

# Integrated Health Service Plan

## ***Integration Priority & Action Plans:***

### ***Enhancing Seniors' Health, Wellness and Quality of Life***

Mississauga Halton Local Health Integration Network

Section Appendix G.3

Appendix  
**G.3**

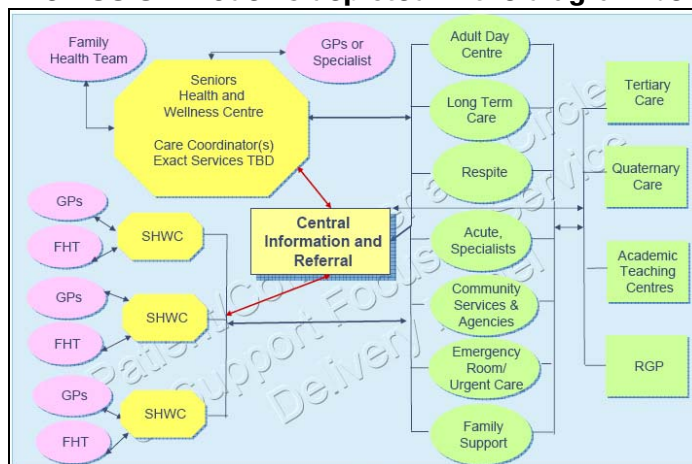
# Enhancing Seniors' Health, Wellness and Quality of Life

## Description

A cross-sectoral group of local providers with expertise in senior's health have taken the initiative to develop an evidence-based, integrated service delivery model for seniors in the Mississauga Halton LHIN.<sup>1</sup> The working title for the model is **"ASSIST"**, which stands for:

- All-inclusive Seamless Services for Independence of Seniors for Today and Tomorrow

The ASSIST model is depicted in the diagram below.



The target population will be adults age 55 or older residing in the Mississauga Halton LHIN. Although seniors are typically defined as age 65+, a broader age range was deliberately selected for the model. In keeping with evidence-based practices for chronic disease management, it was important to target a younger population for proactive health promotion, disease prevention and wellness interventions that may delay or prevent onset of disease in the future. Innovative approaches to service delivery will need to consider the transportation challenges experienced in accessing care for this population.

<sup>1</sup> The Regional Geriatric Advisory Task Force completed a detailed examination of the best practices in service delivery to the frail elderly, seniors and other innovative integrated service delivery models and as a result a report and delegate presentation was made to the Mississauga Halton LHIN for inclusion in their IHSP – the Description of the priority and Action Plan #1 is a direct result of the design, development and implementation planning completed by this cross-sectoral team.

The foundation for the model includes a clear vision, mission, principles and goals:

**Vision:** Working together for seniors' good health

**Mission:** Maximizing health and independence in seniors through an integrated and comprehensive continuum of care

**Principles:** Dignified, Evidence-based practices, Choice, Continuum of Care, Interdisciplinary, Easy access, Joint accountability, Sustainable, Passionate

**Goal:** To design and successfully implement an integrated service delivery model for the seniors of the Mississauga Halton LHIN that fully embraces the guiding principles, and pushes the boundaries by innovatively applying the best available evidence-based practices.

This model embraces the following:

- Builds on **primary health care**.
- Incorporates **health promotion and disease prevention**.
- **Seniors' Health and Wellness Centres** ('SHWC') are geographically dispersed and interconnected hubs that provide common information, intake, assessment, referral and delivery.
- **Access** to services through any provider or a **Central Call-in number**.
- **Care Coordinators** linked to primary care physicians/FHT through the SHWC and are **integral to system navigation and care delivery**.
- Enhances the role and service delivery within **Long Term Care** facilities.
- Links to the **End-of-Life** strategy to enhance the delivery of palliative care.

#### **Seniors' Health and Wellness Centres: The Highlights**

- These Centres can be attached to one or more Family Health Teams or GP's.
- The SHWC can be virtual interconnected providers or could be a physical location.
- They will provide a variety of services, clinics, education, and therapies in a location "or referrals to another location" that is geographically close to home.
- The SHWCs will be integrally linked to the Secondary and Tertiary services (as appropriate) within their specific geographic area to support the close to home model.

#### **Care Coordinator Role: The Highlights**

- Care coordinator moves with the patient across the entire continuum.

- This role will focus exclusively on seniors and exhibit passion and depth of knowledge in complex needs and system navigation.
- Care coordinators are linked to primary care physicians to ensure proactive case finding for high risk individuals.

### **ASSIST Service Levels**

Access to services needs to be considered at multiple levels as high quality of care driven by critical mass is paramount and outlined below:

1) **Local Level** – The services provided require low intensity resources, with the emphasis on preventative, supportive and primary care. All services are easily accessible; examples include, but not limited to:

- Seniors Health & Wellness Centres
- FHT and Primary Care Doctors
- Health Promotion and Disease prevention
- Community Services & Agencies
- Adult Day Programs
- Supportive Housing

2) **Sub-LHIN Geographic Area Level** – These services are focused on health conditions that require more specialized and intensive health resources.

- Long Term Care
- Emergency Room/Urgent Care
- Hospital based care such as access to sub-specialists such as orthopedics, ophthalmology, specialists of Internal medicine, geriatric assessment

3) **LHIN-wide Level** – This level provides highly complex specialty care and resources for geriatric populations.

- Psycho geriatric Behaviour Units/Outreach Teams
- Geriatric Assessment Units (These specialized units to operate effectively require a critical mass of patients to justify the presence of a specialized geriatrician).

4) **Inter-LHIN and Provincial Level** – This provides access to quaternary services, academic health sciences and the flexibility to utilize inter-LHIN referral patterns.

- Academic Teaching Centres

- Regional Geriatric Program
- Highly complex quaternary services

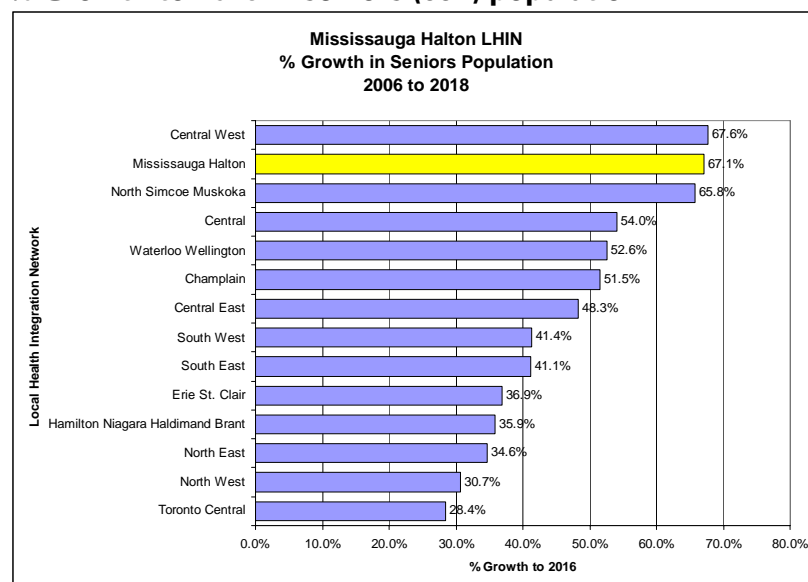
## Rationale

### Environmental Scan:

Mississauga Halton Local Health Integration Network is home to approximately 215,000 adults over the age of 55. It is also the fastest growing LHIN region in the province for the 55+ population projected to 2018. In the next decade the number of older adults will increase 48% to over 317,000. This poses a significant challenge for a local health system that is already pressured to meet the complex needs of a diverse seniors population. There are approximately 107,500 seniors (i.e., residents age 65 years and older) living in Mississauga Halton in 2006. Based on 2001 census data, the current proportion of seniors within the population of Mississauga Halton LHIN is slightly lower than that for the province (see figure below). There is a significantly larger concentration in the community of South Etobicoke (18.5%), though the largest number of seniors is in the City of Mississauga (48,825).

While Mississauga Halton is ranked 5<sup>th</sup> in overall population growth, in seniors (65+ years of age), we are projected to have the second highest growth rate (i.e., percentage increase) in seniors to 2018 among the fourteen LHINs.

### % Growth to 2018 in seniors (65+) population



Acute hospitals are the most costly sector of the health care system and in the Mississauga Halton LHIN, seniors are heavy users of acute hospital services:

- Over 20% of emergency department visits to the Mississauga site of Trillium Health Centre are for people over the age of 65. In 2002/03 over 34% of admissions to Trillium were over the age of 65.
- Patients over the age of 65 represent 37% of the total admissions to the Credit Valley Hospital's emergency department. Their length of stay was longer than patients with the same diagnosis under the age of 65.
- Seniors comprise 47.5% of all admissions to Halton Health Care Services.
- The greatest proportion of ALC days is in the seniors population who are the highest users of the health system.

Large numbers of seniors are admitted to the hospital while only 4% seek assistance from specialized geriatric services. A paradigm shift needs to occur to focus on disease prevention, health promotion, and treatment in the community. Opportunities to improve access and service delivery through enhanced integration, coordination, communication and client-focused care have been identified by both consumers and service providers.

### **Community Engagement:**

#### Phase 1 Engagement:

The importance of addressing Mississauga Halton's rapidly growing seniors population was a recurring theme throughout the community forums. Many providers and residents see this as critical to ensuring the long-term sustainability of our local health system. Some of the specific opportunities identified by stakeholders in relation to improving health services for seniors include:

- Establish a Seniors Neighbourhood Watch Program
- Develop a regional geriatric program
- Develop a "seniors community" (based on the concept of "aging in place") with supportive housing, recreational activities, etc.
- Develop a LHIN-wide falls prevention program
- Identify success factors for keeping seniors at home and invest in these basic supports (e.g. outreach for seniors at risk, day programs, snow shoveling, homemaking, air conditioning units)
- Establish more palliative care teams
- Expand caregiver support programs including respite for caregivers to seniors, parents of children with special needs, etc
- Resources for long-term care homes to reduce need to transfer residents to hospital for minor issues (e.g. stitches)

- Use nurse practitioners in long-term care homes
- Develop designated units in long-term care homes for residents with behavioural issues
- Recognize the challenges seniors face in transportation to receive health services and other programming

The Community Engagement stressed the importance of supporting seniors to maintain their independence in the community but also recognized the need for enhancements to meet the needs of seniors who are residing in long-term care homes. For example, the Mississauga Halton Integration Priority Report<sup>2</sup> identified enhanced partnership between LTC, hospitals, CCACs and clients/families as an integration opportunity.

#### Phase 2 Engagement:

This phase has included dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from the LHIN and the provider conference. From these conversations it has been suggested that:

- Transition support has not been adequately addressed.
- Transportation (non-urgent) is a significant challenge and is not adequately addressed in the plan.
- Wheel-trans is needed across the LHIN.
- Flow of information across providers is limited or non-existent and must improve.
- Health human resources have not been addressed in this priority and we do not have enough skilled professionals in this area.
- Day programs now require CCAC assessments for placement, including:
- Wait time are currently running at 28 days, when previously placements could be made within a few days.
- This change has had considerable negative impact on clients as they now have to be placed in LTC as they cannot function without access to such programs.
- Seniors do not know what services are available
- Education and information is needed by family members and informal caregivers regarding services.
- This information could be disseminated through drop-in centres, doctors offices and other health service facilities.
- Education and information is needed by providers and physicians regarding what services are available and how to access these services.

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<sup>2</sup> Integration Priority Report for Mississauga-Oakville. [http://www.health.gov.on.ca/transformation/lhin/reports/mississauga\\_oakville.pdf](http://www.health.gov.on.ca/transformation/lhin/reports/mississauga_oakville.pdf)

- Language differences further complicates the understanding of the availability of and access to services.
- Concern that patients will not have access to services because of one's address.
- Denied CCAC services in the rural area due to bordering on both Peel and Halton.
- There appears to be a disproportionate number of services for urban centres.
- CCAC home care is excellent if you can get it.
- Dental services for seniors.
- General agreement with the vision and ideas for change.

**Other relevant evidence:**

It is a well-documented fact that age is the greatest predictor of increased prevalence of illness and use of health care services. Some of the health care issues that seniors face that often require medical intervention and/or hospitalization include: falls, osteoporosis, poly-pharmacy, delirium, dementia, mental health, stroke and bladder/bowel concerns.

**Overview of Action Plans**

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The overall implementation plan will require three action plans:

- 1) The detailed planning and implementation of the integrated service delivery model ASSIST includes five key elements within its plan for action, including:
  - Recruit a Coordinator of Integrated Services for Seniors to oversee and manage transformation from the current state to the integrated model.
  - Establish a joint accountability structure with two tiers – a “Coordinating Council” and a “Project Steering Committee”.
  - Form two Detailed Planning and Action teams to confirm the geographic regions and determine the prioritized list of the scope of services through a detailed approach to community engagement and data analysis.
  - Create detailed planning and action teams to focus on specific aspects of the model (e.g. assessment tool, prioritized list of the scope of services, information management, etc).
  - Identification of “early wins” and/or pilot project opportunities (e.g. focus on falls prevention).
  - The integrated service delivery model has wide community support. It embraces the vision of health for Ontario and holds the potential to

benefit seniors, their families and the health system as a whole for years to come.

- 2) Enhance the role of long-term care homes.
  - Use nurse practitioners in long-term care homes.
  - Develop designated units in long-term care homes for residents with behavioural issues.
  - Enhance clinical expertise available in long-term care homes to assist in reducing unnecessary Emergency Department visits i.e. Nurse Practitioners, or hospital expertise to assist long-term care homes, education initiatives.
  - Use long-term care home capacity to reduce reliance on Complex Continuing Care (CCC) beds and ALC utilization.
- 3) Build on the End-of-Life Strategy to develop a comprehensive approach for Palliative Care.
  - Vertically integrated multidisciplinary hospice palliative care teams/ Continuum of Hospice Palliative Care.
  - Establish more palliative care teams.

### **Challenges that Could Impact Successful Implementation**

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Phase 2 Community Engagement consisted of dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from across the LHIN and the provider conference. From these conversations the following challenges have been suggested:

- Non-urgent transportation challenges for this population are significant and must be addressed for both rural and urban settings.
- Organizational agendas may be in opposition to the proposed directions of this priority.
- Need to rationalize and support existing networks.
- Communication to and education of the public regarding the model.
- Cross-Sectoral issues: traditional silos need to be broken down

### **Networks and Current Initiatives Identified to Support Success**

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The following networks responded to the call for input on the integration priorities:

- Regional Geriatric Advisory Group for Mississauga Halton LHIN

- Mental Health & Addictions Leaders Forum for Mississauga – Halton
- Toronto ABI
- Halton Long Term Care Administrators Group
- Halton Peel Palliative Care Network
- GTA Rehab Network
- West GTA Stroke Network

The following initiatives or opportunities were identified through the Phase 2 Community Engagement with the providers as strengths that the Detailed Planning and Action Teams could use as a basis for further development:

- Existing transportation networks could be enhanced
- Education programs such as those at community health centres
- Falls Program has been effective and could be leveraged
- Georgetown supportive housing program: support service coordinators work with clients in their home, supporting aging in place
- Some LTC homes (e.g. Dom Lipa) have excellent end of life care – could be used as a benchmark or pilot study
- Programs need to leverage the role of the CCAC and how it can facilitate this model

## Action Plan #1

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### Implement the integrated service delivery model for seniors.

#### Description

To successfully implement this new integrated service delivery model will require the organizations involved to work together in way that is different from today. This will require a concerted effort and significant leadership, and thus the implementation plan has included many of the critical success factors necessary for successful transformation.

The Regional Geriatric Advisory Task Force completed a detailed examination of the best practices in service delivery to the frail elderly, seniors and other innovative integrated service delivery models. As a result a report and delegate presentation was made to the Mississauga Halton LHIN for inclusion in their IHSP. The Description of the priority and Action Plan #1 is a direct result of the design, development and implementation planning completed by this cross-sectoral team.

#### Deliverables – Years one to three

##### Year 1 Deliverables:

##### **A Role to be Accountable for Design and Implementation – Coordinator, Integrated Seniors' Services**

- To ensure that this complex implementation project is executed, a dedicated resource will be required to lead this initiative. The proposed role is that of the Coordinator, Integrated Seniors' Services, for the Mississauga Halton LHIN. This role would be accountable to the joint accountability structure that is outlined below. This role is responsible for the overall management of a highly complex project with multiple sub-projects working simultaneously with significant interdependencies. The Coordinator will be a pivotal role in the success of this implementation.
- The Coordinator will be responsible for establishing a detailed planning and action team project protocol that will include a team charter, the guiding principles as developed by the RGATF core and extended team, project planning and reporting mechanisms, presentation protocols, and others as appropriate for managing multiple complex projects simultaneously.

##### **Develop a Joint Accountability Structure**

- A joint accountability model is **proposed** for overseeing the implementation of the new service delivery. Two levels of accountability is **proposed** – first the *Coordinating Council* at the macro level that will approve and commit resources and the other the *Project Steering*

*Committee* at the project level to provide guidance and support for the and implementation planning. This two level approach is to recognize the fact that the right people must be at the table to approve the new approaches to service delivery and yet provide the necessary project support required to prepare the necessary business rationale to enable such decisions.

### **Community Engagement and Detailed Data Analysis: Establishing the Foundation**

- In order to determine the array of services available in each of the geographic regions and then to select the most critical detailed planning and action teams, the detailed data collection is required. To determine the appropriate definition and size of the geographic regions, an assessment of the current and future numbers and distribution of seniors will need to be conducted, including an assessment of transportation needs and a proposal put forth. Also two types of detailed data will be required: quantitative and qualitative for this critical step in the process. The quantitative will be secured through such ways as the MOHLTC Information Management Service Centre, the regional planning departments, Public Health, etc. The qualitative information will be secured using the Mississauga Halton Community Engagement Framework that will be focused on seniors and their circle of support to gain valuable insights on their needs, what is working and what is not working in the current system.
- This is a critical project requiring a project leader from the Core Team who has the ability to mobilize a project team that individually has significant depth of expertise in a particular part of the continuum, yet has the broader perspective of the both the continuum and the Mississauga Halton LHIN.
- This detailed evaluation will include the following areas:
  - Detailed understanding of the problems, challenges and issues facing seniors, care givers and the circle of support;
  - Detailed needs assessment;
  - Detailed analysis of current services that enables the leveraging of service excellence (eg. Adult Day Services within Halton and Peel);
  - Detailed gap analysis per geographic region; and
  - Review of existing programs and services to identify duplication and opportunities for improved efficiencies and effectiveness.
- The outcome of the critical detailed analysis work will be an understanding of the following:
  - The scope of services across all sectors required within the Mississauga Halton LHIN;
  - The core services across all sectors required within each geographic region;
  - The geriatric specialty services required for the region; and

- A prioritized list of services for detailed integrated service delivery design.
- The completion of this critical foundation setting work, should establish the gold standard for the detailed planning and action teams. This project should demonstrate depth of analysis, the inclusion of input from both providers and the public and the establishment of well researched evidence based approach to the setting of recommendations.

### **Early Wins**

- Two early win opportunities have been identified, including:
- **Early Win #1: Standardized Screening, Triage, Assessment and Follow-up Process** - One of the fundamental building blocks of an integrated service delivery model for seniors' is the approach to assessment – the standardized, graduated and automated. This was identified as a potential early win. To that end a team will be established to develop the model for this process. It is recognized that work has been completed in this area in various parts of the Mississauga Halton LHIN that will need to be incorporated into the plan forward. In developing the mandate for this team and the membership of the team, the Coordinator and Project Steering Committee will need to take all these things into consideration.
- **Early Win #2: Traveling Patient Record** – The traveling patient record has the potential to be the precursor to the Electronic Patient Record and provides an approach to meet some of the demands of the EPR in the short run.<sup>3</sup>

### **Year 2 Deliverables:**

In addition to the fundamentals outlined above, the second phase of the detailed planning and action will include the following parts of the model:

- Scope of Services Projects – prioritized as part of the *Establishing the Foundation* project team deliverables
- Geographic Region Design Project – once the basket of services required for each geographic region has been approved, the next step is potential configuration of such services within one of the regions. The selection of the region should be based on an approved set of criteria that would facilitate the best decision. This project team will need to understand what is being developed within the scope of services teams that working simultaneously.

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<sup>3</sup> Dr. William Malloy, Professor of Medicine, St. Peter's-McMaster Chair for Studies in Aging, Centre for Aging, St. Peters Family of Services, Hamilton, Ontario - builds on some of the best practice research by Dr. William Malloy.

**Early Wins:**

- **Early Win #3: Falls Prevention Initiative** – Among older adults, the majority of fractures are caused by falls<sup>4</sup>. Given that falls impact almost all facets of the seniors' healthy system, the Core Team identified this as an area that should be addressed sooner than later and potentially in a phased approach. Falls may be a proxy to assess improvements of the new service delivery model. The Coordinator in cooperation with the Steering Team will need to carefully consider the mandate, team membership and the high level project plan so that some aspects could be developed in a stepwise approach so that piloting of potential aspects of the process could be conducted as others are still being developed. This is not an early win in its totality, but is an opportunity that could have both short and longer term design and implementation components.
- **Early Win #4: Pharmacy 'Watch Dog' and Technology Solution** – Identify the requirements to have Pharmacists as part of the promotion, prevention and pro-active case finding by developing approaches to monitor drug interactions across drugs and across providers.

**Year 3 Deliverables:**

- Care Coordinator Role Project – the timing of this project will be dependent upon the need for this role pre or post or concurrently with the geographic region design team.
- Information Requirements and Flow Project – timing of this project needs to be aligned with the e-health strategy for the Mississauga Halton LHIN.
- Performance Management Design and Execution – Performance will need to be tracked and assessed on multiple levels. Firstly and likely most importantly will be the performance monitoring of the execution of this complex multi-phase and multi-project assignment. Secondly as each of the project teams start implementation of their service delivery, each will have performance indicators that will need to be tracked and reported as appropriate. Finally, the Joint Accountability Committees will develop indicators that will require indicators, monitoring and reporting for the overall seniors' services for the Mississauga Halton LHIN. The Coordinator in cooperation with the various groups and teams will work to develop the appropriate indicators, create an approach to tracking the indicators and develop the reporting mechanisms for monthly and/or quarterly reporting of these.
- Point of Access or Entry Project – the timing of this project again will be important as it is both the key entry and it is dependent upon having the necessary services in place and ready for access by the client.

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<sup>4</sup> National Center for Injury Prevention and Control. Falls and Hip Fractures Among Older Adults. Retrieved from: <http://www.cdc.gov/ncipc/factsheets/falls.htm>

## Outcomes

- Quality
  - Improved client/family satisfaction
  - Improved self reported health status
  - Reduced falls
  - Reduced readmission rate
  - Reduced emergency department visit rate
  - Reduced adverse event rate (e.g. medication errors)
  - Improved rate of disease prevention interventions (e.g. flu shots)
  - Increased rate of seniors able to stay in their own homes with assistance from home care
  - Improved rehabilitation outcomes (e.g. functional scores, activation)
- Access
  - Percentage of seniors living where they want to live
  - Wait times to receive first choice long-term care placement
  - Wait times for acceptance to or visits to family physicians
  - Reduced wait times for key seniors related surgeries – hip and knee replacements, cataracts
  - Reduced wait times for access to complex rehabilitation
  - Reduced or delayed need for hip and knee replacements
- Efficiency
  - Care maps and clinical pathways based on best practices/evidence
  - Adoption of standardized approaches/processes
  - Increased units of service provided with same financial allocation
- System/Process
  - Seniors have care coordinators/managers to help them with system navigation
  - Expand the continuum to support aging in place
  - Degree of uptake of Senior's Neighbourhood Watch Program
  - Level of participation in education on Chronic Disease Prevention and Management

## Performance Indicators

- Client/Caregiver/Provider Satisfaction
- Care Transition Measure (CTM), looks at the co-ordination and continuity of a successful care transition
- Functional independence scores
- RHI data as a mechanism to track support for clinical pathways
- Disease Prevention indicator is needed - TBD
- Others as appropriate to be determined by Detailed Planning and Action Team

## **Action Plan #2**

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### **Enhance the role of long-term care homes.**

#### **Description**

An effective integrated health system facilitates the delivery of care to people in the most appropriate setting for their needs. Long-term care (LTC) homes play a unique role in the health system for seniors (and others) who are no longer able to live independently in their own home. With the aging of the population and an increase in community-based options available to seniors, the average age and the acuity level in long term care homes are both rising. Long-term care providers report challenges in responding to the complex needs of residents such as those with mental health and/or addictions issues, behavioural issues and poly-pharmacy<sup>5</sup>.

In 2004/05, Mississauga Halton LHIN had 4,157 long-term care beds in its 23 long-term care homes. Long-term care homes interface with many other parts of the health system. For example, patients may be discharged from hospital into a long-term care home. Patients may also be transferred from a long term care home to hospital due to serious illness or injury. A number of collaborative initiatives are already underway in the LHIN to create partnerships aimed at improving service deliver in the long-term care sector such as:

- Convalescent care beds as a partnership between CCAC, hospitals and LTC homes
- Emergency Services Network audit of long-term care emergency department visits
- LTC/ hospital/CCAC Education Committee
- Education supports (geriatricians - Dr. Barbara Clive, Dr. Greg Thompson, Dr. S Egier) for long-term care – to raise capacity building and education in long-term care homes

Opportunities exist to further enhance the role that long term care homes can play in an integrated system both by strengthening linkages with other sectors and by improving the capacity of long-term care homes to meet the complex needs of their residents.

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<sup>5</sup> The term polypharmacy generally refers to the use of multiple-medications by a patient. The term may also be used to describe the issues arising from drug interactions between these multiple-medications.

## Deliverables – Years one to three

### Year 1 Deliverables:

#### Collaborative development of a plan to enhance long-term care homes

- Establish a Long-Term Care Action Group supported by the Coordinator, Integrated Services for Seniors to develop a work plan.
- Gather a description of the current long-term care homes in the LHIN (this information should already be available from the three CCACs) including a LHIN map showing the location of homes, associated beds, cultural/religious-based homes and special units.
- Analyze the annual long-term care resident classification data to understand the complexity of needs in long term care homes.
- Analyze the staffing mix in LTC homes including volunteers and the impact of specialized units on the staffing demands.
- Understand the impact of the LTC regulations, guidelines and provincial priorities in this area on proposed LTC enhancement opportunities.
- Conduct gap analysis (i.e. existing capacity vs. need).

#### Identify potential strategies for filling gaps

- Through community engagement and review of best practices, identify strategies to improve service delivery and system integration through linkages with other sectors and resource enhancement.
- Develop strategies *for linkages* with other health sectors including:
  - Hospitals (e.g. emergency departments)
  - Mental health and addictions (e.g. mobile crisis team)
  - Primary health care (e.g. access to nurse practitioners/family health teams)
  - Specialized geriatric and psycho-geriatric services
  - Chronic disease programs
  - Medical specialists
- Establish criteria for prioritizing linkage strategies.
- Begin implementation of top priority linkage strategies (this will include ensuring that appropriate structures and processes are in place to support linkages such as partnership agreements).
- Develop performance measures to assess the impact of linkage strategies.
- Link to Palliative Care Network to understand the role and options for end-of-life care within LTC homes today and in the future.

**Year 2 Deliverables:****Continue implementation of linkage strategies between long-term care homes and other sectors**

- Monitor and evaluate the success of the linkages and make course corrections as require

**Develop strategies for enhancing resources in long-term care homes (e.g. addition of nurse practitioners; introduction of special behavioural units)**

- Explore options for enhanced use of nurse practitioners in long-term care homes (e.g. focus on specialized populations vs. general resident population; consultation model vs. shared care model, etc)
- Explore sources of acquiring nurse practitioners (e.g. job sharing with nurse practitioners in other sectors; new funding)
- Identify need for LHIN-wide resources and resources specific to individual long-term care homes
- Develop criteria for allocation of enhanced resources to long-term care homes
- Present recommendations for enhanced long-term care resources to Project Steering Committee for the Integrated Seniors Services Model

**Year 3 Deliverables:****Continue implementation of linkage strategies between long-term care homes and other sectors**

- Monitor and evaluate the success of the linkages and make course corrections as require

**Implement *strategies for enhancing resources in long-term care homes***

- Develop work plan for allocation of enhanced resources to specific long-term care homes
- Appoint leads for implementation of LHIN-wide resource enhancements
- Develop performance measures to assess the impact of resource enhancement strategies
- Monitor and evaluate the success of the resource enhancements and make course corrections as required
- Implement communications strategy to inform providers and residents/families of changes

**Outcomes**

- Quality:
  - Reduced complications

- Reduced unnecessary readmissions to hospital
- Increased client/family satisfaction
- Increased staff satisfaction in long-term care homes
- Reduced adverse events (e.g. incidents related to behavioural issues; falls; medication errors)
- Access:
  - Improved coordination of service delivery across the continuum
  - Improved access to mental health and addictions expertise for residents in long-term care homes
  - Improved access to specialized geriatric expertise for residents in long-term care homes
  - Improved access to chronic disease expertise for residents in long-term care homes
  - Increased use of nurse practitioners in long-term care homes
  - Improve collaboration with dedicated pharmacists as team members
- Efficiency:
  - Reduced transfers from long-term care homes to hospital emergency departments
- System/Process:
  - Increased service provider partnerships
  - Increased use of evidence-based care maps
  - Increased use of mobile services
  - Establishment of convalescent care program including repatriation agreements between hospitals and long-term care homes

### **Performance Indicators**

- Size and type of wait list for LTC filtered by population
- ALC days designated as awaiting LTC home placement
- Inappropriate admissions to hospitals from LTC homes
- Others as appropriate to be determined by Detailed Planning and Action Team

## **Action Plan #3**

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### **Build on the End-of-Life Strategy to develop a comprehensive approach for Palliative Care.**

#### **Description**

As part of the continuum of care, an integrated approach to palliative care is imperative, to ensure patient choice and integrity to the end. “End of life” care is a provincial priority and a strategy is in place to increase focus and investment in this area. Mississauga Halton is well positioned to move forward quickly with the development of enhanced palliative care teams because there are a number of resources upon which to build including: an active Halton Peel Palliative Care Network, several hospices (both community-based and free-standing), a Regional Cancer Centre at Credit Valley Hospital and palliative care expertise in hospitals, CCACs and home care agencies.

Although this integration opportunity is positioned within the Seniors priority area, the palliative care needs of all lifecycle population groups (e.g. children, younger adults) will be recognized in the design and delivery of this service.

This initiative will build on the community’s recommendation set out in the Integration Priority Report as follows:

- Based on the Canadian Hospice Palliative Care Model to Guide Care (CHPCA) and the MOHLTC End of Life Strategy, the idea is to develop local multidisciplinary palliative care teams.
- Recognizing that teamwork is the cornerstone of hospice palliative care; it is essential in ensuring excellence in the provision of care.
- Currently, this important component of hospice palliative care is not available to all patients and their families.
- Team composition will vary depending on the disciplines available in any given geographical area or setting of care, but the patient and family/caregiver(s) are a vital part of the team and should be involved in all decisions about care.

#### Scope of Services

These Teams;

- Provide specialized support and expertise to primary care providers including family physicians
- Include care for any illness/disease
- Provide care from diagnosis to bereavement
- Provide support 24/7

### Processes/Systems

These Teams;

- Assess whether the patient's and family's needs are being met and alter the plan of care when necessary
- Develop comprehensive care plans that determine what services and supports are required based on patient/family need
- Hold team meetings regularly to monitor ongoing patient/family needs
- Maintain a central database of patients within a defined geographic area
- Allow for equal access to services outside patient's home e.g. day hospice, outpatient palliative care clinics

### Linkages

These Teams;

- Would be part of the local service delivery model and require support from an end-of-life network that builds both service delivery and system capacity
- Vertically integrated across care settings; own home-hospital-LTC-residential hospice, etc.
- Multidisciplinary including; physicians, hospice, community and hospital nurses, psycho/social/spiritual care, occupational therapy, physiotherapy, pharmacy, bereavement support, personal support worker, community health organizations, patient/family
- Improve linkages between disease management (oncology, cardiology, neurology, respirology) and palliative care

The objectives are to increase coordination and timely access to palliative care services for patients and families to provide opportunities for collaboration and consultation and a forum for problem solving and increased flexibility of the health team allowing a quicker response to patient/family needs.

## **Deliverables – Years one to three**

### **Year 1 Deliverables:**

#### **Integrate Etobicoke service providers into the Halton Peel Palliative Care Network**

- The Halton Peel Palliative Care Network has a long history in the LHIN and has the potential show leadership in coordination.
- To be truly representative of the LHIN and ensure legitimacy, network membership will need to be realigned with LHIN boundaries and incorporate providers from south Etobicoke.
- Consider including non-provider representation on the Network and/or a

mechanism for gathering non-provider input as required.

- Develop a full inventory of palliative care resources in the LHIN for the education of providers and as a foundation for developing strategies for integration.
- Understand the challenges of movement across the LHIN for providers and patients.

#### **Develop work plan and establish priorities**

- Identify the steps and timelines required to develop a comprehensive palliative care approach for the LHIN including the enhancement of integrated, multidisciplinary palliative care teams.
- Establish criteria for setting priorities.
- Identify priorities and timing for addressing specific activities and initiatives.
- Consider the role of psycho-social-spiritual within the continuum in support of palliative care and other appropriate applications across the continuum.

#### **Initiate implementation of strategies for a comprehensive palliative care approach and enhanced palliative care teams**

- Appoint leads for implementation of LHIN-wide resource enhancements, for example:
  - Development of a care pathway for palliative care or input into care pathways being developed for chronic diseases
  - Increase palliative care teams across the LHINs geography
  - Standardize eligibility criteria and intake processes for hospices and other resources
  - Recommend uses for new funding
  - Develop performance measures to assess the impact of enhancement strategies (include definition of end of life, standard approaches to measurement, common instruments to measure client/family satisfaction etc)
- Monitor and evaluate the success of the enhancements and make course corrections as required

**Year 2 Deliverables:****Continue implementation of strategies for a comprehensive palliative care approach and enhanced palliative care teams**

- Monitor and evaluate the success of the enhancements and make course corrections as required.

**Develop and implement an educational strategy for service providers**

- Oversee the rollout of a LHIN-wide strategy to educate service providers about the comprehensive approach to palliative care and enhancements to palliative care teams
- The educational strategy will have components targeted to palliative care providers and to other providers who may interface with palliative care providers

**Develop and implement an educational strategy for clients, families and the public at large**

- Oversee the rollout of a LHIN-wide strategy to educate clients, families and the public about the LHIN-wide comprehensive, integrated palliative care approach with emphasis on what services are available and how they can be accessed

**Year 3 Deliverables:****Continue monitoring and evaluating the success of the enhancements and make course corrections as required****Outcomes**

- Quality:
  - Increased client/family satisfaction
  - Number of family members receiving educational resources
- Access:
  - Improved coordination of service delivery across the continuum
  - Increased proportion of clients who die in the setting of their choice
  - Increased access to physicians and other health professionals for palliative care in the home
  - Increased outreach capacity
- Efficiency:
  - Reduce ALC days related to palliative clients
- System/Process:
  - Increased service provider partnerships
  - Number of service providers participating in educational events

### **Performance Indicators**

- Palliative Performance Scores from the Edmonton Symptom Assessment Scale ("ESAS")
- Utilization of hospitals for palliative care in relation to the wishes of the family
- Others as appropriate to be determined by Detailed Planning and Action Team