Mississauga Halton
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Mississauga Halton

AGING AT HOME STRATEGY

Directional Plan – October 31, 2007

Ontario

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1. Introduction: The Aging at Home Strategy

The **Aging at Home Strategy** is a three year, $702 Million provincial strategy, developed by the Ministry of Health and Long-Term Care and launched by Minister George Smitherman in August, 2007. It is aimed at providing seniors and their families and caregivers with an integrated continuum of community-based services to enable them to stay healthy and live more independently in their homes.

The Ministry has identified four goals which include:

1. ***Ensuring that seniors' homes support them*** – includes increasing residential options such as supportive housing and long-term care homes, as well as access to mobility devices for use in the home and improving safety in homes to prevent injury.

2. ***Creating supportive social environments*** – includes proactive strategies to reduce or eliminate social isolation for both seniors and their caregivers, like adult day centres, supportive housing, caregiver relief and respite, and friendly home calling and visits.

3. ***Providing senior-centered care that is easy to access*** – includes coordinating access to a flexible continuum of services and supports across sectors, improved care coordination, improving transportation services, and augmenting specialized geriatric services (i.e. exploring opportunities to augment or partner with Family Health Teams (FHTs) and Community Health Centres (CHCs) in the provision of preventative, maintenance and restorative services/programs).

4. ***Identifying innovative solutions to keep seniors healthy*** – includes a minimum of 20% of funding earmarked for innovative approaches to deliver prevention and wellness strategies, partnerships with non-traditional providers that allow and recognize 'informal services', new services that include preventative and wellness philosophies, and approaches that take advantage of like groups and individuals to deliver informal care such as friendly home visits, telephone calling and transportation to appointments.

Provincial guiding principles for the strategy are as follows:

- ***Senior-centered*** - the design and delivery of services should respond to the needs of seniors.
- ***Community-based and integrated*** - services should be community-based and integrated within the broader health care system.
- ***Equitable*** - demographic and geographic challenges must be considered to reach a goal of equitable access to services.
- ***Cost-effective*** - the best care at optimal cost, recognizing benefits of volunteerism, can contribute to cost-effective and sustainable services.
- ***Results-oriented*** - with those results being defined and measured.

- ***Local community oriented*** - services can build on capacity in local neighbourhoods and within communities of common ethno-cultural, linguistic, religious and sexual orientation.

The strategy aims to keep seniors healthy through traditional services combined with innovative practices by providing a comprehensive mix of services for seniors and their caregivers. The new funding is targeted to 2 main areas:

A. Increase the overall supply (range and quantity) of services (e.g., capacity building) (represents up to 80% of LHIN allocation) for seniors to stay healthy and live with independence and dignity in their homes with Aging at Home services, *such as:*

- Community support services
- Home care
- Assistive devices
- Supportive living
- Long-term care beds
- End-of-life care

B. Leverage change through innovation (represents 20% or more of LHIN allocation over three years) for example:

- Innovative approaches to keeping seniors healthy, through preventive and wellness services and partnerships with non-traditional providers;
- Community economic development approaches for service delivery that will increase access and equity for marginalized and at risk seniors and engage people from communities (e.g. cultural, linguistic) who can identify and connect with service providers and build capacity for helping each other; and
- Linkages to primary care such as community health centres and family health teams.

1.1 Aging at Home and the Role of Local Health Integration Networks

Consistent with their role as the local health system manager, LHINs have been asked to manage the local process for determining priorities and to fund and monitor implementation of local initiatives related to the Aging at Home Strategy.

All LHINS have been asked to prepare 2 submissions:

- A high level directional plan (October 31 2007)
- A detailed service plan for funding (January 31, 2008)

This document is intended to give a high-level overview of the draft 2008/2009 directions that the Mississauga Halton LHIN is proposing for their Aging at Home strategy. It also outlines initiatives that will begin in 2008/09 to help inform subsequent allocations.

2 Mississauga Halton LHIN: Developing the Aging at Home Strategy

2.1 Aging at Home Funding Allocation to the Mississauga Halton LHIN

For Mississauga Halton LHIN, the Aging at Home strategy represents a significant financial investment and a real opportunity to advance the *Integrated Health Service Plan* goals within the Seniors' Health, Wellness and Quality of Life priority. Advancing these goals will provide seniors the support they need to achieve greater independence and better health so they can remain in their own communities, close to friends and loved ones.

Individual LHIN allocations for the Aging at Home Strategy were based on a new Health Based Allocation funding model.

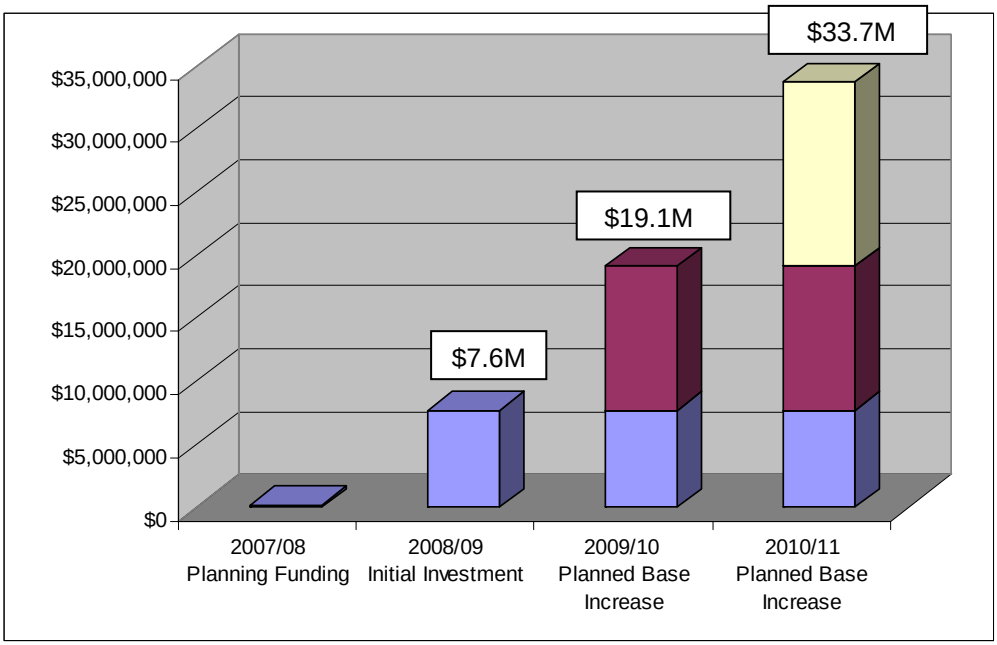


Figure 1: Aging at Home Funding Allocation – Mississauga Halton LHIN

2.2 The Planning Framework for the Directional Plan

Within Mississauga Halton LHIN there has been significant community consultation and planning in the development of the Integrated Health Service Plan (IHSP) and the Annual Service Plan. These two key documents have a significant focus on improving seniors health, wellness and quality of life and as a result have formed the basis of the directional submission related to the Aging at Home Strategy. Flowing out of these two documents is additional planning work ongoing through

Detailed Planning and Action Teams as well as the Appropriate Level of Care Committee. The work going on in these planning bodies has also been used to help inform the directional priorities outlined in this plan. Once the directional plan has been completed we will use existing forums and networks to test the directional priorities and begin the process of identifying specifically which health services providers will receive funding to advance the identified priorities.

2.2.1 The Integrated Health Service Plan

The Mississauga Halton LHIN's *Integrated Health Services Plan (IHSP)* was developed through engagement and consultation with our local communities, health services providers and key health partners, and through analysis of supporting population health and health planning data.

As depicted in Figure 2 below, the Mississauga Halton LHIN has identified five integration priorities along with six enabling strategies which are fundamental to integrating and transforming heath care services locally. These priorities are interdependent and address community issues and needs.

The IHSP priorities are:

- Improving Health System Performance
- Preventing and Managing Long-lasting (Chronic) Conditions
- Enhancing Senior's Health, Wellness and Quality of Life
- Strengthening Primary Healthcare
- Integrating Mental Health and Addiction Services

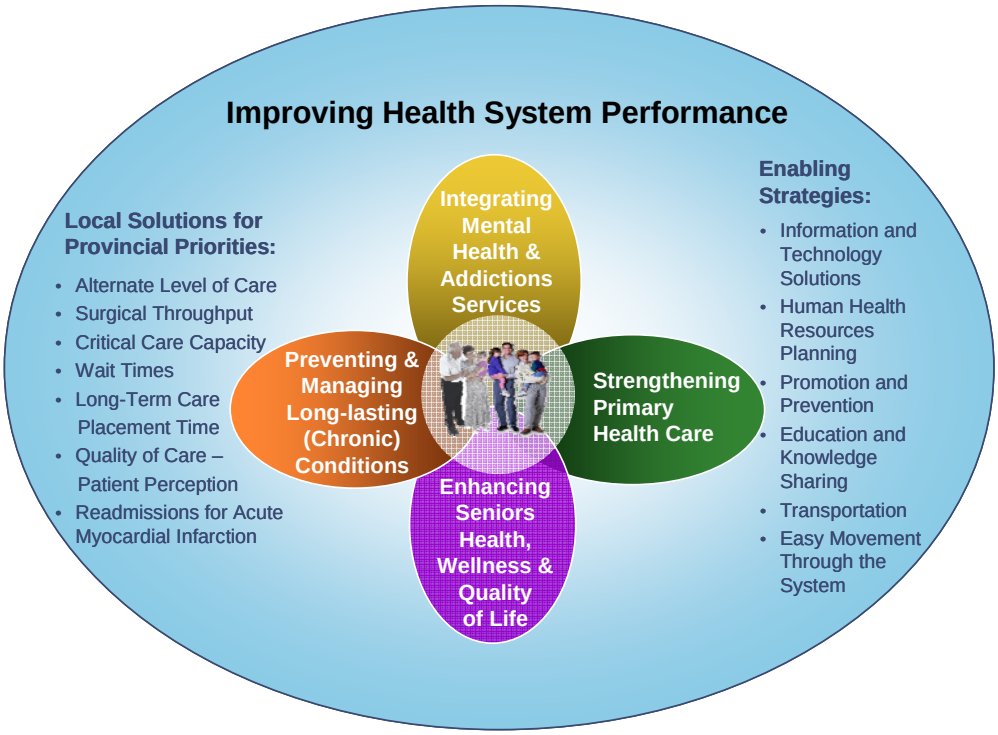


Figure 2: Integrated Health Service Plan Priorities and Enabling Strategies

2.2.2 The Annual Service Plan

In August 2007, The Mississauga Halton LHIN submitted its first Annual Service Plan (ASP). The ASP outlines the Mississauga Halton LHIN's funding priorities to advance the IHSP and addresses pressures and opportunities within the local health system. The ASP explains how the Mississauga Halton LHIN will achieve its priorities for change. It includes projects that will see health service providers across Mississauga Halton working together to build an integrated, efficient, effective and sustainable health system. Many of the projects address the health, wellness and quality of life needs of seniors by building on service strengths, addressing service gaps and system integration problems, such as moving patients out of hospitals and into their homes, when they no longer need acute care, and bringing in needed services, so they can recuperate in the most appropriate setting.

2.2.3 The Appropriate Level of Care Steering Committee

To address the growing number of individuals who are occupying acute care beds while waiting for care in the community, the Appropriate Level of Care Committee was established to achieve the following objectives:

- To maximize the available acute care capacity and system flow by developing and implementing system-wide best practices and innovative strategies and solutions.
- To ensure that patients no longer requiring care in the hospital setting are transitioned quickly and compassionately to the most appropriate level of care based on their individual needs.
- To improve the overall patient and family experience with the placement and transition process.

The Mississauga Halton LHIN, in partnership with the three local hospitals, the Mississauga Halton Community Care Access Centre (CCAC), Long-Term Care (LTC) Homes and the community support services sector have expressed their shared commitment to improve patient/client flow through better system navigation and care coordination.

3 Mississauga Halton LHIN: The Directional Plan

3.1 Overall Goals

The Aging at Home strategic goals that are in addition to those outlined in the IHSP and by the MOHLTC herein include:

- Ensuring culturally competent programs and services.
- Leveraging and maximizing existing services and capacity across the continuum.
- Creating a comprehensive and integrated approach to seniors' services across the continuum.
- Supporting the ongoing strategic and detailed planning for seniors services.
- Ensuring seniors will have access to services in the most appropriate place.

3.2 Overall Performance Measures

The Aging at Home strategy will drive many benefits for seniors that will be captured within the specific initiatives, however the key performance indicators at a macro level include:

- Reduction in ALC days
- Reduction in Wait List for LTC
- Reduction in rate of institutionalization
- Increase in number of services being provided to seniors.

Note: All performance measures based on number of patients will be age-adjusted.

3.3 Overview of the Aging At Home Strategy

The approach to this plan will consider two types of investments – Innovation and Capacity Building, the later of which is further categorized into Expansion and Productivity Improvement and Maintenance initiatives.

Capacity Building Investments:

- *Expansion & Productivity Improvement:*
  - Increase Community Support Services
  - Enhance Supportive Housing
  - Implement a LHIN-wide Falls Prevention Strategy
  - Expand Geriatric Mental Health Outreach
  - Support Residents of LTC through Nurse Practitioner Model
  - Expand Geriatric Emergency Management
  - Enhance Community Grants to Support Seniors
  - Develop the Frail Seniors Pathway/Assessment Tool
  - Improve and Enhance Access to Palliative Care/End of Life Care
  - Enhance Community Referral by EMS

- *Maintenance:*
  - Sustain Current Services of Community Support Services Agencies

Innovation Investments:

- All-Inclusive Seamless Services for Independence of Seniors for Today and Tomorrow (ASSIST) Model

3.4 Specific Priorities, Objectives and Performance Measures

Capacity Building: Expansion & Productivity Improvement

3.4.1 Increase Community Support Services

To successfully age at home, some seniors require support services within the home as well as in the community. To better meet the needs and the cultural diversity of the growing number of seniors, the LHIN will need to expand community services with the CCAC, supportive housing and community support services. Community services included in this initiative are:

- **Adult Day Programs**
  When seniors age at home there is increased risk that these individuals will then suffer from isolation and loneliness. In addition, caring for a senior who has functional and/or cognitive impairments can result in family and caregiver burn-out.

  The goal of this initiative is to work with Health Service Providers (HSPs) to increase capacity of adult day programs as suggested by wait lists and unmet needs, specifically to meet the needs of cultural diverse and cognitively impaired populations.

  Objectives:
  - To increase capacity of adult day programs.
  - To promote social interaction and involvement.
  - To allow seniors to live at home as long as possible (e.g., prevent or delay the need for institutionalization).
  - To help maintain the health and well-being of seniors.
  - To provide respite for families and caregivers.

- **Respite**
  The ability of a senior with functional and/or cognitive impairments to continue to age at home often depends on the ability of families and caregivers to provide care and support. However, providing care for a senior with complex needs can take a physical, mental and emotional toll on families and caregivers.

  Currently, within Mississauga Halton, in-home respite is limited and unplanned respite lacks consistency of delivery.

The goal of this initiative is to work with HSPs to increase the capacity of and improve equitable access to in-home respite.

Objectives:

- To increase the capacity for the provision of in-home respite services as a way of preventing the primary care giver from becoming ill and unable to care for their loved one.
- To increase the ability of seniors with functional or cognitive impairments to age at home.

o **Meals**

As individuals' age, daily tasks of living such as meal preparation become increasingly more difficult and may act as a barrier to aging at home.

The goal of this initiative is to work with HSPs to increase the provision of nutritious, culturally-appropriate foods for seniors.

Objectives:

- To increase capacity of the meal services across the LHIN.
- To help seniors maintain independence in their home longer, thereby increasing their quality of life.

o **Transportation**

For many seniors transportation is a challenge and as a result accessing medical appointments and health and wellness programs proactively is sometimes not a possibility. If transportation for such activities were more accessible, seniors may be able to prevent some of the crisis situations.

The goal of this initiative is to work with HSPs to maximize the utilization of existing transportation capital across the LHIN and to provide more services to seniors' to support them attending medical appointments and health and wellness programming.

Objectives:

- To maximize the utilization of existing transportation capital across the LHIN to provide more service to seniors for attendance at health appointments and programming.
- To work with current HSPs to propose how this increased capacity can be implemented.
- To improve access to services for seniors.

o **Personal support / homemaking**

Part of any aging at home strategy will require greater capacity to provide personal support and homemaking services within the homes of qualified seniors to remain in their homes as long as possible. Additional services may be required to support transfers from a hospital setting to the home

and the necessary provisions must be in place to allow these enhancements to be provided.

The goal of this initiative is to work with HSPs to increase the capacity of personal support and homemaking services.

Objectives:

- To increase capacity of personal support and homemaking services as suggested by wait lists, enhanced service requirements for some seniors, to transition from acute care to community setting, and unmet needs.

Performance Measures*:*

- Increased number of seniors accessing services in the community and at home.

3.4.2 Enhance Supportive Housing

a) **Expanding the number of supportive housing units and outreach.**

The Mississauga Halton LHIN will experience a large percentage increase in the seniors' population over the next 3 years and beyond. This increase combined with that of the 85 years of age and older population will put tremendous pressure on our hospitals, LTC facilities and community services. Additional investments across sectors including supportive housing in the right quantity for use by those who have the appropriate level of need is a necessity that we need to build for now in anticipation of the need that will arise as our population ages.

The goal of this initiative is to increase the capacity of supportive housing and related outreach services to assist the frail elderly in maintaining their independence and providing an alternative to institutional care.

Objectives:

- To ensure patients/clients/residents are receiving care in the most appropriate setting across the continuum.
- To increase the number of units that are funded.
- To reduce the demand for LTC beds and to provide more timely access for individuals who need this level of care.
- To reduce ALC patient days and acute care pressures.

Performance Measures*:*

- An increase in the number of units funded.

b) **Development of common wait list and common assessment tool**

Currently, within Mississauga Halton, the supportive housing agencies utilize different tools to assess individuals, as well all agencies maintain their own wait lists.

The goal of this initiative is to identify and implement a common assessment tool, and develop a centralized wait list across the LHIN to ensure the most appropriate individuals are placed.

Objectives:

- To establish a common framework with appropriate definitions for Supportive Housing which include a model common language, assumptions, appropriate admission criteria, etc.
- To develop a standardized assessment tool for implementation across the LHIN.
- To identify requirements for the development of a centralized registry for the Mississauga Halton LHIN.
- To identify training implications, and recommend methods to implement training across providers.

Performance Measures*:*

- Central Registry developed
- Standardized assessment tool implemented
- Increased number of appropriate seniors accessing supportive housing units

3.4.3 Implement a LHIN-wide Falls Prevention Strategy

Injury due to falls is a significant issue for seniors. Falls and falls-related injury often leads to ongoing functional problems for patients; over 60% of seniors who fall do not return to their previous functional levels. Falls and falls-related injuries and complications are also the leading cause of death in older adults in Canada. Additionally, the population of Mississauga Halton is aging. As the population ages, the number of people in the region at risk of falls will increase as well. A proportion of patients hospitalized after a fall never return home but move onto a Long-Term Care (LTC) Home bed. Forty percent of admissions to LTC are falls-related.

Seniors' falls prevention and management is a LHIN-wide initiative, providing a significant opportunity to maintain the well-being, quality of life and independence of individuals and the people who care for them while decreasing the demand for more costly hospital and institutional care. This was also identified as an area that needed to be addressed early on during the development of the seniors' health, wellness and quality of life integration priority and specifically the development of the ASSIST (All-inclusive Seamless Services for Independence for Today and Tomorrow) model.

Currently, a comprehensive, client-focused, evidenced-based, LHIN-wide falls prevention strategy is being developed. The next phase will be the implementation of the strategy.

Objectives:

- To reduce falls and falls-related injuries in older adults.
- To decrease falls in elderly individuals and decrease fall-related visits to the Emergency Department.

- To decrease falls-related hospital admissions.
- To decrease LTC admissions.

Performance Measures and Outcomes*:*

A variety of tools will be used to evaluate outcomes of this project:

- Agency and staff feedback.
- Client and community feedback.
- Evidence of compliance across agencies with best practices.

The following indicators will be tracked (pre and post):

- Number of clients reached
- Number of new linkages between programs
- Number of visits to ER for falls related injuries
- Number of falls-related admissions to hospitals and LOS
- Number of falls experienced by patients receiving information/education/support form various components of regional falls programs
- Severity of falls experienced by participants in programs, as determined by injury, visit to ER/doctor
- Cost savings achieved through shifting of resources

3.4.4 Expand Geriatric Mental Health Outreach

Individuals who suffer from cognitive impairments and/or behavioral disorders can be difficult to manage at home. This can prevent individuals from aging at home i.e. can result in premature institutionalization. It can also prevent or delay patients from being discharged home from acute care.

The goal of this initiative is to work with HSPs to expand and improve access to geriatric mental health outreach services across Mississauga Halton.

Objectives:

- To expand and improve access to geriatric mental health outreach services as suggested by wait lists and unmet needs.
- To increase the ability of seniors with severe mental illnesses and/or behavioral disorders to remain at home.
- To support families / caregivers and LTC homes in managing individuals with cognitive impairments and/or behavioral disorders.

Performance Measures:

- Decreased acute readmissions (Caplan, 2004, Hogan, 1990; Thomas, 1993)
- Reduced rate of emergency department admission (Caplan, 2004; Gagnon, 1999)
- Decreased length of stay (Gustafason 1991, Lipski, 1996; Nikolaus, 1999)

3.4.5 Support Residents of LTC through Nurse Practitioner Model

In an effort to positively impact the quality of care for residents and reduce / prevent the need for transfers to emergency departments, Long-Term Care (LTC) Rapid Response Teams (RRTs) were established through funding from the Emergency Department Support Fund. Exploring the use of nurse practitioners in LTC homes is also identified as a key strategy within the seniors health, wellness and quality of life integration priority to help enhance resources in LTC homes.

Rapid Response Teams are comprised of an inter-disciplinary group of LTC home staff, physicians, a primary care nurse practitioner (NP) extended class designation and Community Care Access Centre (CCAC) case managers. To support the addition of a NP on the RRT, we will provide support for:
(1) Base budget for pilot.
(2) Sustain and expand the program within Mississauga Halton.

Objectives*:*
Establish Rapid Response Team to support LTC homes in the ongoing management of residents who have an injury or illness in order to positively impact the quality of care for residents and prevent transfers to Emergency Departments (EDs). Each response team will work collaboratively to support LTC homes with the ongoing management of residents who have sudden or semi-urgent injuries or illness. The aim of this initiative is:

- To support the resident to receive care within their home setting rather than in a hospital;
- To reduce the number of unnecessary transfers of residents from LTC to EDs;
- To reduce the number of acute care admissions by performing certain interventions within the LTC home that normally required hospitalization;
- To increase the opportunities for education and monitoring within LTC homes; and
- To facilitate earlier discharge back to LTC from the hospital as a result of enhanced skills within the LTC setting.

Performance Measures*:*
Metrics to be used include:

- Numbers of patients seen by Nurse Practitioners.
- Numbers of times collaboration between CCAC and Nurse Practitioner occurs.
- Numbers of patients transferred to the ED from LTC Homes (both pre- and post implementation).
- Numbers of patients from LTC Homes seen in EDs and discharged back to LTC Homes.
- Numbers of patients admitted to the hospital from LTC Homes.
- Average hospital length of stay for LTC Home residents.
- Numbers of residents identified where an ED visit or hospital admission was avoided.

Evaluation through family and residents satisfaction surveys and through focused audits will be conducted by NPs. The Medical Directors of the LTC Homes will be interviewed quarterly through the pilot project for their input.

A goal of a reduction of 10-15% of the number of patients arriving in EDs from 2005/06 year to 2007/08 will be targeted.

3.4.6 Expand Geriatric Emergency Management

Geriatric Emergency Management (GEM) is consultation by a specialized geriatric health professional in the emergency department providing assessment, diagnosis, identification of "at risk" elderly, initiating appropriate treatment, and networking with community and primary care.

GEM is most effective in concert with other special programs for older adults at risk, including care coordination, home care, sub-acute units, geriatric hospital units, advance directives, and well organized, guideline driven primary care.

Objectives:
Develop or expand the GEM nurse role within EDs at each hospital to:

- Provide appropriate assessments and pertinent clinical decision making in the identification of acute symptoms, underlying health conditions, physical, functional, emotional and cognitive status, home environment issues and required home supports for the frail elderly.
- In collaboration with others, develop innovative, goal-oriented patient-centered care plans.
- Provide ongoing support and leadership to the emergency department staff in developing elder-friendly emergency health care environments.
- Assists in the development of standardized protocols to screen and refer the high risk elderly in the emergency department.

Performance Measures*:*

- Decreased acute readmissions (Caplan, 2004, Hogan, 1990; Thomas, 1993)
- Reduced rate of emergency department admission (Caplan, 2004; Gagnon, 1999)
- Decreased length of stay (Gustafason 1991, Lipski, 1996; Nikolaus, 1999)

3.4.7 Enhance Community Grants to Support Seniors

Mississauga Halton Local Health Integration Network (LHIN) is home to approximately 215,000 adults over the age of 55 and is the fastest growing LHIN region in the province for this age group. In the next decade the number of older adults will increase 48% to over 317,000. As individuals' age, daily tasks of living (e.g., yard work, snow shoveling, home maintenance) become increasingly more difficult. These individuals' often do not require medical support, however, they do require assistance to remain at home and maintain independence.

The aim of this initiative is to support the delivery of non-medical services to seniors' who require assistance (means test for determining appropriateness for services) with daily tasks of living to remain independent and at home. This may include non-traditional partnerships and building capacity of community members to help each other (e.g. high school volunteers, seniors helping other seniors).

Objectives:

- To help seniors' maintain independence in their home longer, thereby increasing the quality of life.
- To build community capacity ("help each other").

Performance Measures:

- Number of seniors who want to stay at home having the ability to do so.
- Number of seniors taking advantage of this grant.

3.4.8 Develop the Frail Seniors Pathway / Assessment Tool

The goal of this initiative is to identify and implement a frail seniors' assessment tool and pathway to improve the management of seniors within the hospital setting and to help seniors return home after their acute episode.

Objectives*:*

- To improve quality, efficiency, coordination and integration of services for frail seniors admitted to acute care.
- To help seniors return home.

Performance Measures:

- TBD

3.4.9 Improve and Enhance Access to Palliative Care / EOL Care

As part of the continuum of care, an integrated approach to palliative care is imperative, to ensure patient choice and integrity to the end.

The goal of this initiative is build capacity and expand palliative care/EOL services across Mississauga Halton.

Objectives:

- Increase coordination and timely access to palliative care services for patients and their families.
- Increase flexibility of the health team to provide quick response to patient/family needs.

Performance Measures:

- Improve access to end of life services.
- Improve knowledge of resources.
- Improve access to hospice.
- Support sub-LHIN areas without access.

3.4.10 Enhance Community Referral by EMS

Paramedics often respond to calls for assistance and transportation of patients whose underlying problems have worsened or who are having an acute crisis creating the need for treatment and transport to an emergency department.

Paramedics are responding to treat the immediate need of the patient and often the underlying cause of the problem goes unchanged.

The Community Referrals by Emergency Medical Services (CREMS) was designed by Toronto EMS to help identify and respond to the underlying cause of the problem. The Halton Peel Emergency Services Network (HPESN) recognized the benefits of such a program and secured funding through Ministry of Health and Long-Term Care initiatives to initiate a similar program within Halton-Peel.

CREMS is a collaborative referral program for paramedics from Peel Regional Paramedic Services, Halton Regional EMS and Dufferin County Ambulance Services designed to give paramedics the ability to affect positive change in the lives of patients, their families, and caregivers by addressing the underlying problems or having greater assistance provided to patients by allied agencies. Paramedics refer patients they identify to the Community Care Access Centres through CREMS for information and linkage to community resources and/or assessment for in-home services.

The goal is to implement a formal referral program for frequent 911 users from the paramedics to the Community Care Access Centres within Mississauga Halton. The CCAC will close the loop back to the EMS with a summary of action taken.

Objectives*:*

- To help individuals maintain independence in their home longer, thereby increasing the quality of life.
- To facilitate access to and increase the level of in-home care received by the patient.
- To better manage chronic disease conditions and social and emotional need.
- To utilize EMS as one-point of contact to identify patients who are frequent users of 911 and make referral to CCAC for assessment.
- To alleviate the strain repeat patients place on emergency services.
- To give paramedics the ability to affect positive change in the lives of patients, their families and caregivers by addressing the underlying problems or having greater assistance provided to patients by allied agencies.
- To decrease reliance on 911.
- To reduce the need for emergency and acute care services.
- To achieve better management of chronic disease conditions and social and emotional needs, assisting in reducing wait times in the Emergency Department.

Performance Measures*:*

Performance measures to monitor the program and identify ongoing opportunities for improvement:

- Number of referrals from paramedics to the CCAC will be compared to the number of known appropriate clients who frequently call for an ambulance.

- Number of clients who refuse a referral to the CCAC.
- Number of calls for an ambulance by patients who historically had high use of the ambulance services pre and post-referral to the CCAC.
- The types of referrals to the CCAC.
- Length of time to assessment from point of referral.
- Paramedic and patient satisfaction with the program.

Capacity Building: Maintenance

3.4.11 Sustain Current Services of Community Support Service Agencies

As seniors age the need for home care also rises. According to statistics, the proportion of seniors receiving home care increases from 8% among those aged 65 to 74 to 42% among those ages 85+.

As the population of Mississauga Halton ages, the need for community support services will continue to grow.

In addition, currently many of the community support service providers are at risk of reducing service levels without additional funding support.

Objectives:

- Ensure current service levels are maintained across CSS agencies.

Performance Measures*:*

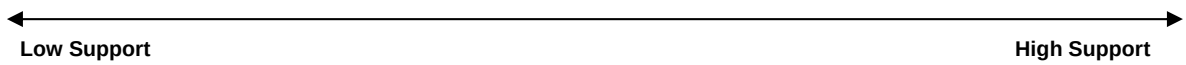
- Current services are retained.
- Staffing is stabilized.

Innovation:

3.4.12 Detailed Design for the ASSIST Model

a) **Basket of Services Design** – local, geographic area and regional programming

A continuum of services is required to respond to the range and complexity of seniors' needs. Services are required with varying levels of support provided and in various settings (e.g. in-home, community-based, or institutional). The diagram below reflects a typical health services continuum for older adults.



Community Agencies	Community Support Service Agencies	Community Care Access Centres	Supportive Housing	Long-Term Care Facilities	Hospitals
• Social and recreation • Wellness • Public health programs (e.g., falls prevention) • Primary health care (e.g., family physicians)	• Meal programs • Transportation • Adult Day programs • Security & safety • Client intervention • Caregiver support & education • Home help/ homemaking • Friendly visiting • Special needs (vision/hearing) • Home maintenance & repair	• Personal support and homemaking • Nursing • Social Work • Occupational Therapy, Physiotherapy, Speech/ Language pathology • Diabetic therapy • Information & Referral • Placement Coordination	• Personal support & homemaking + 24 hour access • Seniors		• Acute Care • Complex Continuing Care (chronic care) • Rehabilitation • Psychiatric
Independent Living	**Assistance + support with activities of daily living**	**Assistance with activities of daily living + professional care**	**Assistance + access to 24 hour care and support**	**24 hour care + assistance with activities of daily living**	**24 hour care + medical/ professional care**

Home Care **Institutional Care**

(Adapted from the Toronto District Health Council)

The scope of services for seniors in Mississauga Halton will mirror this continuum and be driven by the needs of the target population. The aim will be to have service availability that is 24/7, 365 days per year. There will be a broad range of services (from preventative to specialized treatment) and venues (from home to community to various types of institutions).

Objectives:

- Develop the basket of services at the local, geographic area and regional level.
- Develop the implementation plan for roll-out across the LHIN.

b) Care Coordination for Seniors

The care coordination approach includes the full interdisciplinary team, primary care physician, the patient and their circle of support. The care coordinator moves with the patient across the entire continuum. Care coordinators 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 and seamless service delivery.

Care coordination is a key aspect of the model and reflects a global trend towards increased acknowledgement of the need to support clients/patients in navigating the health system.

Objectives:

- Develop care coordination that supports the ASSIST model and enables effective and efficient system navigation for the frail seniors.
- Develop the implementation plan for the care coordination role within the LHIN.

c) Integrated Common Assessment Tool

ASSIST will incorporate a common assessment approach that is available to the interdisciplinary team and provides for:

- Standardized, graduated and automated (part of the electronic health record) assessment tools;
- Support for continuous reassessment once in the system;
- Automated triggers that flag individuals for appropriate next steps based on clinical pathways;
- Mechanisms for involving the patient and their circle of support; and
- Flexibility to enable assessments to be done in the home or an appropriate facility.

Objectives:

- Develop the common assessment tool that supports the ASSIST model.
- Develop the implementation plan for roll-out within the LHIN.

d) Points of Entry/Access

The model will facilitate entry from multiple points along the continuum that all ensure access to the necessary services. Public awareness of how to enter the system will be promoted using a number of mechanisms including a widely distributed and marketed telephone number. A consumer will only need to enter the system once.

The model will leverage the important role that primary health care providers play as the first point of contact with the health system. In the proposed model, primary health care providers will take a proactive approach to identifying the target population. For example, Family Health Teams are implementing clinical management systems that will have the capacity to provide electronic alerts/reminders of specific patient triggers (e.g. time for a diagnostic test or annual exam). To support the promotion and prevention focus of the model, by using these systems primary health care providers can be alerted when a patient turns 55. This event would trigger an appointment for an annual examination, a very brief assessment of need using a standardized tool and provision of

information to the patient about the range of services available through the integrated delivery model.

Objectives:

- Develop the access approach for ASSIST model.
- Develop the implementation plan for roll-out across the LHIN.

e) Linkages to and Fit within the Continuum

Review the model to ensure integration and linkage with both the ongoing care systems and other specialty services. The close and continued involvement of the client/patient's primary care physician and care coordinator is essential to the provision of services across the continuum.

Objectives:

- Review the linkages and fit of all services across the continuum for the ASSIST model to ensure integration and seamless navigation.
- Develop any recommendations for refinement.

f) Information Requirements and Flow

Review the model to ensure it incorporates a single shared database that builds on the electronic health record and common assessment tool, including:

- Common dataset
- Web enabled
- Information can be modified and is accessible to all members of the interdisciplinary team at all times
- Must align with privacy legislation requirements
- Enhanced videoconferencing capability to facilitate shared educational opportunities and effective deployment of scarce resources such as geriatric specialists.

Objectives:

- Review the linkages and fit of all services across the continuum for the ASSIST model to ensure integration and seamless navigation.
- Develop any recommendations for refinement.

Performance Measures for ASSIST*:*

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.

4 Workplan

The following work plan details the activities to be accomplished over the next 12 months and provides high level direction to 2010.

Capacity Building Investments: Expansion and Productivity Improvement

Initiative	Actions	Most Accountable	Start Date	Finish Date
Community Engagement for the Aging at Home Strategy	Develop the plans to engage HSPs, other providers as needed and the public to provide information and solicit feedback.	LHIN and other HSPs as appropriate	CE will be completed as required to inform the detailed design for each of the initiatives.	
Increase Community Support Services	Call for Proposals	LHIN	Nov. 5	Dec. 3
	Decision Making	LHIN	Dec. 4	Dec. 21
Enhance Supportive Housing	Detailed planning for increasing S.H. units	LHIN/PCA	Nov. 5	Dec. 3
	Develop proposal methodology for C.W.L. and C.A.T.	Supportive Housing Task Force (S.H.T.F.)	Nov. 5	Dec. 3
Implement the LHIN-wide Falls Prevention Strategy	Develop proposal and business case for the Falls Prevention initiatives	Falls Prevention Steering Committee	Nov. 5	Dec. 3
Expand Geriatric Mental Health Outreach	Develop business case for expansion of GMHO services	Seniors Health & Wellness DPA Team Subgroup	Nov. 5	Dec. 3
Support Residents of LTC through Nurse Practitioner Model	Develop an updated business case to continue to implement and evolve the model with expanded service delivery in Mississauga Halton LHIN	N.P. LTC Rapid Response Team Steering Committee (Mississauga Halton LHIN members only)	Nov. 5	Dec. 3
Expand Geriatric Emergency Management (GEM)	Develop a integrated business case for creation or expansion of the GEM role	Hospital VP's responsible for ED	Nov. 5	Dec. 3
Develop the Frail Seniors Pathway/ Assessment Tool	Detailed planning for the development and implementation plan for the Frail Seniors Pathway/Assessment Tool	ALC Steering Committee	Nov. 5	Dec. 14
Improve and Enhance Access to	Develop a business case for expansion of services	Palliative Care DPA Team	Nov. 5	Dec. 3

Palliative Care/End of Life Care				
Enhance Community Referral by EMS (CREMS)	Develop updated business case to sustain the CREMs initiative with feedback mechanism within Mississauga Halton LHIN	Emergency Services Network	Nov. 5	Dec. 3
Enhance Community Grants to Support Seniors	Call for Proposals for an integrated business case for the provision of non-traditional senior services	LHIN	May / 08	Dec. / 08

Capacity Building Investments: Maintenance

Initiative	Actions	Most Accountable	Start Date	Finish Date
Sustain Current Services of Community Support Services Agencies	Costing and clarifying expectations for 2008/09	LHIN	Nov. 5	Dec. 14

Innovation Investments: ASSIST Model

Initiative	Actions	Most Accountable	Start Date	Finish Date
Phase 1: Basket of Services Analysis - Local - Geographic - LHIN-wide (what, where, how much)	- Create a detailed work plan for designing the basket of services - Execute work plan	DPA Team/ALC Steering Committee	Nov. 5	Dec. 1
Phase 2: Has 2 waves of detailed design Wave 1 first and then Wave 2	Detailed Design and Implementation Plan for each service	DPA Team	May 1/08	Dec/08
			Jan./09	Dec./09
Care Coordination	Develop the Detailed Model & Implementation Plan	DPA Team Sub Team	Apr. 1/08	Dec./08
Integrated Common Assessment Tool	Develop the Detailed Model & Implementation Plan	DPA Team Sub Team	Apr. 1/08	Dec./08
Access – Points of	Develop the Detailed Model & Implementation	DPA Team	Apr. 1/08	Dec./08

Entry	Plan	Sub Team		
Linkages to & Fit with the Continuum Analysis	Review the detailed model design to ensure linkages and fit across the continuum	DPA Team	2009	2010
Information Requirements & Flow	Review the detailed model design to ensure that the information flow and requirements are effective and support integration	DPA Team	2009	2010

5 Policy/Legislative Enablers

The following have been identified by the Ministry of Health and Long-term Care as requiring legislative changes:

- A high level overview of applicable legislation, policies and regulations
- Key Acts to be reviewed:
  i. Local Health Systems Integration Act, 2006 (LHSIA)
  ii. Long-Term Care Act, 1994 (LTCA)
  iii. Community Care Access Corporations Act, 2001 (CCACA)
  iv. Elderly Persons Centres Act (EPCA)
  v. Section 13 of Regulation 552 under the Health Insurance Act (HIA)

In addition, the following recommendations regarding government/MOHLTC policy and regulatory changes are being proposed:

Policy/ Regulation	Description
Physiotherapy limitations	If you go to convalescent care, the number of physiotherapy treatments you are allowed are used up. Convalescent care visits should not count against your allotment under Schedule 5. (across the system)
HR Issues	Insurance/liability for staff of one organization working for another
Homemakers and Nursing Services Act	Municipality contributes $200K and the Ministry will contribute $800K – Region of Peel initiative
Respite	Placement policy for Respite
LTC Placement	• Placement in first available (appropriate) bed while waiting for first choice – while desirable, this is not consistent with the existing Regulations – this adds to ALC challenges and results in inappropriate care being provided • Review number of days where beds should be held • LTC home funding formula needs to be reviewed • Reuniting spouses in LTC homes gets a fast track – Category 2 • RAI assessment currently completed by CCAC Case Manager only • LTC homes can't officially decline having a patient on their waitlist but can refuse to take patients for 'care reasons' – individual remains on their Wait List • Real time measure for LTC Home acuity – CMI – need more current and consistent process
Supportive Housing policy	Supportive Housing is apparently only possible in subsidized/social housing – 1994 Policy Manual – being able to provide supportive housing anywhere would greatly increase availability to use this service. In other words, if there is a cluster of seniors in a condo/retirement home/apartment, why should an individual requiring supportive housing need to move to receive the services?

Please Note: MOHLTC will review this submission to determine any additional policy, regulatory or legislative issues.