



Aging at Home – Year 3

Presentation to Central East LHIN Board
February 16, 2010

Provincial Aging at Home Strategy: Funding Overview

- \$702 million investment over three years to provide support to seniors to stay healthy and live with dignity and independence

• First-Year Planning for LHINs	\$ 3,000,000
• Assistive Devices Program Funding	\$ 40,000,000
• Provincial Priorities	\$ 66,000,000
• Allocations to LHINs	\$593,000,000
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	\$702,000,000

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Provincial Aging at Home Strategy: Goals

1. Ensure seniors' homes support them.
2. Supportive social environments.
3. Senior-centred care that is easy to access.
4. Innovative solutions to keep seniors healthy.



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Aging at Home Strategy: CE LHIN 3 Year Funding Summary

Fiscal year	2007/08 Planning Funding	Three Year Allocation to Central East LHIN			
		Initial Investment 2008/09	Planned Base Increase 2009/10	Planned Base Increase 2010/11	Total Annual Base Funding
2007- 08	\$288,000				\$0
2008 - 09		\$4,641,877			\$4,641,877
2009 - 10			\$6,893,811		\$11,535,688
2010-11				\$8,838,111	\$20,373,799
Out-years					\$20,373,799

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Aging at Home – Year 1 – Overview

- The Strategy's vision, set out by the former Minister of Health and Long-Term Care George Smitherman, was grassroots oriented, focused on enabling seniors to remain in their home with dignity and independence.
- While embedded in the provincial ALC Strategy, in Year 1, the AAH Strategy was never publically positioned in this manner.

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Aging at Home – Year 1 – CE LHIN Priorities

In its first year (08/09), the Central East LHIN's Aging at Home investments focused on enhanced care in the home and community including:

- **Community Support Services**
 - meals, emergency response systems
- **Supportive Housing**
 - expanded existing as well as new programs
- **Caregiver Supports**
 - respite, adult day programs

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Aging at Home – Year 1 – CE LHIN Investments

Community Support Services	\$ 1,336,342
Supportive Housing	\$ 1,881,000
Caregiver Supports	\$ 1,001,975
Other (Palliative Care)	\$ 422,560
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Total:	\$ 4,641,877

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Aging at Home - Year 2 - Overview

- In its second year, the emphasis for AAH changed provincially to target the reduction of *Alternate Level of Care* and *Emergency Department* wait times.
- This was to be accomplished by funding services that *prevent, divert and/or directly* impact ALC/ED.
- The amount of Year 2 AAH funding that would be directed to each of these categories was based on the *ALC performance* within the LHIN.
- The timing of the change came late in the process – after calls for proposals had launched.
- Many community support service agencies were challenged to see how their services “fit” the new emphasis.

Aging at Home - Year 2 – CE LHIN Priorities

1. Community Support Services

- Emphasis: Improving access to the coordination and scheduling of transportation to social and medical appointments

2. Caregiver Support and Well-Being

- Emphasis: Improving equity across the LHIN related to forms of relief and support for the caregiver such as in-home respite and adult day programs

3. Supportive Housing/Assisted Living

- Emphasis: Improving equity of access to supportive housing throughout Central East (must implement within 2009-2010)

4. Specialized Geriatric Services

- Emphasis: Exploring models of Community Comprehensive Geriatric Assessment (cCGA) that consider a multi-disciplinary approach

Aging at Home - Year 2 – CE LHIN Investments

Community Support Services	\$ 624,310
Supportive Housing/Assisted Living	\$ 1,644,501
Caregiver Support and Well-Being	\$ 350,000
Specialized Geriatric Services	\$ 4,275,000
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Total:	\$ 6,893,811

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Aging at Home – Years 1 and 2 – CE LHIN Investments

Priority	2008/09	2009/10	Total	% of Total
Community Support Services	\$ 1,336,342	\$ 624,310	\$1,960,652	17%
Supportive Housing	\$ 1,881,000	\$ 1,644,501	\$3,525,501	30%
Caregiver Supports	\$ 1,001,975	\$ 350,000	\$ 1,351,975	12%
SGS	-0-	\$ 4,275,000	\$4,275,000	37%
Other (Pall. Care)	\$ 422,560		\$ 422,560	4%
Total	\$ 4,641,877	\$ 6,893,811	\$11,535,688	100%

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Aging at Home - Year 3 - Overview

Aging at Home proposals for 2010-2011 must demonstrate the following*:

1. The *quantifiable contribution* to reducing time spent in the ER and optimizing inpatient capacity by reducing ALC days.
2. CCAC alignment and optimization in order to ensure consistent approaches to *leveraging the capacity of the CCACs* and forging strong relationships.
3. Cross-LHIN collaboration with respect to *sharing leading practices* and addressing the cross-LHIN flow of patients.

* Memo from Ken Deane – November 2009

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Aging at Home – Year 3 - Overview

Priorities	Description
Additional Temporary Care Bed Capacity	Initiatives targeted to increase capacity across the post-acute spectrum of care including rehab, Complex Continuing Care, Convalescent Care, Interim LTC and other innovative settings to enable appropriate discharge from acute care and transition back to the community.
Admission Avoidance / Timely Discharge Initiatives (Hospital process enhancements)	<p>Initiatives targeted to seniors to avoid unnecessary ER admissions and support timely discharge from ER and hospital.</p> <p>Initiatives permitted: enhanced case management functions in the ER and hospital, Flow Coordinators, GEM nurses in the ER and hospital, psycho-geriatric nurses in ER and hospital</p>
Enhanced Home Care (Building community based services)	<p>Initiatives that enhance the range of home care services for seniors to avoid unnecessary ER visits, ER and hospital admissions, and support timely discharge of seniors</p> <p>Initiatives permitted: intensive community-based case management, in-home primary care, enhanced community support services, enhanced mental health and crisis services, etc. LHIN examples include Safe at Home, Wait at Home, Home at Last, etc.</p>
Outreach Teams	Targeted support to provide enhanced nursing assessment and treatment services in any home setting (e.g. home, LTC home, Supportive Housing). Targeted outreach service towards high risk seniors who comprise high ER volume or high volume of ALC patients (e.g. psycho-geriatrics, inter disciplinary teams).

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Aging at Home – Year 3 – Overview (2)

- MOHLTC held back **25%** of all LHINs' AAH Year 3 funding, to be directed to “yet to be determined” provincial priorities.
- For CE LHIN, this translates into a **\$2.2M** reduction for Year 3.
- Priorities have evolved as parameters for funding have.
- At the request of LHIN CEOs, timeframe for submission of AAH Year 3 Detailed Service Plans has been extended from January 31, 2010 to **February 28, 2010**. This notification was received in December 2009.

Aging at Home Strategy - CE LHIN Funding

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2008 - 09		\$4,641,877			\$4,641,877
2009 - 10			\$6,893,811		\$11,535,688
2010-11				\$6,628,584	\$18,164,272
Out-years					\$18,164,272

25%
reduction

* Plus \$228,772 of Year 2 non-base funding available

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Aging at Home – Year 3 – CE LHIN Priorities

Year 3 AAH priorities for Central East include:

- **Community Comprehensive Geriatric Assessment**
- **Senior-Friendly Hospital Initiative/Home First**
- **Restorative Care Beds**

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Community Comprehensive Geriatric Assessment

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Community Comprehensive Geriatric Assessment

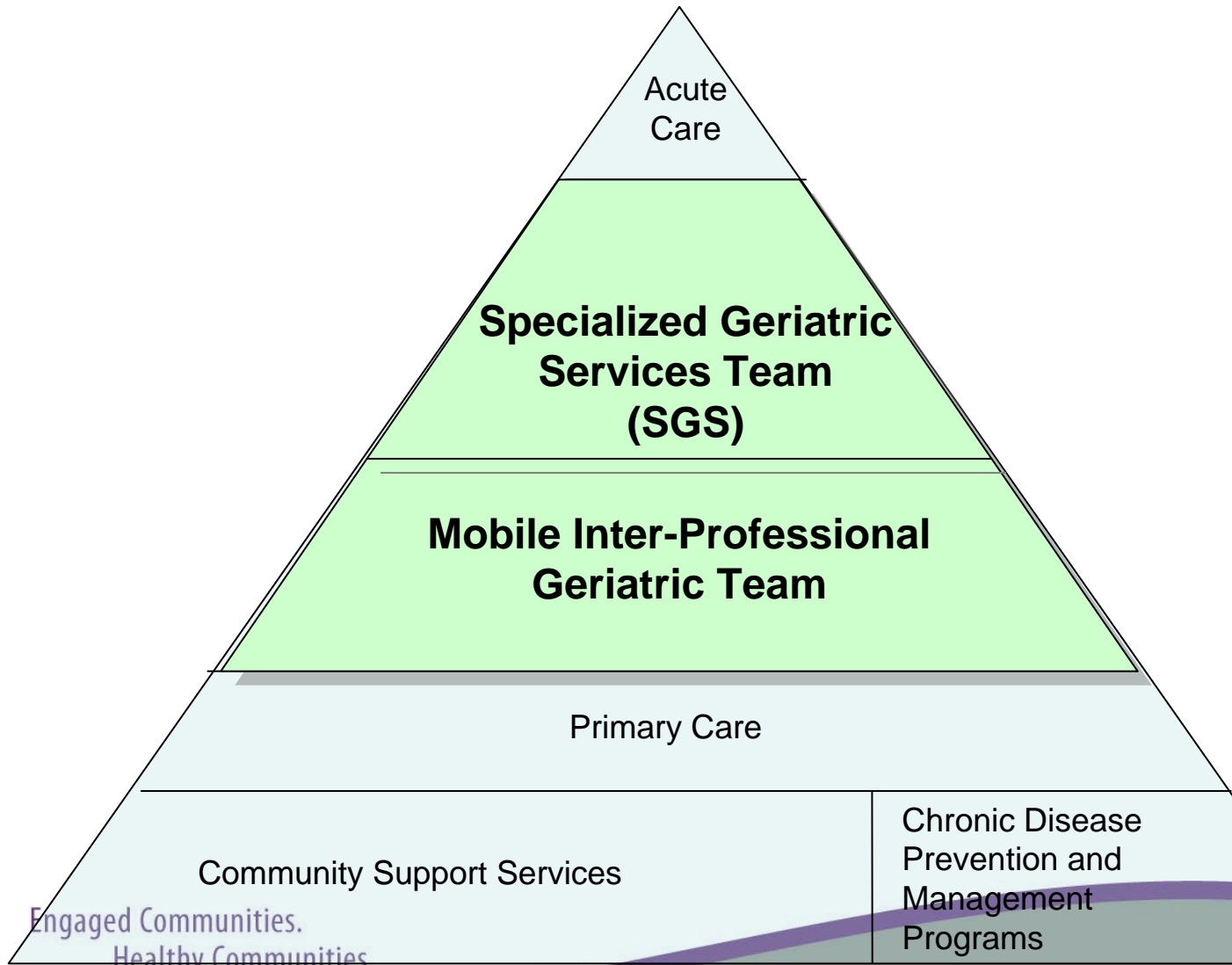
- The ***Geriatric Assessment and Intervention Network (GAIN)*** is a community based service/program that targets frail seniors to prevent unnecessary emergency department visits and expedite appropriate community discharge from hospital.
- The model is based upon the need to build a stronger foundation of health care services for frail seniors in their local communities. As such, the service provides support for community practitioners to develop additional capacity to assess, diagnose and manage frail seniors before an ED visit or hospital admission is required.
- Intent is to identify conditions early and prevent and/or reverse functional decline and deterioration that often results in hospital visits, admissions and/or prolonged stays in acute care facilities when that level of care is no longer required.

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How will the model be implemented?

- Developing community capacity throughout the LHIN (mobile interprofessional geriatric teams);
- Health career case management for the most high risk frail seniors (to manage and coordinate health care transitions and services in the home);
- Triaged access to scarce, highly specialized expertise (Geriatrician led specialized teams), and
- Various linkages to community and hospital services including GEM nurses, NP Outreach Teams, Psychogeriatric resources, etc. to divert potential hospital admissions and facilitate early discharges back into the local community.

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Expected Outcomes (still under development)

Clients Served Annually: 1,000

Admission Avoidance / Timely Discharge Initiatives (Hospital Process Enhancements)

- 2400 – 3600 ED visits avoided at all hospitals on a phased in approach
- 6000 – 12000 ALC days reduced at all hospitals on a phased in approach

Enhanced Home Care (Building Community Based Services)

- 10% increase in the perceived integration of community support and specialized services
- 75% of survey respondents indicate increased knowledge and confidence in caring for seniors with complex conditions

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Budget: CCGA Northeast Cluster and Durham North/East

Target: \$3,000,000

Total budget of cross-LHIN CCGA Program: \$5.4M

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Senior-Friendly Hospital Initiative/ Home First

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Senior-Friendly Hospital/Home First

- Target services that enable seniors to transition well from acute care back to the community;
- Funding will relate to CCAC services;
- CCAC working with the LHIN and partners to determine types and levels of services;
- Detailed service plan will be complete for submission to MOHLTC by deadline;
- **Targeted Investment: \$2M**

Restorative Care Beds (Convalescent Care)

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Restorative Care Beds – Village of Taunton Mills (VTM)

- Twenty beds in the retirement home section of VTM used for hospital inpatients who do not require hospital-level intensity of care but cannot yet transfer to their discharge destination.
- VTM aims to contribute to improved flow through the ED by shortening length of stay (LOS) of alternative level of care (ALC) and ALC-like patients, thereby freeing up beds sooner for ED patients requiring admission.
- The target LOS is 45 days and the maximum LOS is 60 days to ensure that this unit truly performs as a transitional destination. VTM is intended to enhance patients functional and cognitive ability.
- Significant promising practice: 4,500 patient days saved in 8 months

Outcomes Being Measured: Village of Taunton Mills

- ED length of stay at referring hospital
- ALC days at referring hospital
- Avg. length of stay in Convalescent Care Unit (CCU) in days
- Avg. length of stay based on discharge destination
- # of patients discharged in the month whose ultimate discharge destination was lower than the initial destination
- # of transfers from hospital to CCU (i.e., new admissions to CCU per month)
- # of discharges from the CCU for the month
- Admission to CCU from Hospital bed type

Challenges: Compliance with Current Legislation

- Efforts are being made provincially to bring new beds funded through AAH, UPF and/or P4R within current legislative requirements
- New Transitional Care Framework introduced by MOHLTC
- Staff of VTM, LHIN and Compliance Branch have been vigorously discussing the future of the VTM project
- At this time, there remain some outstanding issues that may not be able to be resolved, resulting in the imminent closure of these beds
- Briefings being developed for Ken Deane
- **Targeted Investment: \$1.4M**

Other AAH Year 3 Funding Allocations

Kawartha Participation Projects
St. John's Centre
Meals on Wheels/Caregiver Support

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Aging at Home – Year 3 – CE LHIN Summary Recommendations

Specialized Geriatric Services (CCGA)	\$3,000,000
Home First Related Services (CCAC)	\$2,000,000
Restorative Care Beds (Convalescent Care – VTM)	\$1,400,000
Other	\$ 457,356
Total: Year 3	\$6,857,356

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THANK YOU!!!

QUESTIONS?

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