approaches.

Recommendations:

R16. The Ministry of Health and Long-Term Care and Local Health Integration Networks should realign investments, reconfigure current models, and target investments to:

    a. create opportunities for "Assess and Restore" in Complex Continuing Care/Rehabilitation sectors, recognizing that such services are oriented to more complex patients, or in the absence of CCC/Rehab, in specialized Long-Term Care facilities with the appropriate resources.

    b. ensure that CCC/Rehab Hospitals make "Assess and Restore" philosophy central to their mission through applicable accountability agreements and performance targets.

    c. standardize admission criteria and assessment tools for rehabilitation beds and CCC programs and develop processes to ensure that these destinations are considered for all appropriate patients.

Many seniors are placed on a waiting list for LTCH placement either from a home environment, or after an acute care hospital admission where they remain as ALC while waiting for their first choice of LTCH. Hospital settings, particularly the acute care hospitals, are not designed to appropriately meet the needs of such ALC patients and inadvertently contribute to their physical and mental deterioration. Best medical practices identify that seniors need to be provided with timely opportunities to be restored to previous levels of mental and physical function. Experience in the field has demonstrated that restorative programs have enabled seniors to return home with supports, or to enter assisted living arrangements or other community-based programs, rather than pursue permanent placement in LTCHs.

Recommendation:

R17. Local Health Integration Networks and Community Care Access Centres ensure through their respective roles that seniors are provided with timely "Assess and Restore"/Transitional Care in Long-Term Care Homes while waiting for their first Long-Term Care Home choice, in order for patients to have an opportunity to regain previous levels of function and to prevent deterioration.

The ministry currently funds physiotherapy in LTCHs, patient homes and in much smaller volume, community clinics, with expenditures growing in the double digits annually.[14]

In all settings, but particularly in LTCHs and in other group patient homes, the ministry has lost the leverage to direct providers to provide services to those Ontarians that need them most. The current program structure of Ontario Health Insurance Plan (OHIP) funded physiotherapy may be such that resources are not being most appropriately directed to rehabilitative services in the community, such as those who have suffered a stroke, or are recovering from surgery for a fracture or joint replacement. The way the ministry funds and delivers physiotherapy must fundamentally change to ensure effective and appropriate care is provided and that providers are held accountable.

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[14] Ministry of Health and Long-Term Care. OHIP Utilization Reports. 2006/07-2011/12.

In addition, evidence indicates that a significant portion of post-operative hip and knee replacement patients admitted to post-acute care beds for rehabilitation can have their rehabilitation needs met in the community as part of an out-patient rehabilitation framework without adversely affecting clinical outcomes[15] Reducing system reliance on in-patient rehabilitation and optimizing opportunities for rehabilitation in community settings will help to realign capacity to patient needs.

Recommendations:

R18. Local Health Integration Networks support through various mechanisms, including accountability agreements, the systemic adoption of best practices in the utilization of in- and out-patient rehabilitation.

R19. Hospitals adopt best practice rehabilitation care pathways, primarily for patients who are recovering from hip and knee joint replacement, hip fractures or stroke.

R20. The Ministry of Health and Long-Term Care review OHIP funded community rehabilitation services (particularly Designated Physiotherapy Clinics) to ensure that these investments are aligned with the higher care needs of the elderly, particularly stroke and fracture patients.

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[15] Orthopaedic Expert Panel Recommendations, January 2011. Performance Measurement for primary hip and knee replacement.

Specialized and Differentiated Long-Term Care Capacity

As previously mentioned, LTCHs are a final destination for many seniors.[16] The Long-Term Care (LTC) sector emphasizes permanent placement in LTCHs, and provides programs and capacity aligned with this purpose. While permanent placement may be appropriate for some, for many others the ability to transition through LTC to access a temporary restorative program (e.g., convalescent care), and then move home or to other community settings may be a more appropriate option. If a portion of LTC capacity were allotted to this transitional purpose, with an accompanying change in the physical design of LTCHs, far more individuals could access short-term, convalescent care. For those with highly complex needs, LTCH resource capacity would still be available on a permanent basis.

The challenges of appropriately supporting an aging population neither can, nor should be, solely reliant on expanding current LTCH capacity. While LTCH capacity expansion may be the right solution for certain communities, this static option has been shown to be ineffective, and in many instances counter-productive. When last implemented, many individuals who did not meet benchmarks of need entered LTCHs and shortly thereafter, the number of ALC patients rose again.

In looking at other jurisdictions, two examples are of interest – Denmark and England – for their approach to services provided in the LTCH sector.

"Denmark has more than any other EU countries given explicit policy priority to community care over residential care, promoting older people's living in their own home. Therefore, relatively few older persons are in long-term care institutions compared to other EU countries. Since the law on dwellings for older people from 1987, no new nursing homes have been constructed, and instead a varied range of dwellings adapted for older persons have been developed. People in need for care living in their own home or in special dwellings for the elderly are eligible to receive home nursing, home care and practical help."[17]

In addition, the UK model of a short-stay respite bed in LTCH provides seniors (and their caregivers) a welcome break and allows a comprehensive review of the client's circumstances.[18]

A foundation is already present upon which to build this shift to transitional, cyclical care in the LTC sector. As part of the Aging at Home Strategy, many LHINs have funded transitional or short-term, interim beds in LTCHs. These programs could be enhanced and expanded to better align with seniors' care needs and preference to return to the community after a restorative period.

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[16] It must be mentioned that there are also younger long-stay patients whose social, emotional and psychological needs are not being met in LTCH that are designed for, and occupied by, the elderly. This younger, high needs population also requires complex LTC services, while also needing to be surrounded by their contemporaries.

[17] German Institute for Economic Research Berlin, Erika Shulz, August 2010. Discussion Papers: The Long-Term Care System in Denmark.

[18] Accessing Respite Care. www.nhs.uk/CarersDirect/yourself/timeoff/Pages/Accessingrespitecare.aspx. Accessed on June 11, 2011.

Recommendations:

R21. Local Health Integration Networks support the specialized and differentiated use of Long-Term Care capacity as a transitional place of stay on a short-term basis, while providing support for patients with highly complex needs on a more permanent basis. Local Health Integration Networks and Long-Term Care Homes make this capacity central to the sector's mandate through accountability agreements.

R22. The Ministry of Health and Long-Term Care ensure that the appropriate physical design requirements are in place to support this shift in care delivery.

As the care needs for seniors who are placed in LTCHs become increasingly complex and specialized, LTCH capacity must have access to health human and interventional resources that can respond to and deliver higher intensity services. Tomorrow's patient with complex conditions will require medical, nursing and other expertise that allows episodic or deteriorating health status to be managed in the LTCH rather than by a trip to the ED. Intravenous therapy, wound care, post-operative care and other procedures traditionally requiring a trip to hospital would be managed on site.

Recommendation:

R23. The Ministry of Health and Long-Term Care pursue and implement policies that enhance the health human and interventional resources available in Long-Term Care Homes with the goal of expanding capability to effectively meet the care of patients with more complex conditions.

Furthermore, the current capital planning and funding models should be reviewed to make sure they address the needs and preferences of the current senior population and the needs and preferences we can anticipate as the population ages. The model incents LTCH operators to build more preferred beds than basic beds, even though the wait time for basic beds is many times longer, and to build large facilities in urban areas where there is a supporting population density, without assessment of the needs in non-urban areas.

Recommendations:

R24. The Ministry of Health and Long-Term Care:

    a. review the current distribution of basic and preferred beds and ensure availability of affordable options.

    b. ensure that the geographic location of Long-Term Care Homes corresponds with identified need.

Lastly, LTCHs are incented to run at close to 100 per cent capacity, making it difficult for the system to surge. Flexibility in surge capacity is required to ensure timely placement of complex care patients whose needs could be met in a LTCH.

Recommendation:

R25. The Ministry of Health and Long-Term Care build incentives for Long-Term Care Homes to have the flexibility to address surge capacity.

System Enablers

In order to support effective and sustained implementation of the recommendations identified in this report, system enablers relating to governance and accountability, health human resources, information technology, provider and public education, and process efficiency are essential. One enabler of the utmost importance is that governance and accountability throughout the system must be strengthened.

Governance and Accountability

LHINs play the key role in strategic planning and oversight of the local system, and must continue to lead system transformation as enabled by the ministry. It is apparent following site visits to many LHINs that where governance and applied accountability has been exercised in a productive and prioritized fashion, results have been impressive. However, across the system, processes that promote knowledge exchange at all levels of the organizations, including the leadership level, need to be created and utilized to address the variability in effectiveness and the degree of fragmentation in policy implementation.

The ministry needs to identify goals, while LHINs must ensure accountability for meeting identified targets and objectives, aligning incentives with the desired outcomes. In particular, accountability agreements should clearly articulate the objectives, while metrics should be applied, reported and used as a tool for change. Financial incentives should be aligned with the stated desired outcomes.

Recommendations:

R26. The Ministry of Health and Long-Term Care identify an internal ministry lead for the next 3 to 4 years, responsible and accountable for the care of the aging population, including the Alternate Level of Care file. Furthermore, the government should align both the mandate and the title of the "Ministry of Health and Long-Term Care" to reflect the shift from a predominantly institutional model to a more community focused care delivery framework.

R27. The Ministry of Health and Long-Term Care use accountability mechanisms that are readily available to hold the Local Health Integration Networks accountable for objectives, targets and outcomes (e.g., Ministry-LHIN Accountability Agreement).

R28. Local Health Integration Networks must hold their providers accountable for objectives, targets and outcomes, and ensure that corresponding incentives are aligned.

Health Human Resources

Over the next half century, caring for a frail older population with complex medical conditions will be one of the largest challenges for our health care system. While the system must adapt to this reality, it will be important that our educational system produce health human resources who will be equipped to address this challenge. An unmet need exists across the spectrum of health care providers to ensure sufficient numbers of professionals such as geriatricians, psycho-geriatricians, family physicians, nurse practitioners, nurses, social workers, rehabilitationists, and a host of others. We are currently producing experts oriented to the problems of today, not tomorrow.

Recommendation:

R29. The Ministry of Health and Long-Term Care, in conjunction with the academic and licensing institutions, identify Health Human Resource targets to meet the needs of an aging population. Furthermore, the ministry should consider funding existing practitioners for completion of intensive educational programs addressing the spectrum of issues concerned with caring for an aging population.

Information Technology and Systems

Ontario has much catching up to do in e-health. Pervasive platforms that allow for identification, follow-up, best practice, and automation of complex functions require sophisticated information technology. For example, the Resource Matching and Referral program has been shown to be highly effective in matching needs with resources in the post-acute care sector.

Furthermore, advances made in the use of Telehomecare should be disseminated and adopted broadly for certain ALC populations. Telehomecare allows for remote monitoring of patients using advanced information communication technologies that deliver health services and exchange health information between patients and health care providers.

Lastly, improved communication between institutions, and between primary care and CCAC through the use of an electronic medical record is essential.

Recommendation:

R30. The Ministry of Health and Long-Term Care identify hard targets for the implementation of pervasive information technology and management.

Health Professional and Public Education and Awareness

Transformation of any system will require significant efforts in educating health professionals and the public regarding aging, and safe and healthy home environments. In the absence of fully developed community support, and without a strong information and education capacity, it is understandable that families and their caregivers turn to LTC as the preferred option.

Recommendation:

R31. The Ministry of Health and Long-Term Care should, in partnership with the health professional bodies, hospitals, Local Health Integration Networks, Community Care Access Centres and the Community Support Services sector, undertake a variety of education and awareness activities related to the care of the elderly, primacy of home-based care, indicators for hospital care, and appropriate use of transitional and Long-Term Care amongst other things.

Process and Patient Flow Efficiency

The ministry has been successful in implementing a structured and standardized province-wide program aimed at improving the processes and flow of patients in the Emergency Department (Emergency Department Process Improvement Program – ED PIP). This valuable resource should be expanded and reoriented towards the ALC issue. An ALC Process Improvement Program (PIP) would advance the development and adoption of best practices across all LHINs relating to the discharge and system flow of ALC patients and patients at risk of becoming ALC. The program would standardize patient assessment, referral, admission, and discharge processes and practices across all sectors and affect system coordination and integration.

Recommendation:

R32. The Ministry of Health and Long-Term Care create an ALC Process Improvement Program (ALC PIP) focused on the continuum of care.

Conclusion

An opportunity, and in fact a duty, exists to transform our health care system to meet the needs of an increasingly aged population, who will live longer in both states of health and illness. From an individual perspective, seniors want to live in their homes for as long as possible, provided that dependable community supports are provided. To do so, the community sector, including CCACs and CSS, must be provided with additional and sustained resources to support "Home First" and other programming, increase the availability of group home models, and provide support to caregivers.

From a system perspective, hospital Emergency Departments should not be used as the entry into acute care admission for the purpose of eventual transfer to a more permanent, and often not necessary, placement in a LTCH. In fact, early screening and case management by Primary Care and CCACs should prevent ED visits. For those admitted with reason and ready for discharge, programs and services aimed at restoring and reactivating level of functioning must be implemented so that the patient may return back to the community. In this case, LTC should become specialized and differentiated for use as a transitional place of stay on a short-term basis, while providing support for highly complex needs on a more permanent basis.

It is time to identify a longer term strategy to address the phenomenon confronting society. As incrementally and sequentially implemented, our aging population should be provided dignified, appropriate care and intervention in the home or its equivalent, acute care hospital care only when truly required, opportunity at all points in the spectrum, including CCC/rehab for optimizing functioning, and LTC as either a transitional or more permanent resource depending on need.

Without this transformation, effected as soon as possible, the acute care system will increasingly be swamped by large numbers of patients who could have been far more appropriately cared for elsewhere, and challenged by many ALC patients waiting for placement in LTCHs who would prefer to be, and could be better cared for, elsewhere.

Summary of Recommendations

	Recommendation	Accountability	Implementation Timeline
R1.	The Ministry of Health and Long-Term Care and the Ontario Medical Association jointly create performance targets and other mechanisms that incent behaviours to emphasize primary prevention through community-based screening programs.	Ministry	Implement in 2012/13
R2.	Local Health Integration Networks and Community Care Access Centres jointly establish accountability agreements that establish CCACs' role and responsibility in service delivery through community-based screening programs.	LHINs and CCACs	Implement in 2011/12
R3.	The Ministry of Health and Long-Term Care monitor seniors' access to primary care across community, Long-Term Care and other settings, and modify accountability, performance targets and other mechanisms to drive improvements where required.	Ministry	Immediate and ongoing
R4.	The Ministry of Health and Long-Term Care, in consultation with stakeholders, develop a Geriatric Assessment Clinic model that works with and supports family physicians, and takes into consideration the existing primary care models.	Ministry	Implement in 2012/13
R5.	Local Health Integration Networks appoint Primary Care Leads as part of their senior administrative structure.	LHINs	Implement in 2011/12
R6.	Local Health Integration Networks realign, refocus and enhance investments in: a. The Community Support Services sector to support seniors and caregivers in the community, to relieve the resource pressures on Community Care Access Centres. Such investments would focus on homemaking services, caregiver support and respite services, and adult day programs for frail seniors and those with cognitive impairments. b. Community Care Access Centres to further implement the "Home First" philosophy and resulting programs in a standardized, intensified, and prioritized manner.	LHINs	Immediate
R7.	Local Health Integration Networks invest in new models of care that provide opportunities for high-risk seniors or seniors with complex needs to be cared for in group home models.	LHINs	Implement in 2012/13

	Recommendation	Accountability	Implementation Timeline
R8.	The Ministry of Health and Long-Term Care along with Local Health Integration Networks support through funding and/or policy changes the implementation of additional "Virtual Ward" models, where appropriate, advancing community discharge with professional and specialty supervision during the patient's recovery.	Ministry and LHINs	Implement in 6 months
R9.	The Ministry of Health and Long-Term Care support creation of special units/programs in the community and Long-Term Care Homes for seniors with special needs. Targeted investments should focus on adding new human resources specialized in responsive and challenging behaviours in Long-Term Care Homes, developing and deploying Mobile Behaviour Teams, and expanding services in the community.	Ministry	Immediate
R10.	Local Health Integration Networks support ongoing intensive assessment of long-stay ALC patients and investments to create the required resources and opportunities to place these patients in the right care settings.	LHINs	Immediate
R11.	Local Health Integration Networks embed "Senior Friendly" Hospital principles through accountability agreements with hospitals, which should be considered as an accreditation standard.	LHINs and Hospitals	Implement in 2012/13
R12.	The Ministry of Health and Long-Term Care ensure that capital processes are established to facilitate the implementation of "Senior Friendly" Hospital principles.	Ministry	Ongoing
R13.	Hospitals adopt best practices in bed utilization management to achieve improvements in lengths of stay and utilization of capacity.	Hospitals	Implement in 2011/12
R14.	Hospitals shift the role and responsibility for discharge planning for this population to Community Care Access Centres to ensure identification of appropriate discharge destinations (interim and permanent) using system level, consistent admission criteria, facilitated by automated systems such as Resource Matching and Referral.	Hospitals and CCACs	Immediate
R15.	The Ministry of Health and Long-Term Care develop and apply criteria to determine small, rural hospitals that appropriately meet the needs of their ALC patients so that these patients are no longer considered ALC. Such hospitals should be considered critical in the care of the frail elderly, and should be supported in the continuation of this role through policy and funding changes as required.	Ministry	Implement in 2011/12

| Recommendation	Accountability	Implementation Timeline
R16. The Ministry of Health and Long-Term Care and Local Health Integration Networks should realign investments, reconfigure current models, and target investments to: a. create opportunities for "Assess and Restore" in Complex Continuing Care/Rehabilitation sectors, recognizing that such services are oriented to more complex patients, or in the absence of CCC/Rehab, in specialized Long-Term Care facilities with the appropriate resources. b. ensure that CCC/Rehab Hospitals make "Assess and Restore" philosophy central to their mission through applicable accountability agreements and performance targets. c. standardize admission criteria and assessment tools for rehabilitation beds and CCC programs and develop processes to ensure that these destinations are considered for all appropriate patients.	Ministry	Implement in 2012/13
R17. Local Health Integration Networks and Community Care Access Centres ensure through their respective roles that seniors are provided with timely "Assess and Restore"/Transitional Care in Long-Term Care Homes while waiting for their first Long-Term Care Home choice, in order for patients to have an opportunity to regain previous levels of function and to prevent deterioration.	LHINs and CCACs	Immediately
R18. Local Health Integration Networks support through various mechanisms, including accountability agreements, the systemic adoption of best practices in the utilization of in- and out-patient rehabilitation.	LHINs	Implement in 2011/12
R19. Hospitals adopt best practice rehabilitation care pathways, primarily for patients who are recovering from hip and knee joint replacement, hip fractures or stroke.	Hospitals	Implement in 2011/12
R20. The Ministry of Health and Long-Term Care review OHIP funded community rehabilitation services (particularly Designated Physiotherapy Clinics) to ensure that these investments are aligned with the higher care needs of the elderly, particularly stroke and fracture patients.	Ministry	Implement in 2011/12

Recommendation	Accountability	Implementation Timeline
R21. Local Health Integration Networks support the specialized and differentiated use of Long-Term Care capacity as a transitional place of stay on a short-term basis, while providing support for patients with highly complex needs on a more permanent basis. Local Health Integration Networks and Long-Term Care Homes make this capacity central to the sector's mandate through accountability agreements.	LHINs	Implement in 2011/12 and 2012/13
R22. The Ministry of Health and Long-Term Care ensure that the appropriate physical design requirements are in place to support this shift in care delivery.	Ministry	Implement in 2011/12 and 2012/13
R23. The Ministry of Health and Long-Term Care pursue and implement policies that enhance the health human and interventional resources available in Long-Term Care Homes with the goal of expanding capability to effectively meet the care of patients with more complex conditions.	Ministry	Implement in 2012/13
R24. The Ministry of Health and Long-Term Care: a. review the current distribution of basic and preferred beds and ensure availability of affordable options. b. ensure that the geographic location of Long-Term Care Homes corresponds with identified need.	Ministry	Implement in 2011/12 and 2012/13
R25. The Ministry of Health and Long-Term Care build incentives for Long-Term Care Homes to have the flexibility to address surge capacity.	Ministry	Implement in 2012/13
R26. The Ministry of Health and Long-Term Care identify an internal ministry lead for the next 3 to 4 years, responsible and accountable for the care of the aging population, including the Alternate Level of Care file. Furthermore, the government should align both the mandate and the title of the "Ministry of Health and Long-Term Care" to reflect the shift from a predominantly institutional model to a more community focused care delivery framework.	Ministry	Implement in 2012/13
R27. The Ministry of Health and Long-Term Care use accountability mechanisms that are readily available to hold the Local Health Integration Networks accountable for objectives, targets and outcomes (e.g., Ministry-LHIN Accountability Agreement).	Ministry	Immediately
R28. Local Health Integration Networks must hold their providers accountable for objectives, targets and outcomes, and ensure that corresponding incentives are aligned.	LHINs	Immediately

| Recommendation	Accountability	Implementation Timeline
R29. The Ministry of Health and Long-Term Care, in conjunction with the academic and licensing institutions, identify Health Human Resource targets to meet the needs of an aging population. Furthermore, the ministry should consider funding existing practitioners for completion of intensive educational programs addressing the spectrum of issues concerned with caring for an aging population.	Ministry	Implement in 2012/13
R30. The Ministry of Health and Long-Term Care identify hard targets for the implementation of pervasive information technology and management.	Ministry	Implement in 2012/13
R31. The Ministry of Health and Long-Term Care should, in partnership with the health professional bodies, hospitals, Local Health Integration Networks, Community Care Access Centres and the Community Support Services sector, undertake a variety of education and awareness activities related to the care of the elderly, primacy of home-based care, indicators for hospital care, and appropriate use of transitional and Long-Term Care amongst other things.	Ministry	Implement in 2012/13
R32. The Ministry of Health and Long-Term Care create an ALC Process Improvement Program (ALC PIP) focused on the continuum of care.	Ministry	Implement in 6 months

Appendices

Appendix A – Data Relating to ALC in Ontario

A: % ALC Days by LHIN from Q1 09/10 to Q3 10/11

LHIN ALC Trend
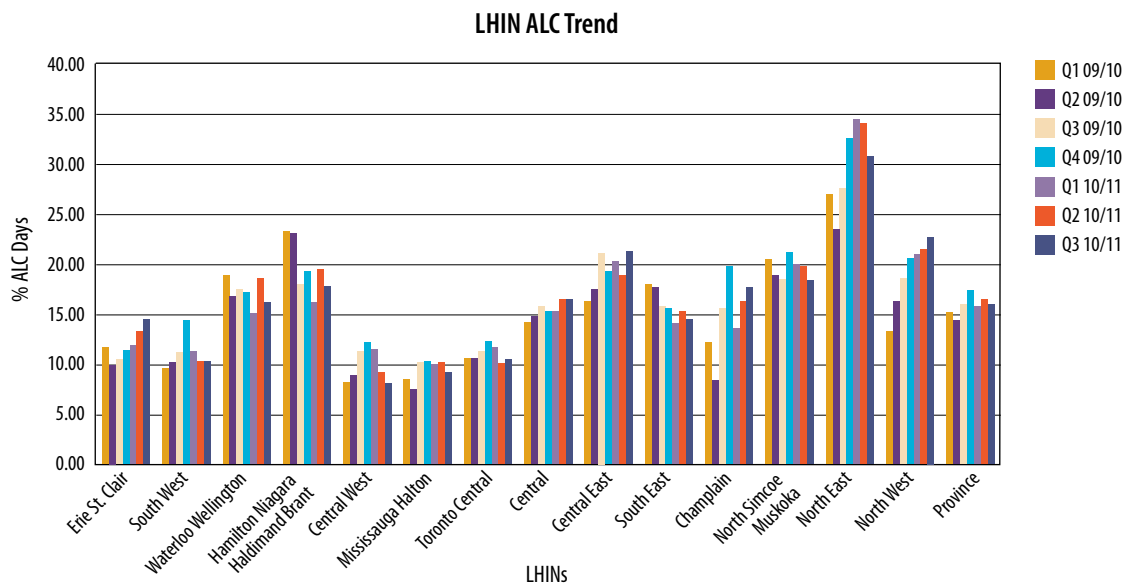
% ALC days: The number of in-patient days occupied by patients designated as ALC expressed as a percentage of the total number of in-patient days.

Source: CIHI Interim Discharge Abstract Database Data; April 1, 2011 data cut; MOHLTC, Health Analytics Branch

B: Age Distribution of ALC Patients

% ALC Separations by Age Group, 2009/10
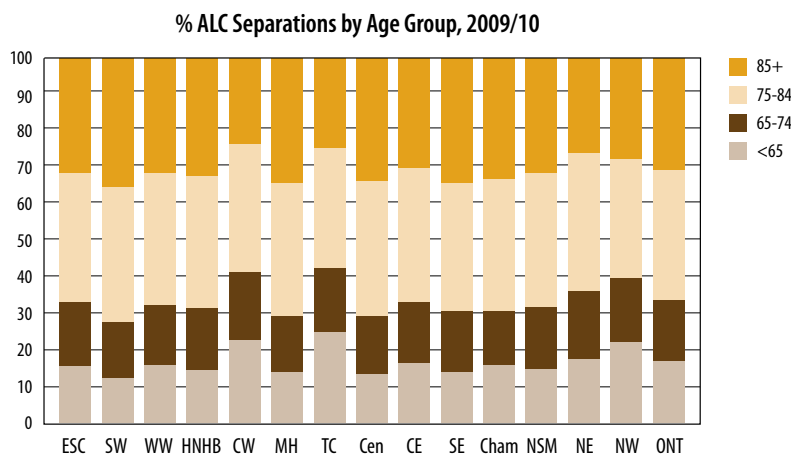
- 65.9% of ALC separations in 2009/10 were patients over 75 years of age; 83.1% over 65.
- 67.7% of ALC days in 2009/10 were patients over 75 years of age; 84.6% patients over 65.
- Note: ALC separations are patients that have been discharged.

Source: Inpatient Discharges Main Table, Discharge Abstract Database, FY 2009/10; Ministry of Health and Long-Term Care; Intellihealth Ontario. Analysis provided by: Ministry of Health and Long-Term Care, Health Analytics Branch.

C: Population Growth for Seniors Age 75+

Projected Population Age 75+, 2011-2021
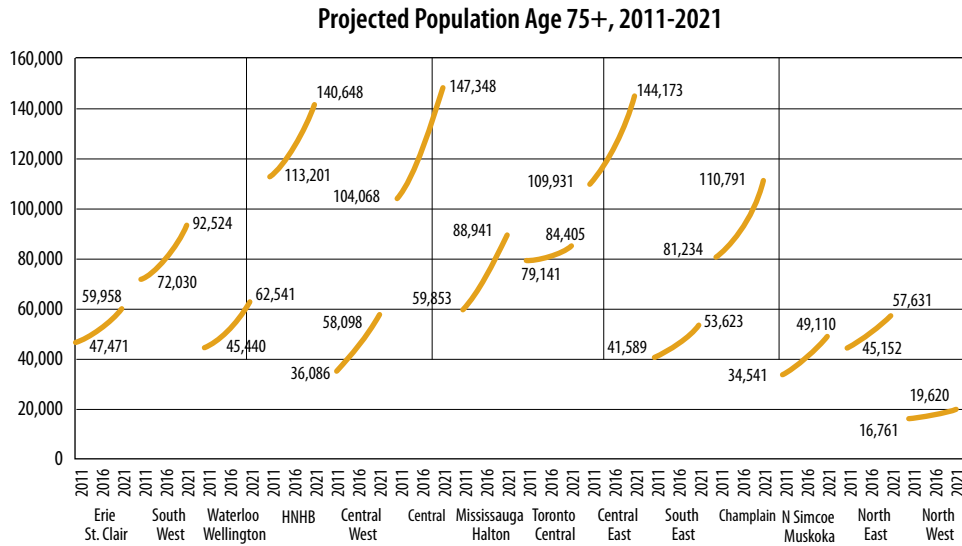
- The figure shows that the areas surrounding the Toronto Central LHIN (Central, Mississauga, and Central East) will experience the most growth in the population of seniors.
- Toronto Central has more seniors than other areas but will experience less of an increase in the senior population in Toronto Central.
- Growth in the number of seniors is also forecasted to be moderate for North East and North West LHINs.
- In addition to LHIN variation, the projected growth in seniors is also highly variable within LHIN areas.

Source: Population Projections LHIN, [Ministry of Finance], 2011-2021; MOHLTC; Intellihealth Ontario. Analysis provided by: MOHLTC, Health Analytics Branch.

D: ALC Patients – Distribution by Gender
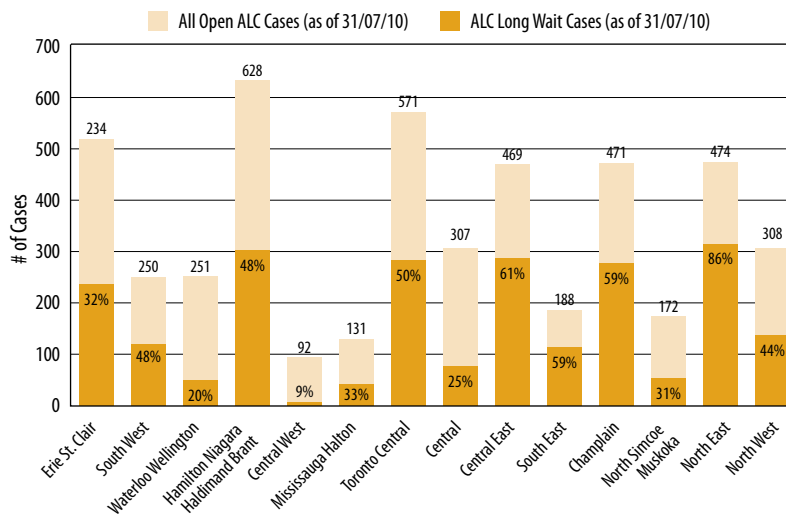
% ALC Separations, Female
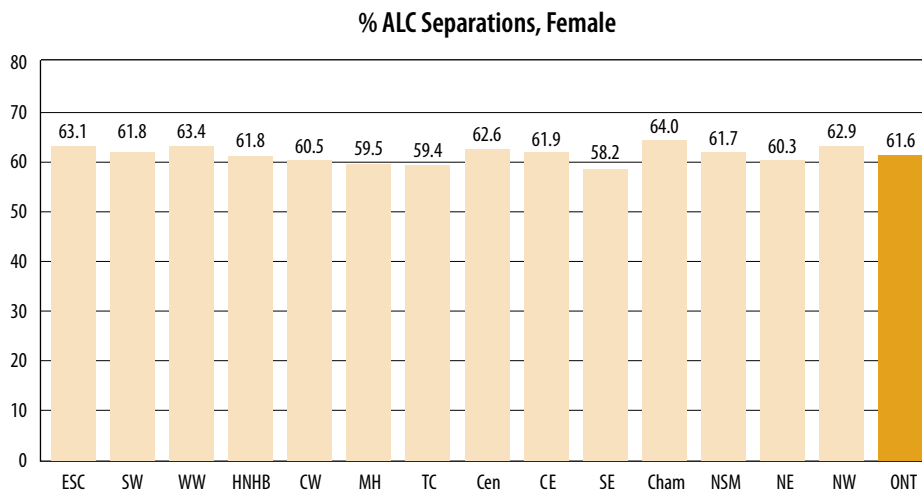
- 61.6% of discharged ALC patients 75+ years of age are female.
- Females are often the informal caregivers for their spouses and their hospitalization may require their spouses to be placed in a care setting.
- Females are more likely to require a LTC Home placement if their spouse is unable to provide care at home.
- Note: ALC separations are patients that have been discharged.

Source: Inpatient Discharges Main Table, [Discharge Abstract Database], FY 2009/10; MOHLTC; Intellihealth Ontario. Analysis provided by: MOHLTC, Health Analytics Branch.

E: ALC Long Wait Cases

ALC Long Wait Cases as a % of All Open ALC Cases, by LHIN

Legend: All Open ALC Cases (as of 31/07/10) — ALC Long Wait Cases (as of 31/07/10)

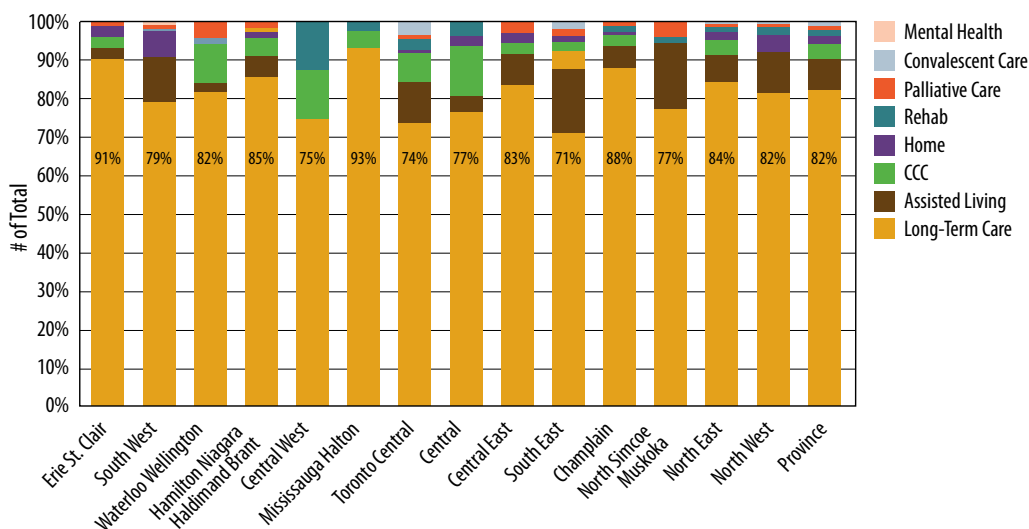| LHIN	Max ALC LOS (Min = 40)	90th %ile ALC LOS
Erie St. Clair	473	232
South West	1,756	598
Waterloo Wellington	423	261
Hamilton Niagara Haldimand Brant	1,535	412
Central West	145	145
Mississauga Halton	299	200
Toronto Central	3,739	695
Central	804	219
Central East	1,704	395
South East	988	478
Champlain	1,796	566
North Simcoe Muskoka	486	390
North East	1,180	395
North West	3,002	677
ON	**3,739**	**459**

- ALC long wait cases as a percentage of all open ALC cases, by LHIN, ranged from 9% (Central West) to 66% (North East).
- In Ontario, 47% of all open ALC cases are waiting longer than 40 days (2,132 out of 4,546), with a 90th percentile wait time of 459 days.

Source: Cancer Care Ontario. ALC Interim Upload Tool, and ALC Long Wait Cases Survey Data (as of July 31, 2010).

F: ALC Long Waits and Discharge Destinations

% ALC Long Wait Cases, Discharge Destination and LHIN

Legend: Mental Health, Convalescent Care, Palliative Care, Rehab, Home, CCC, Assisted Living, Long-Term Care

- The majority of ALC long wait cases are waiting for LTCHs, followed by assisted living, except for those in the Mississauga Halton and Central West LHINs.
- Mississauga Halton LHIN has the largest proportion (93%) of ALC long wait cases waiting for LTCHs.

Source: Cancer Care Ontario. ALC Long Wait Cases Survey Data (as of July 31, 2010).

G: Forecasting LTC Bed Demand

LTC Home Beds Demand: Forecasting Scenarios

Legend:
- **Current LTCH beds supply**
- **Scenario 1 – No change in demand**
- **Scenario 2 – Current demand – 37%**
- **Scenario 3 – High LHINs lower rates to provincial average**
- **Scenario 4 – All LHINs lower rate to current lowest LHIN rate**

All scenarios incorporate population growth rate and assume that there are no changes in utilization patterns due to efficiencies or program changes.

Scenario 1: Assumes that future demand and utilization rates will not change and that all seniors on the LTCH waitlist will require placement.

Scenario 2: Assumes that 37% of seniors on the LTCH waitlist could be diverted to other services.

Scenario 3: Applies the provincial rate of LTCH residents per 1,000 residents 75+ to LHINs who are currently above that rate.

Scenario 4: Applies the best LHIN rate of LTCH residents per 1,000 residents 75+ to the other 13 LHINs.

Sources:
Facilities Monitoring Information System, Client Profile Database and Occupancy Monitoring, as of June 30, 2010; Extract date January 11, 2011;

Population Projections LHIN, [Ministry of Finance], 2011-2021, MOHLTC; Intellihealth Ontario. Analysis provided by: MOHLTC, Health Analytics Branch.

Appendix B – Immediate, Short-Term, High Impact Strategies

Dr. Walker recommended three immediate, short-term, high impact strategies which need to be aligned and linked in the short-term to amplify the benefits within the next six months. While the first solution represents a new approach which has not yet been implemented, the other two build on existing initiatives already underway across most LHINs and look promising in helping reduce the ER and ALC burden in the short, medium and longer term.

1) Provide "capacity relief" to acute care hospitals immediately, yet only for a short period of time of one year, by funding beds linked to the ER. The beds will be earmarked as Express Unit or Short-Stay Program. Strict conditions of funding will apply as follows:
   - The Express Unit/Short-Stay Unit will be required to accept only patients admitted through the ER
   - The unit will have a length-of-stay of up to 72 hours, or less, to ensure quick patient turn-around
   - Performance metrics will be tracked for:
     – Time to inpatient bed
     – Time to Disposition Decision to admit
     – ER Length-of-Stay for admitted patients

2) Intensify the Home First Program
   - The Home First Program will act to continuously reduce the supply of ALC patients, which will, in turn, free up bedded capacity.
   - Performance Metrics will be tracked for:
     – Number of newly designated ALC patients (open cases)
     – Number of Long-Stay ALC Patients (over 30 days)
     – % ALC days

3) Expand Intensive Case Management Program for Long-Stay ALC Patients
   - The model will enable reduction/elimination of Long-Stay situations by enabling the continuous and effective identification of patients at risk of becoming long-stay ALC, assessment of complex ALC patients and alignment of required services in the community to facilitate transition.
   - Performance Metrics will be tracked for:
     – Number of discharged ALC patients
     – Readmissions/returns to hospital

Appendix C – Provincial ALC Lead and ALC Action Team Site Visit Summary

Below are the main themes that have been identified from the Provincial ALC Lead and ALC Action Team site visits, as reflected in the individual, specific LHIN *Action Plan Reports*.

1) **Leadership and Accountability** – Increased and sustained accountability at the senior leadership level (LHIN, hospital, CCAC, etc.) is required for the reduction of ALC and the appropriate placement of patients in the community.

Related to Primary Care Recommendations:

2) **Engagement of Primary Care and CCACs** – Engagement of Primary Care Physicians and CCACs in the early risk identification and pro-active care of seniors is required to ensure patients' needs are being appropriately met.

Related to Community Care Continuum Recommendations:

3) **"Home First" Philosophy** – Decreased reliance on LTCHs as a destination for ALC patients, and a subsequent uptake and wide-spread adoption of the "Home First" philosophy.

4) **Community Services** – Sustained, strengthened and consistent funding for community resources (CCAC and CSS) that provide support for seniors in their homes and in the community.

Related to Cross-System Responsiveness to Special Needs Populations Recommendations:

5) **Long-Stay Patients and Specialized Populations** – Sustained and strengthened support and prioritization for long-stay patients and specialized populations.

Related to the Role of Acute Care Hospitals in Seniors' Care Recommendations:

6) **Bed Utilization** – Improved bed management, bed utilization and discharge planning processes in conjunction with the CCAC is required in order to facilitate patient flow.

7) **Small Hospital** – Re-evaluation and re-definition of the role of the small rural hospital in the provision of care for seniors.

Related to "Assess and Restore" Recommendations:

8) **Activation for hospitalized seniors** – Activation programs within hospitals should be developed, including ones targeted at long-stay frail elderly patients in the ER, to decrease the current decline in Activities of Daily Living that is seen from pre- to post-admission.

Related to Specialized and Differentiated LTC Capacity Recommendations:

9) **Public expectations of the role of the hospital and LTC** – Hospitals, CCAC and LTC need to be more assertive in communicating that the hospital is not an option for people to wait for LTC placement and that LTC placement does not have to be permanent. A consistent approach should be undertaken to notify the public about the services that hospitals and LTC provide, why alternatives are a better place than hospitals to wait for the next level of care, and what services aside from LTC are available in the community when a senior is discharged from a hospital.

Related to System Enablers:

10) **Collaboration/Sharing of Best Practices** – Seeking out internal and external best practices and lessons learned is required to ensure all LHINs are utilizing new approaches and initiatives aimed at reducing ALC and ensuring patients are receiving the right care at the right time in the right place.

11) **Health Professional Education and Designation vs. Destination** – Delineation of the role of the physician versus the CCAC: physician provides care and determines the designation of the patient; CCAC determines the destination of the patient.

12) **Data** – Optimization of IM/IT resources is required to facilitate the placement of seniors in the community with proper supports and to demonstrate successes and create buy in at the organizational level.

13) **Sustaining Gains** – Continued prioritization of activities that aim to support all improvements in ALC and the care of seniors is required to ensure that any gains are sustained.

Appendix D – Best Practices

1. Theme – Engagement of Primary Care and Community Care Access Centres (CCACs):

Engagement of Primary Care Physicians and CCACs in the early risk identification and pro-active care of seniors is required to ensure that patient needs are being met appropriately.

Example of a best practice
Early risk identification in the Hamilton Niagara Haldimand Brant (HNHB) LHIN:
As a follow-up to the recommendations within the Two Day Alternate Level of Care Designation 2011 report, the HNHB LHIN has committed to using available risk stratification criteria tools for frail elderly, elderly at risk of functional decline and elderly at risk for inappropriate hospital utilization, and to complete a related test pilot project.

Two tools are being used: the Community Assessment Risk Screen (CARS) for the primary care population, and Triage Risk Screening Tool (TRST) for the targeted hospital population.

The HNHB LHIN will pilot the CARS tool in a family medical practice, consisting of 14 primary care physicians in Burlington, and a modified TRST tool in two HNHB LHIN hospitals. The hospitals will pilot the tool in the ER and on one medical floor. Each site will be evaluated against pre-determined performance metrics using a Plan/Do/Study/Act approach, so that adjustments or refinements of the screening tool can occur. The planning phase for the pilots is currently underway, with the upcoming pilot phase expected to take six months to complete.

The CCAC is expected to receive increased referrals from primary care and ER as seniors at risk are identified through the pilots. The CCAC will determine if these individuals are already receiving CCAC services: if they are, a determination of whether or not the client's status/needs have changed needs to occur; if they are not, a determination of whether or not they should receive CCAC services or whether they need referral to community support services will occur. Additionally, with the tools being used, the CCAC could be contacted earlier for individuals admitted to medical units.

In order to prepare for the expected increase in referrals, the HNHB CCAC is reviewing the referrals currently received from the physicians in the primary care practice. They are currently recruiting staff and are submitting a budget to the LHIN to support the potential increased referrals, which could shift costs from the hospital to the community.

In addition to this work, a Physician Lead position has been created, and the HNHB LHIN is the only LHIN to do this to date. Amongst numerous other projects, the Physician Lead is working with Burlington LTCH Medical Directors and Directors of Care to strategize on reducing avoidable LTCH transfers to the ER in Burlington.

2. Theme – "Home First" Philosophy:

Decreased reliance on LTCH as a destination for ALC patients, and a subsequent uptake and wide-spread adoption of the "Home First" philosophy is required across the province.

Example of a best practice
Implementation of "Home First" in the Mississauga Halton (MH) LHIN:
"Home First" is an evidence-based, person-centred, transition management philosophy focused on keeping patients, specifically high needs seniors, safe in their homes for as long as possible with community supports. If/when acute hospital care is required, "Home First" aims to support patients to return home on discharge prior to assessment for and/or admission to a LTCH or other appropriate care setting. Under "Home First," transferring patients from hospital to a LTC home is considered only after all other community options are considered.

"Home First" was first introduced in Ontario by the MH LHIN in 2008 to address significant patient flow issues within hospitals that were resulting in increased numbers of individuals designated as ALC. Implementing the philosophy provided MH LHIN with an opportunity to invest in targeted community investments and transform care delivery in hospitals, the CCAC, LTCH and CSS to focus on providing quality care in the right place at the right time.

MH has been able to successfully implement "Home First" by:
- Focusing on the 4Rs (Right care, Right setting, Right time, Right cost) and ensuring the Right Community Capacity is in place to manage seniors with complex daily living needs to stay at home or in the community;
- Implementing a comprehensive change management strategy;
- Ensuring all providers target seniors with complex needs to avoid ALC; and
- Sustaining dedicated leadership and focus on "Home First" by hospitals, CCAC and all providers.

MH can attribute the following successes to the adoption and implementation of the "Home First" Philosophy:
- The monthly average number of ALC patients in acute care, CCC, Rehabilitation and Mental Health facilities has decreased from 220 in September 2008 to 97 in March 2011.
- The number of patients deemed ALC to LTC has decreased from 152 in September 2008 to 36 in March 2011, representing a fourfold improvement.
- MH has the lowest percentage (6 per cent) of acute care and other in-patient care beds occupied by ALC patients than any other LHIN in the province.

"Home First" (or models similar to "Home First") have been introduced in each of the 14 LHINs, with each LHIN being at a different stage of planning or implementation. Although LHINs have shared knowledge and best practices around "Home First," a single provincial approach to implementation of "Home First" was not in place. Because of the variation of practices across the province and the early stages of implementation, the *Home First Implementation Guide & Toolkit* (February 2011) was developed in conjunction with leaders from MH as a "how-to" manual. LHINs are encouraged to use this document as a resource as they continue to implement "Home First."

3. Theme – Leadership and Accountability:

Increased and sustained accountability at the senior leadership level (LHIN, hospital, CCAC, etc.) is required, for the reduction of ALC and the appropriate placement of patients in the community.

Example of a best practice
Governance, authority and accountability for ALC in the Toronto Central (TC) LHIN:
In the TC LHIN, the LHIN, CCAC and hospitals share accountability for local ALC issues. There are several structures in place to ensure this accountability is shared:

Hospital Sector Table: The LHIN, all hospital CEOs, the CCAC CEO and the TC LHIN Management Team meet quarterly to strengthen the alignment of hospital and LHIN priorities. Specifically, this forum is structured to allow for collaborative discussion regarding:
- Performance on key indicators and performance improvements
- Consistency of service definition and delivery
- Models of integration
- Risk mitigation, quality, etc.
- System wide issues

ER/ALC is a standing item on the Hospital Sector Table meeting agenda. Data typically reviewed by the hospital CEOs includes the LHIN MLPA performance targets (including ER wait time targets, per cent ALC days, readmission rates, etc.)

CCAC/Hospital Accountabilities: There are agreements in place between the TC CCAC and TC LHIN hospitals on specific improvements and accountabilities for the performance metrics related to ALC. The metrics shared with the hospitals and LHIN on a monthly basis specific to ALC, beyond referral patterns includes:
- # of ALC-LTC waiting in hospital acute care, Rehab/CCC
- # of new placement applications
- # of crisis applications from ED
- # of same day referrals

CCAC/LHIN Accountabilities: There are also agreements in place between the TC CCAC and the LHIN on specific improvements and accountabilities for the performance metrics related to ALC.

1. *Multi Sector Accountability Agreement* – this agreement, in part, outlines specific deliverables and targets that the CCAC is accountable for with respect to long-stay ALC patient numbers, facilitating patient transitions, and service delivery. These indicators and accountabilities are monitored regularly.
2. *Steward for Difficult to Place Clients* – given the unique and legislated role that the CCAC plays as "broker" for specific health care services, the TC LHIN appointed the TC CCAC as the steward for the flow of "difficult to place" ALC clients. Further to this, the CCAC has also been appointed to lead a LHIN wide quality improvement program in collaboration with TC LHIN hospitals to aid in the early identification of new complex ALC patients and transition of these clients using an intensive case management model.

This authority and accountability for ALC across sectors and at varying levels, has resulted in the TC LHIN's strong track record of successful initiatives and related ALC reductions.

4. Theme – Long-Stay Patients and Specialized Populations:

Sustained and strengthened support and prioritization for long-stay patients and specialized populations is required across the province.

Example of a best practice
Reducing Long-Stay ALC and Facilitating Client Transitions in the Toronto Central (TC) LHIN:
In the summer of 2010, Access to Care (on behalf of the ministry) conducted a survey of all Ontario hospitals for each ALC patient with a stay of >40 days, in order to understand the true characteristics of the long-stay ALC population. Provincial gaps were identified and each LHIN was provided with their local findings.

The TC LHIN convened a Long-Stay ALC Task Group to advise the LHIN on short, medium and long-term strategies to reduce the number of long-stay ALC patients, one of which was to implement an Intensive Case Management and ALC Review Model. They subsequently worked with a cross-sectoral, clinical review/discharge planning team to review all ALC patients and develop appropriate transition plans to move patients to the most suitable alternative destination.

Since completing the review:
• 148 long-stay ALC patients (representing 32.2 per cent of total ALC patients in TC LHIN as of December 21, 2010) were individually reviewed;
• 28 patients have been transitioned out of ALC beds to an alternate destination;
• 22 patients originally identified as ALC for LTC and were deemed medically unstable and not ALC;
• There has been a 34 per cent reduction in the number of ALC patients.

Given the recent findings of the Long-Stay ALC Review, the TC LHIN recently convened four task groups of health service providers from across the continuum to address many of the recommendations in the TC CCAC's final report: *The Long Stay Alternate Level of Care (ALC) Review & Intensive Case Management Project in the Toronto Central LHIN: Final Report – January 2011*.

Building on their progress, over the last year the LHIN has expanded its focus to better understand and address the needs of these long-stay patients. A comprehensive review and plan was developed with two specific aims: transferring long-stay ALC patients to more appropriate care settings, and implementing a plan to prevent the generation of new long- stay ALC patients.

In addition, the LHIN together with the CCAC and hospitals have been able to alter entrenched system-level behaviours and patterns of care in the local health care system that have been extremely hard to change. These changes are essential to sustaining gains made in ER wait times, patient flow and ALC reduction, achieving health system integration, and achieving continuous quality improvement and the goals of Excellent Care for All.