Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

Building Community-Based Capacity in Ontario:

Innovations from the Independent Living Sector

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OCSA Conference, Toronto

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IHPME

Building Community-Based Capacity to Meet Ontario's Needs

A BRIEF FROM THE ONTARIO ASSOCIATION OF INDEPENDENT LIVING SERVICE PROVIDERS (OAILSP)

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Where Are We Now?

A Growing Care Gap

Milestones: *Walker (2011)*

- ALC hospital beds are occupied by people who no longer require hospital care
  - Lacking community-based care, people end up in hospitals with few discharge options
  - Because hospitals are not designed to meet "restorative, supportive and rehabilitation needs" extended hospitalization can increase the likelihood of "default" to residential long-term care

Caring For Our Aging Population and Addressing Alternate Level of Care

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

Dr. David Walker, Provincial ALC Lead
June 30th, 2011

Milestones: Sinha (2012)

- Ontario's requires a seniors strategy to coordinate care across a continuum:
  - Promote health and wellness
  - Strengthen access to community-based primary care and home and community care
  - Promote senior-friendly hospitals with timely discharge to home and community
  - Improve capacity within residential LTC to support short-stay and restorative options and discharge back to the community.

Living Longer, Living Well

Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario.

Dr. Samir K. Sinha, MD, DPhil, FRCPC
Provincial Lead, Ontario's Seniors Strategy

December 20, 2012

Milestones: Donner (2015)

- While Ontario has many excellent programs and services, it has no coordinated system strategy
    - Result is too much variability in access to services, too little accountability for outcomes and a system that "fails to meet the needs of clients and families".

Milestones: Patients First: Roadmap to Strengthen Home and Community Care (May, 2015)

- Goals include:
  - Put Clients and Caregivers First: "Everyone who has needs that can be reasonably met in the home or community will receive support to do so"
  - Plan for and Expand Capacity: "increasing capacity and improving performance"

Milestones: Ontario's ALC Strategy (June 2017)

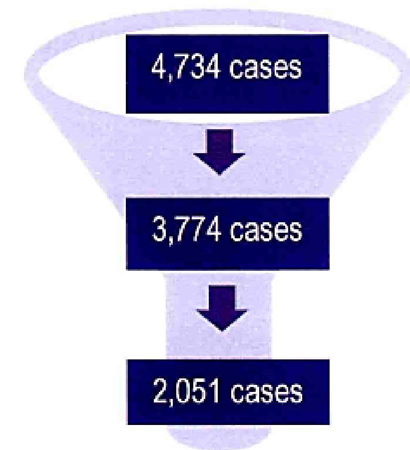
ALC PRESSURES – CURRENT STATE

- ALC volumes have increased year over year.
- There are predictable fluctuations in ALC volumes within each year (i.e. increases during flu season).
- Many persons designated ALC remain in hospital because:
  - Home and community care may not be able to deliver the intensity of services required to meet care needs in the community;
  - An individual's home is unsuitable for them to return to;
  - There is a lack of supportive housing units;
  - There is a long waitlist for long-term care (LTC) beds and it is unclear if all people on the waitlist require LTC-level of care.

All Open ALC Cases (as of January 31, 2017)

Aged 65+ and Older

Discharge Destination = Long-Term Care



The average cost to care for one patient designated ALC in a hospital is $730/day

On January 31, 2017, this represented a per day cost of ~ $3.5M

Milestones: *Ontario's ALC Strategy (June 2017)*

ALC STRATEGY

Phase 1 (2017/18): Reduce ALC in Immediate Term	Phase 2 (2018/19): Maintain Reduced ALC Rates
Short-Term Transitional Care Models Work with LHINs to identify local solutions	**Provincial Approach to Reducing ALC** Evaluate short-term transitional care models and use lessons learned to develop a provincial approach to transitional and permanent care and accommodation.
Supportive Housing Add 200 new seniors supportive housing units in 2017/18.	**Supportive Housing** 50 new units in each of 2018/19, 2019/20, 2020/21
Hospital Role Process improvement/flow	**Capital Projects** Repurpose existing infrastructure

Bridging the Care Gap:

Innovations from the Independent Living Sector

Who the IL Sector Serves:

Persons with Functional Needs

- 50+ years experience serving people of all ages, many of whom would have lived all or most of their lives in institutional settings
  - Cerebral Palsy, Arthritis, Stroke, Multiple Sclerosis, Muscular Dystrophy, Spinal Cord Injury (SCI), Spina Bifida and Huntington's Disease; ABI; communications disabilities (e.g., non-speaking)
  - Persons with disabilities who are aging and who may also experience age-related health issues such as diabetes, stroke, renal failure and COPD
  - Growing numbers of older persons (and caregivers) at the verge of losing independence

What the IL Sector Provides:

Non-Medical Supports

- Activities of daily living (ADLs)
  - Personal hygiene (bathing and toileting), mouth & dental care, dressing, assistance with eating, exercises, transferring/positioning/turning; bowel and bladder care
- Instrumental activities of daily living (IADLs)
  - Homemaking, laundry, assistance with appointments and groceries
- Case management & system navigation
  - Care navigation and linkages to funding, housing and other community resources, assistance with transitions

What the IL Sector Provides:

Non-Medical Supports

- Education
  - Assessment, education and skills development; in-home safety and accessibility; mobility and seating, self-care; household management; communication
- Caregiver support
  - Respite; education and counselling
- Some medical services (often by exemption)
  - Oxygen, ventilators, wound care

Core Service Models

- Direct funding/Self-directed care
  - Clients use personalized budgets to manage their own care

Core Service Models

- Outreach/mobile
  - Clients receive a tailored mix of services and supports for daily living up to 24/7
  - Choice of care setting (at home, at work or at school)
- Supportive housing
  - Clients receive a flexible mix of supports from on-site staff up to 24/7
  - Accessible, often rent-geared-to-income (RGI) apartments

Innovations: Regional Provider Networks

- Link multiple agencies to expand scope and build capacity over large geographic areas
  - Northern Group of Independent Living Providers
    - 7 agencies share knowledge and best practices, identify common priorities, and plan joint initiatives
    - One agency (rotating) identified as the "lead" for each initiative
    - Minimizes administrative burden for providers and funders
    - Builds visibility and political capital

Innovations: Transitional Care

- Short-term community support to transition from a hospital or LTC bed back to the community, or to remain in the community while waiting for a LTC bed
  - Bellwood's Community Connect (CC) program, Toronto
    - Ease reintegration of hospital ALC patients with physical disabilities
    - Mix of 24/7 personal and instrumental supports in a supportive housing setting for up to 14 months (averaging less than 6 months)
    - Access to *Mobile Independent Living Education (MILE)* -- assessment, education and skills development

Innovations: Hub & Spoke

- "Hubs" radiate resources from a central location to a geographic catchment area defined by distance (1-2 km) or travel time (10-15 minutes) – "spokes"
  - Hubs often in supportive housing buildings
    - Could also be in day programs, LTC, "campuses of care"
  - Assisted Living Southwestern Ontario (ALSO), Windsor
    - 11 supportive housing sites ("hubs") owned by other orgs
    - Scheduled or will call, even at night
    - Multiplies capacity by serving 30-40 clients living in their own homes ("spokes") – "virtual supportive housing"
    - Now moving into rural areas

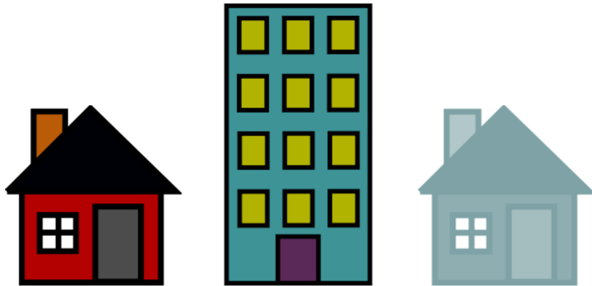
Innovations: Mobile Supports

- Extends range of Hub and Spoke model
  - ADL and IADL supports to clients and caregivers in their own homes
  - 24/7/365 coverage, pre-scheduled and will-call

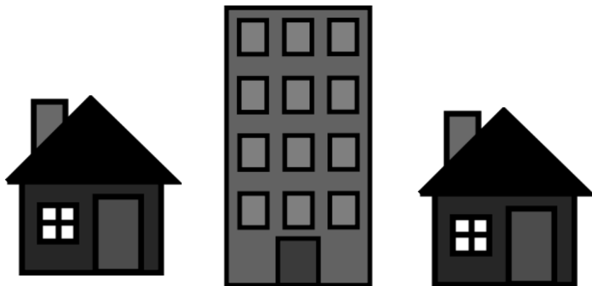
  - Supports for Daily Living Program, Nucleus Independent Living, MH LHIN
    - Supports high needs seniors and caregivers in their own homes
    - Partnership with 7 other CSS providers (“hubs”)
    - 24-hour practical assistance with ADLs and IADLs

ALSO: "Layering" to Build Capacity

Phase 1: Attendant Services – Supportive Housing and Outreach.

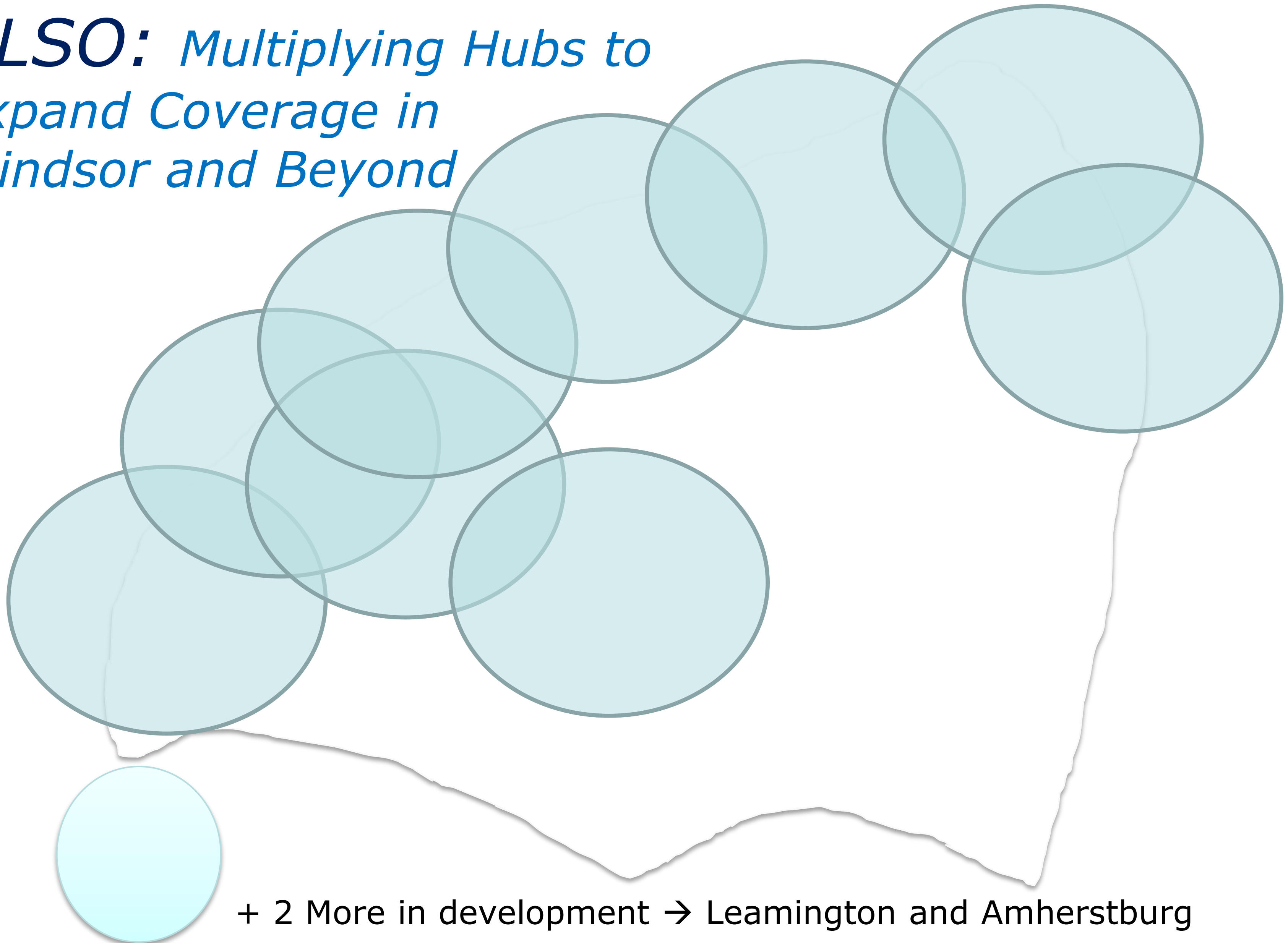


Phase 2: Addition of Mobile Services to traditional model.



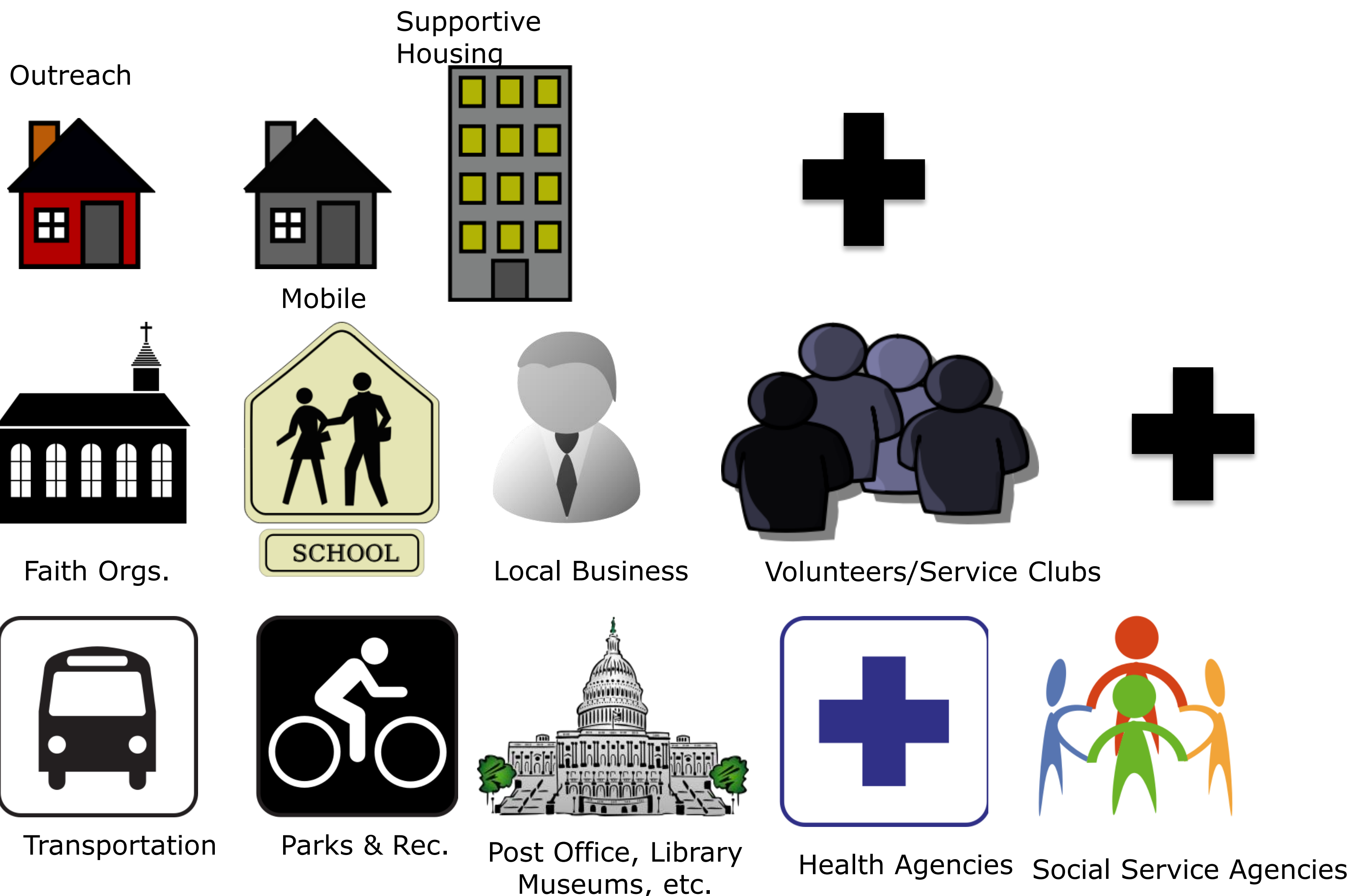
Phase 3: Intra-agency integration of Services → spoke and hub model.

ALSO: Multiplying Hubs to Expand Coverage in Windsor and Beyond



+ 2 More in development → Leamington and Amherstburg

Thinking Bigger: Neighborhoods of Care



The Bottom Line:

Meeting Ontario's Needs

Where Ontario Wants to Go

- Put Clients and Caregivers First: “Everyone who has needs that can be reasonably met in the home or community will receive support to do so”
- Plan for and Expand Capacity: “increasing capacity and improving performance”
  - AND reduce growing ALC challenges which now tie up 15%+ of hospital capacity

The IL Bedrock:
Person-Centred Care

- Rooted in the IL philosophy
  - Clients direct their care to the extent they are able
  - Services provided in client's choice of locations: at home, at school, in the workplace
  - Coverage up to 24 hours/day when needed

Rapid Scalability & Comparable Costs

- Build capacity quickly
  - Can transform existing housing stock, including family homes and private apartments, into transitional care and “virtual supportive housing”
  - Avoid massive capital costs and lengthy construction timelines
- Lower/comparable operating costs
  - Direct funding and outreach less costly than LTC
  - Supportive housing costs comparable to LTC
  - All less costly than ALC beds

Improved Access and Equity

- Approaches pioneered and proven for persons with disabilities now being successfully adapted to other high needs populations
- Regional provider networks and rural hubs can build capacity in underserviced rural/remote areas with high ALC and LTC placement rates

High Performance

- Assessment data from Waterloo-Wellington show needs in outreach and comparable to or exceeding LTC residents
- Evaluation data from Mississauga-Halton show 1000’s of high needs older persons transitioned successfully from hospitals reducing ER visits, average length of hospital stay and LTC wait lists
- In Windsor, ALSO has transitioned 500+ individuals from ALC, ICU and CCC, contributing to significant reductions in ALC

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