Central East LHIN
RLISS du Centre-Est

Central East LHIN Strategic Aims

2013-2016 IHSP Seniors Aim Update

October 22, 2014

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Agenda

- Background/Overview
- Aim metrics update
- Initiatives
- Next Steps

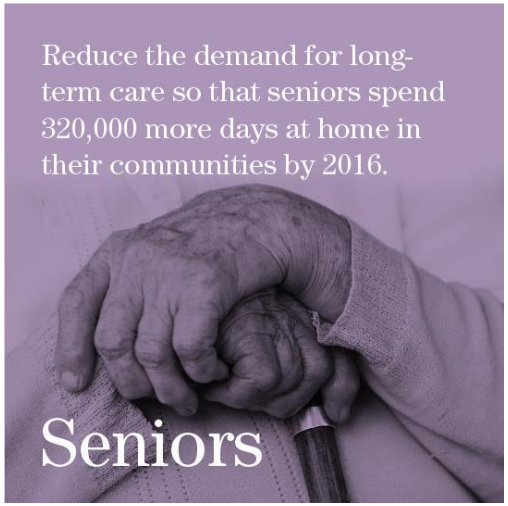
Seniors Update Objectives

- To provide a progress report on our IHSP Seniors Strategic Aim

- To provide a progress report on initiatives within the Seniors portfolio, including:
  - Systems of Care:
    - Assisted Living Services for High Risk Seniors
    - Adult Day Program Expansion
    - GAIN Redesign and Community teams
  - Seniors Friendly Hospital Initiative

Background/Overview

- Seniors Aim – 320,000 days in the home & the community



Background : How were savings calculated?

LTCH Demand = Current Residents + Wait List

- Number of individuals on the wait list is used as a proxy for demand
- Number of people saved =

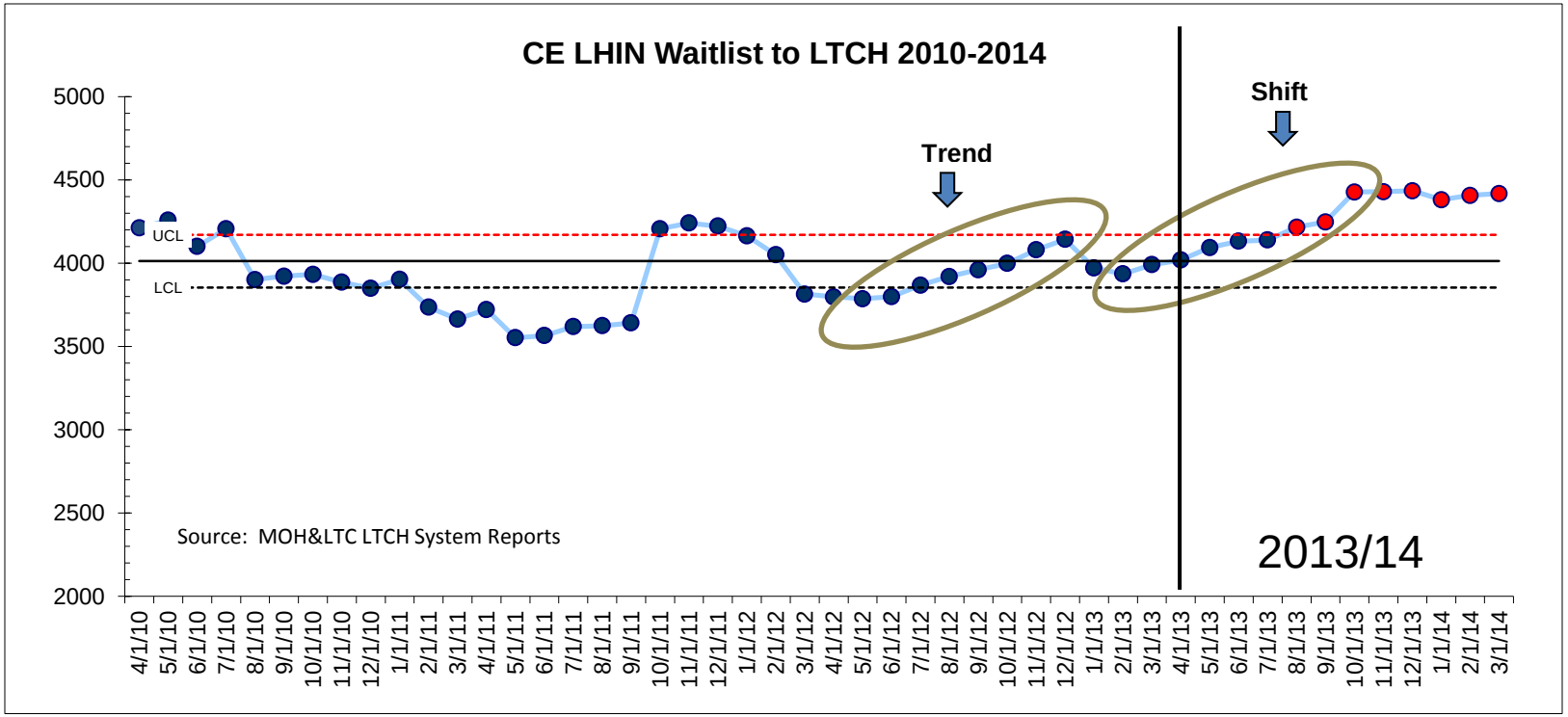
  Projected monthly waitlist minus actual monthly waitlist
- Number of days saved =

  Number of people saved multiplied by the average time to placement of the previous fiscal year

Background: Assumptions and Parameters

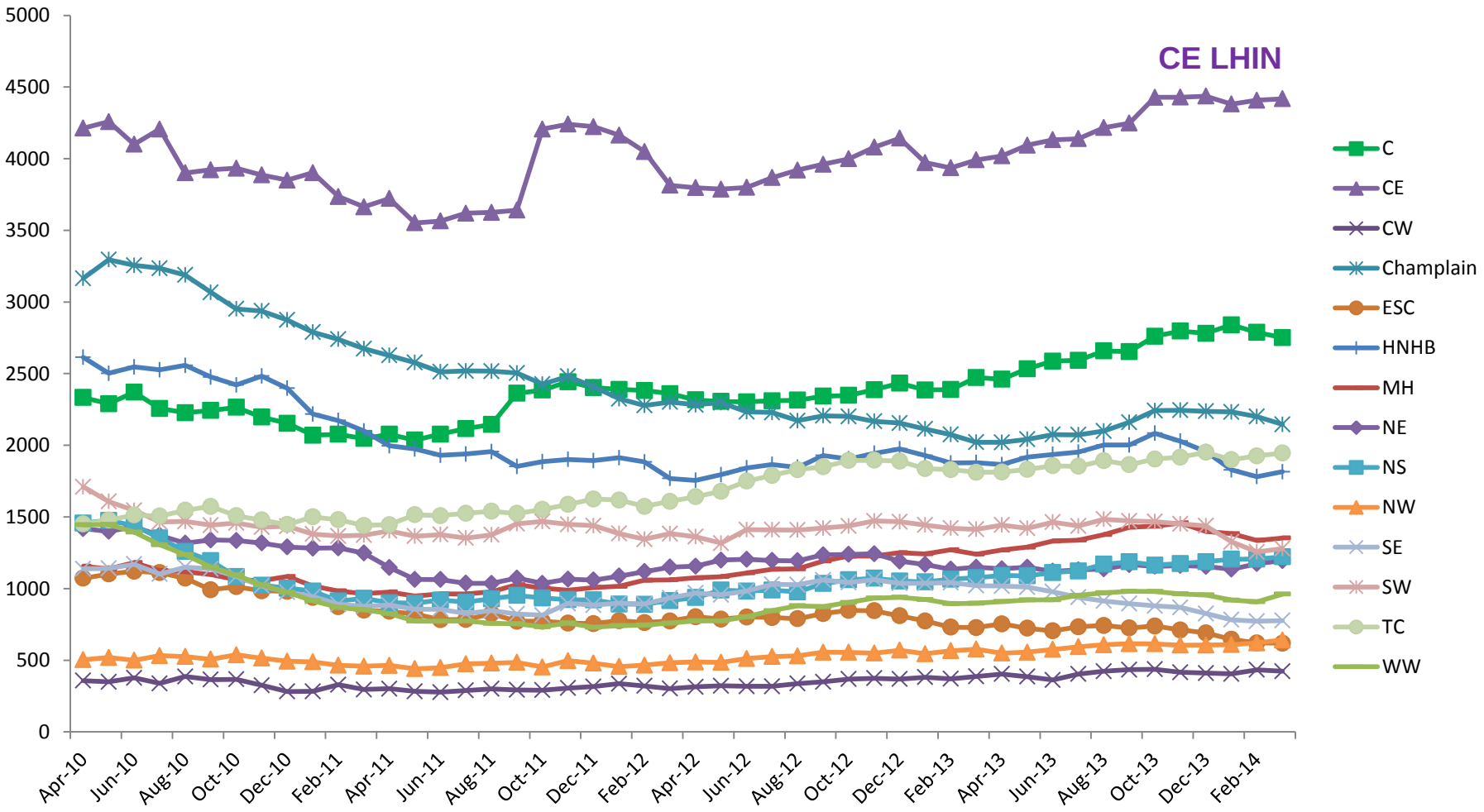
- Projections were initially based on:
  - No change in LTCH bed supply (9,500 beds) ✓
  - Bed occupancy will remain at 98% ✓
  - No change in LTCH admission criteria ✓
  - Number of residents will remain stable ✓
  - Wait list would increase by 5% based on historical trending (-2% to 7% annually) ✘
  - Average time to placement is 126 days ✘
    - During 2013/14, there has a 9% increase in Wait list
    - During 2013/14, the Average time to placement is 132 days

Waitlist to LTCH



Analysis: In FY 2013/14, Central East LHIN's actual waitlist has increased by 9%. The projected rate of increase, based on 3 years of historical trending, was 5%. This was reflective of an average of 4,000 individuals on the wait list between 2010/11 and 2012/13. In May 2013/14, the waitlist started to increase and has remained stable at 4,400 waitlisted individuals per month for the last 6 months of FY 2013/14.

Waitlist: Pan LHIN (Source: LTCH System reports)



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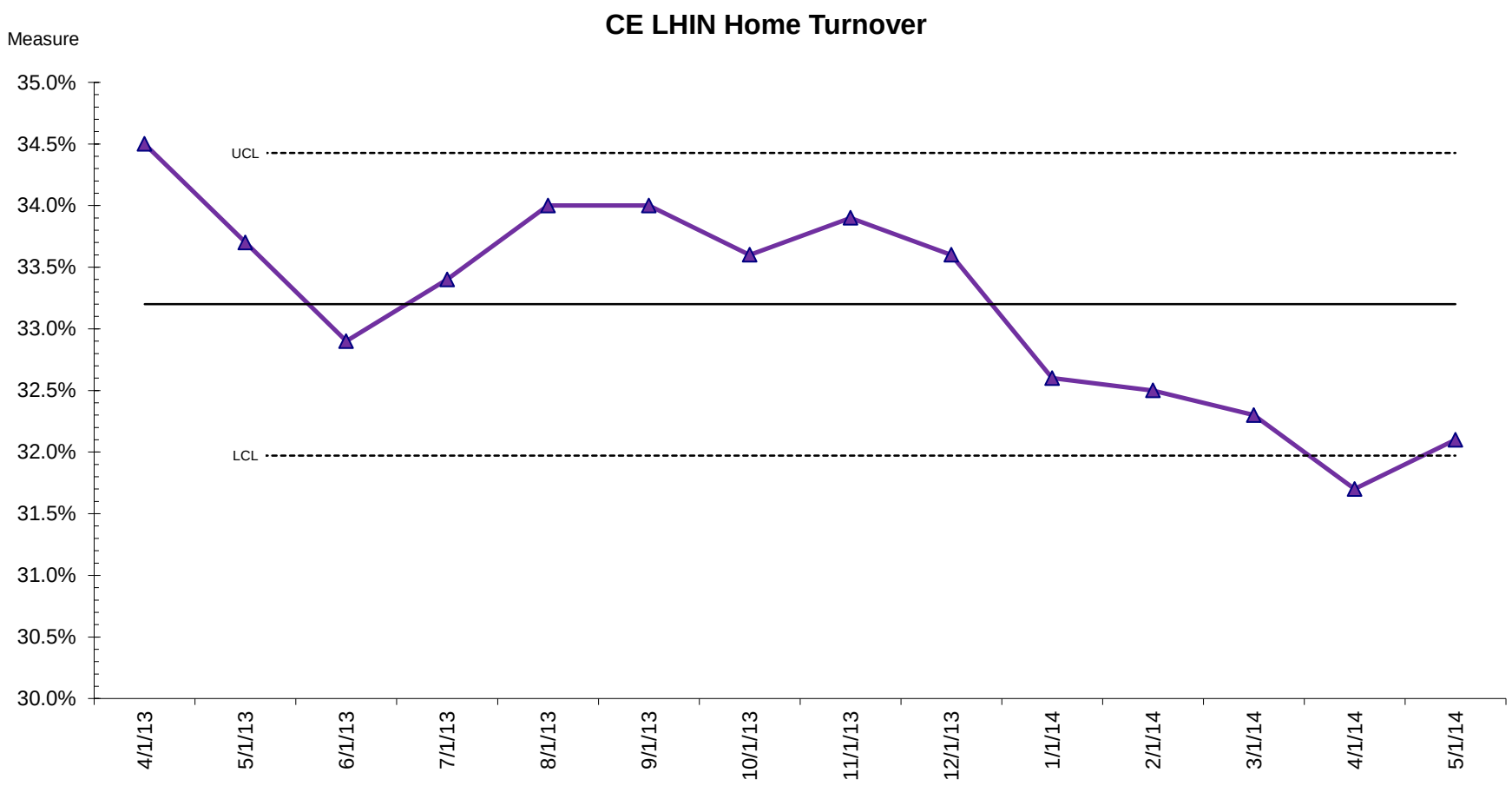
LTCH (home) Turnover (Source: LTCH System reports)



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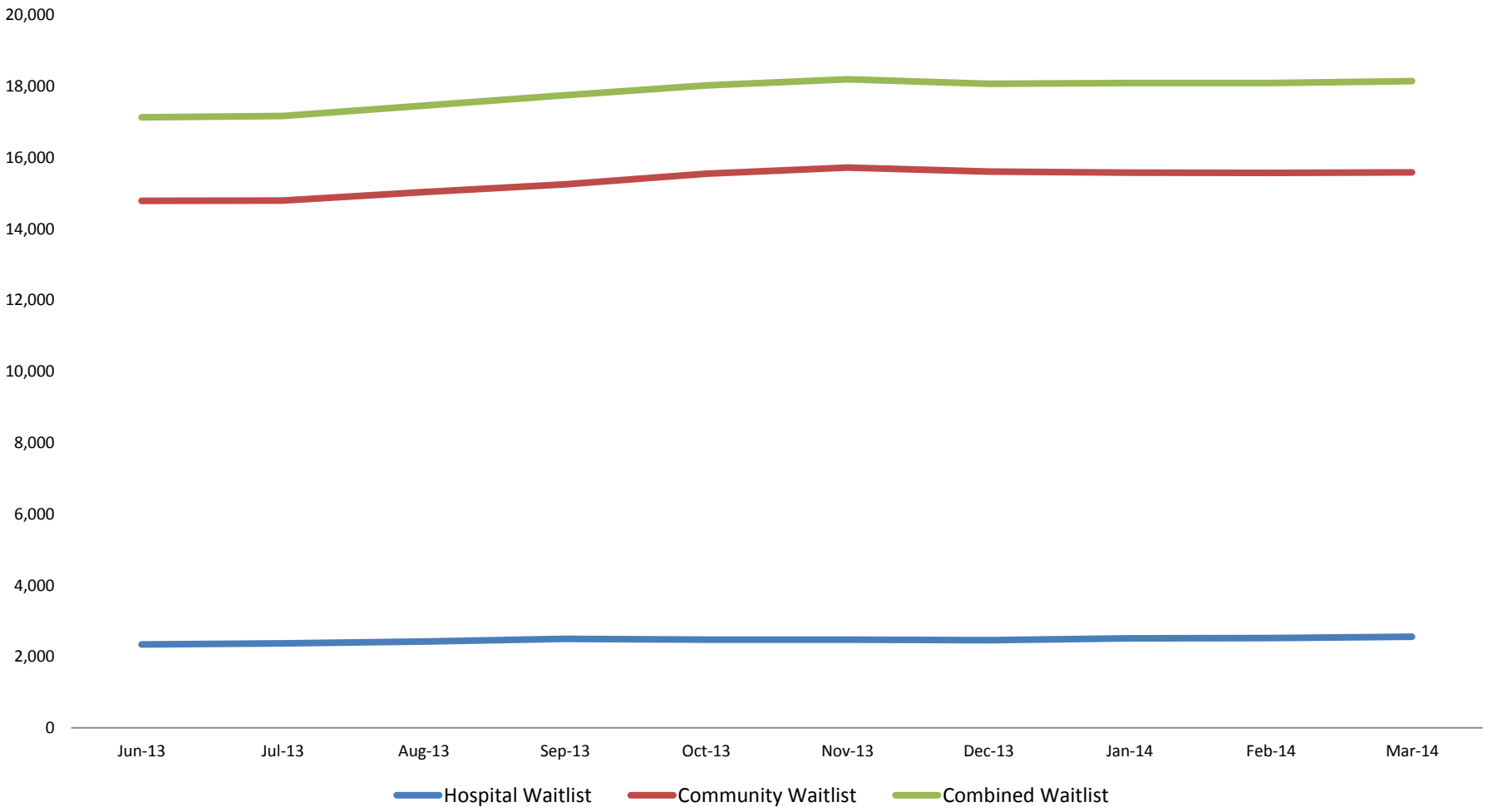
Waitlist: Hospital versus Community (Source: CCAC)



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Summary of changes between 2012/13 and 2013/14

- CE LHIN has seen a statistically significant shift in the LTCH waitlist starting in October 2013 and is outside the Upper Corridor of historical trending.
- Average Waitlisted Individuals has increased from 4,000 to 4,400 per month (LTCH System Reports).
- CE LHIN has the greatest number of waitlisted individuals across all LHINs (followed by Central and Champlain LHINS).
- Average time to placement has increased from 126 to 132 average days.
- CE LHIN has 3rd highest Avg time to placement.
- Bed occupancy has increased from 98% to 99%.
- Waitlist demand by “CE LHIN” residents versus “out of region” residents (seeking CE LHIN LTCHs); for the “out of region” residents, the demand is decreasing. For CE residents, demand is increasing (CCAC).

Summary of changes continued

- Overall waitlist demand is greatest for LTCHs in Scarborough followed by Whitby and Port Hope. Demand in Campbellford and Lindsay appear stable, with some slight fluctuations. Demand in Haliburton and Peterborough appears to be declining. In 2013 Scarborough and Whitby accounted for 83% of all waitlist demand.
- Using the CCAC LTCH Placement statistics, there is a very slight increase in the overall number of “Community” waitlist.
- Durham Cluster contributes to “Hospital” waitlist while Scarborough has the highest “Community” waitlist (CCAC reports).
- Both the “home” and “system” turnover (LTCH System Reports) show a downward trend until the end of FY 2013/14. In other words, little occupancy turning over.

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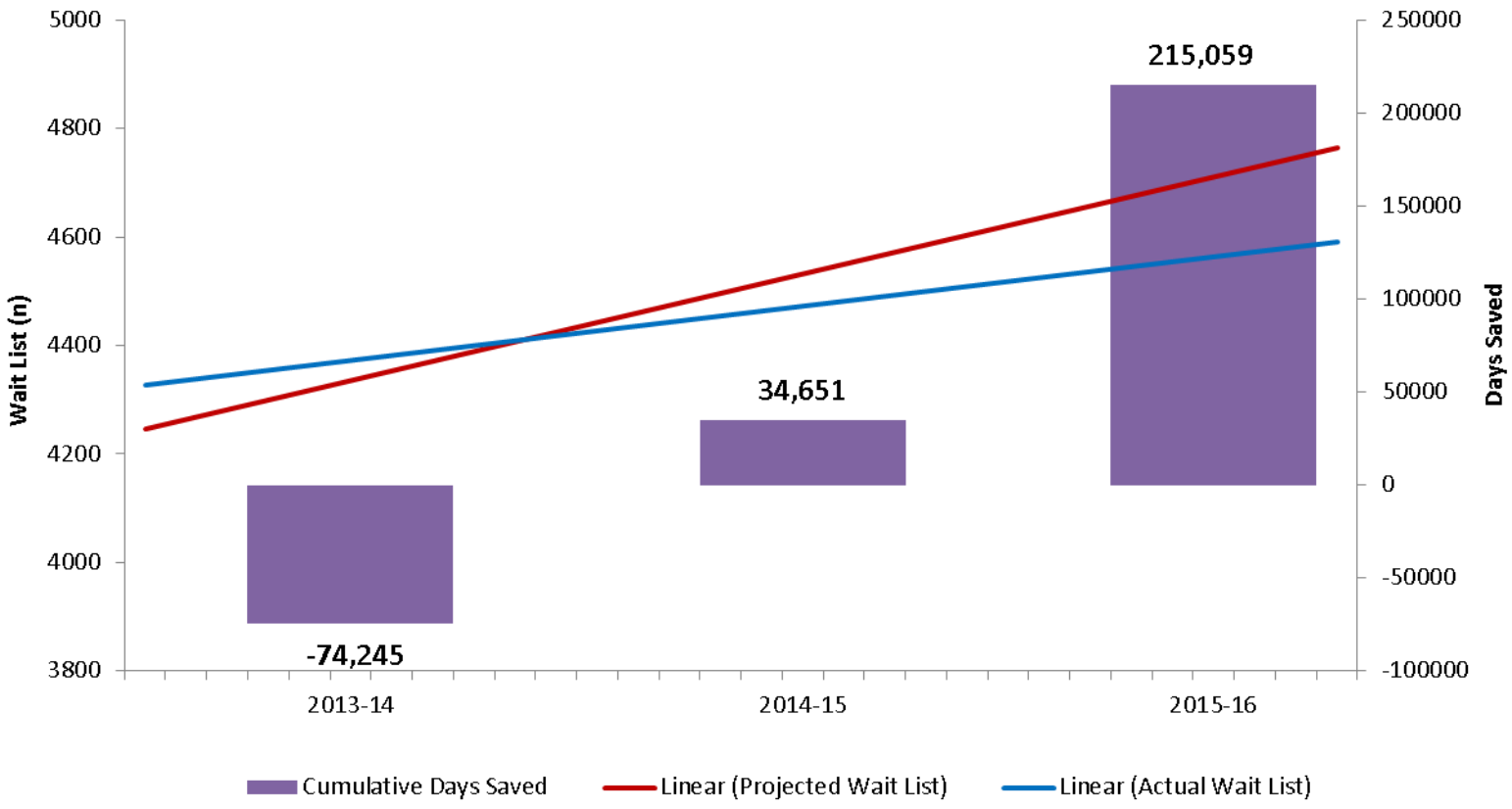
AIM METRICS UPDATE

Seniors Aim Update – Potential Days Saved



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Supporting Indicators – Definitions

Terms	Definition
Indicator Name **(increase) or (decrease)**	The desired direction of performance is shown in purple colored text after the indicator name.
Baseline	Where there is sufficient data, the baseline is the average 2011/12 and 2012/2013.
CE LHIN Target	The formal Central East LHIN target for that indicator (typically developed for use in existing scorecards, such as the MLPA). This formal target is indicated by **bold formatting**. Where there is no formal target, the baseline less 10% is used as an informal Central East LHIN Target to track the performance of supporting indicators for the IHSP aims.
Current Performance	The CE LHIN performance for the indicator using the most current data available.
Current Status	The current performance is compared with the CE LHIN target and the result is summarized by a colored dot following the parameters below: • A red dot indicates that the current performance deviates from the desired target by more than 10%. • A yellow dot indicates that the current performance is within 10% of the target • A green dot indicates that the current performance meets the target or is performing better than the desired target
Trend	The indicator trend uses all the data from the baseline and any additional data, up to and including the most current data available.

Seniors Aim Supporting Metrics Update

Indicator	Baseline	CE LHIN Target	Current Performance	Current Status	Trend
CCAC – 90th Percentile Wait Time for Home Care Services From Discharge to First Service (in Days for Hospital Clients) (Goal: decrease)[1]	10.8	9.7	15.0		
Clients With MAPLe Scores High And Very High Living In The Community Supported by CCAC (Goal: increase)[1]	7831	**6000**	8332		
Falls-Related ED Visits in older adults aged 65+, Rate per 1,000 (Goal: decrease)[1]	17.7	15.9	19.0		
Low-Acuity Emergency Visits for LTCH residents, Rate per 1,000 (Goal: decrease)[2]	22.8	20.5	18.8		
Percentage of ALC days by age (75+) (Goal: decrease)[1]	23%	20%	26%		
Waitlisted patients to LTC, rate per 1000 age 75+ (Goal: decrease)[1]	34.9	31.4	37.6		

Notes:
1 Most recent available data: 13/14 Q4
2 most recent available data: 13/14 Q1

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INITIATIVES

Geriatric Assessment & Intervention Network

PROGRESS TO DATE

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Progress to Date

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Highlights of GAIN

- Overall, GAIN positions were 77% occupied by the end of Q1. Most positions will be filled by end of October.
- All GAIN Community Teams report direct engagement with local primary care providers. Engagement activities vary among sites, depending on practice needs, and include:
  - Recurring Stakeholder/Advisory Committee meetings
  - Open house events
  - Weekly case review rounds with involved primary care providers
  - One-to-one follow-up on client care plans

Highlights of GAIN (II)

- Six of ten teams now sufficiently staffed to offer extended hours (Evenings/Saturdays). By November, two additional teams will begin offering extended hours.
- Four regional orientation days were planned and delivered. Incoming team members are also actively pursuing further gerontological training and a competency profile for GAIN practitioners is in development.

Highlights of GAIN (III)

- Across all GAIN teams, as of Q1, all teams were receiving referrals and seeing clients.
- Teams are indicating that about 25-30% of these clients will be suitable (sufficiently complex and in need of frequent intervention) for enrollment in Intensive Case Management (ICM) once processes are finalized and enrollment begins.

	Hospital Teams	Community Teams
Referrals Received	**1241**	**165**
Client Visits	**1881**	**576**

Highlights of GAIN (IV)

Behavioural Support Clinicians

- Six of the seven BSO community positions have been hired by funded organizations.
- Process maps and other documents are supporting integration into GAIN teams.
- Clinicians meeting weekly with Psychogeriatric Resource Consultants (PRCs) support, to review current active cases share learning, successes and challenges.
- For the period April through June, BSO clinicians assessed and provided interventions to 35 clients and families and the demand continues to grow.

Geriatric Assessment & Intervention Network

CURRENT PRIORITIES

Current Priorities

- Finalize GAIN Care Coordinator roles/functions and accelerate their integration into the Community GAIN Teams.
- Begin formally enrolling clients/patients into ICM.
- Support clinical quality through the standardization of the approach to comprehensive geriatric assessment and a program of clinical support including education/Professional Development plans.
- Hire the GAIN Regional Manager and expedite required knowledge transfer.

Current Priorities (II)

- Develop plan/strategy to formalize the GAIN/Health Link Strategy.
- Initiate partnership agreements and schedules outlining the role of SGS providers and programs, such as GAIN.
- Finalize the GAIN indicator set and develop the related data dictionary.

Senior Friendly Hospital (SFH) Initiative

PROGRESS TO DATE

SFH Initiative update

- Seniors Care Network continues to take a leadership role in improving Senior Friendly Hospital (SFH) care in the CE LHIN
- The Senior Friendly Hospital Working Group, consisting of membership from all Central East LHIN Hospitals, (RGP of Toronto, CE LHIN and Seniors Care Network) continues to meet on a monthly basis.
- The update of the SFH Scorecard is almost complete and will be provided to all hospitals to aid them to track their progress toward optimal senior friendly care.
- A SFH Walkabout Framework was developed and forwarded to the Central East LHIN Vice President and Chief Nurse Executive Steering Committee. A Walkabout is a management tool that can be implemented to improve the patient experience and health outcomes of the older adults and can be combined with other patient experience strategies.

SFH Initiative update

- The Gerontological Infrastructure Task Group met on September 10, 2014 and finalized the draft values (respect, compassion, integrity, excellence, advocacy and autonomy) and corresponding definitions. This group is focused on creating a sustainable foundation for senior friendly care across the Central East LHIN
- The Senior Friendly Hospital Capacity Grant Steering Committee continues to develop the curriculum and logistics for the Advanced Leadership Training Program which will support the development of leaders of Senior Friendly Hospital care

SFH Initiative update

- All hospitals in the CE LHIN are currently in the process of completing their respective SFH environmental scan templates for submission to the RGP of Toronto (on behalf of the RGPs of Ontario) by October 31, 2014.
- The SFH Indicator Evaluation Working Group met on September 8, 2014 to review the draft of the final report, which is expected to be released by the RGP of Toronto this Fall. This report will share the results of feasibility testing of indicators for delirium and functional decline, two significant health service quality indicators that impact the care of older adults

Assisted Living For High Risk Seniors (ALS-HRS)

PROGRESS TO DATE

ALS-HRS – Current Status

- Hubs across the Central East LHIN region continue to operate successfully and address the needs of high risk seniors and support them to reside at home through the assistance of both scheduled and non-scheduled personal support, homemaking, security checks and reassurance services on a 24/7 basis

- Eligible seniors are being maintained at home as long as possible and avoid institutionalization (hospital or LTC) were possible. The program is a collaborative approach between the Central East Community Care Access Centre (CECCAC) and the Community Support Service (CSS) agency with the client at the core

- Needs of seniors are being met by providing service scheduling flexibility and the aim is to further reduce avoidable Emergency Department visits.

ALS-HRS – Next Steps

- CECCAC and the Central East LHIN will be meeting to review the program with focus on aligning all the Memorandums of Understanding

- CECCAC will organize and lead a roundtable discussion with all ALS-HRS providers to review the program and discuss any issues/concerns/challenges

- CECCAC along with the providers, will arrange monthly meetings to share information, decide on next steps, and address any issues or concerns in a timely manner

- Metrics review and refresh will be conducted shortly

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NEXT STEPS

Next Steps

- Identified risks include
  - Changes in bed supply
  - Changes in screening criteria for long-term care
  - Changes in criteria for crisis placement
  - Historical trending may not be entirely representative of future state
    - Wait list continues to increase
    - Average time to placement increases
    - Percentage of Bed Occupancy increases

- Mitigation plans
  - Continued progress on Community Investments, e.g. GAIN
  - Strategic Investments in 2014-15 Community Investments.

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DISCUSSION

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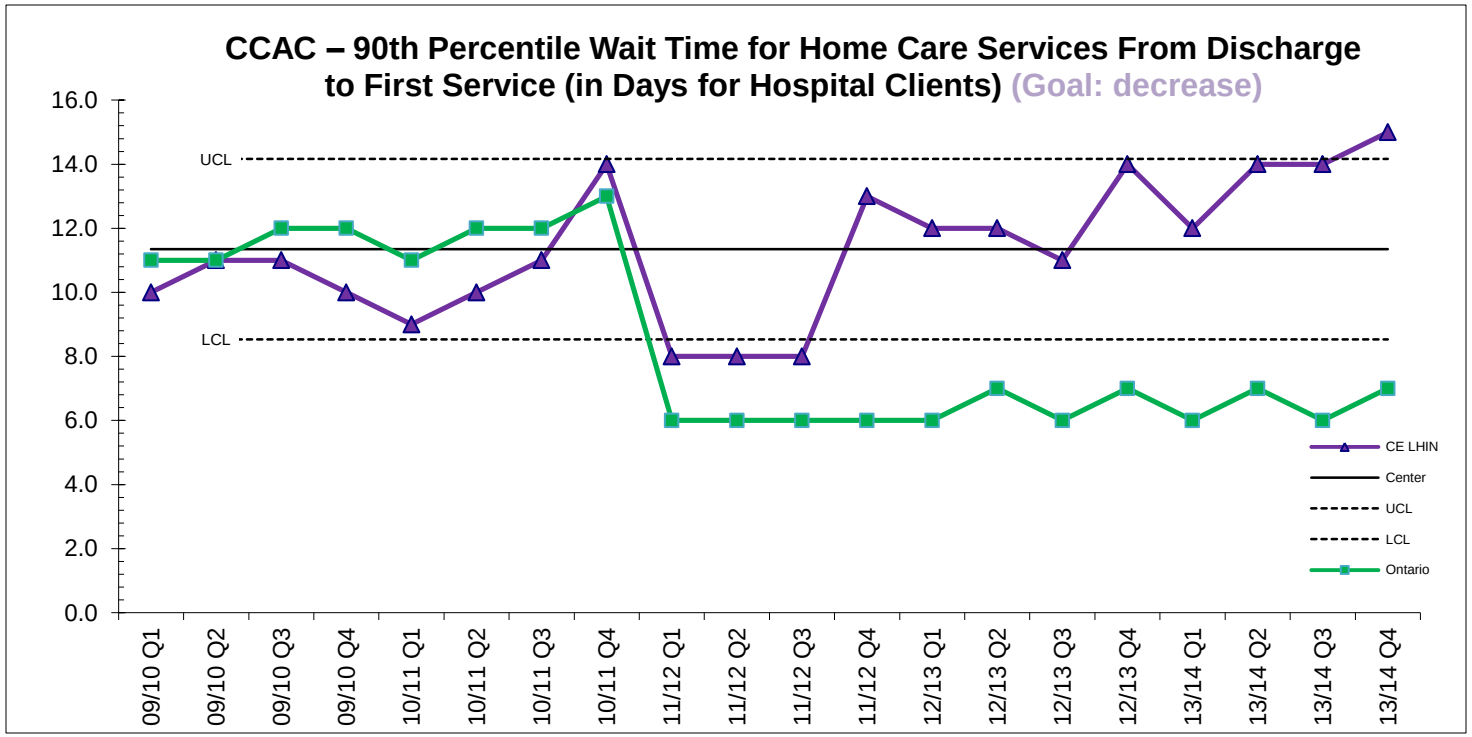
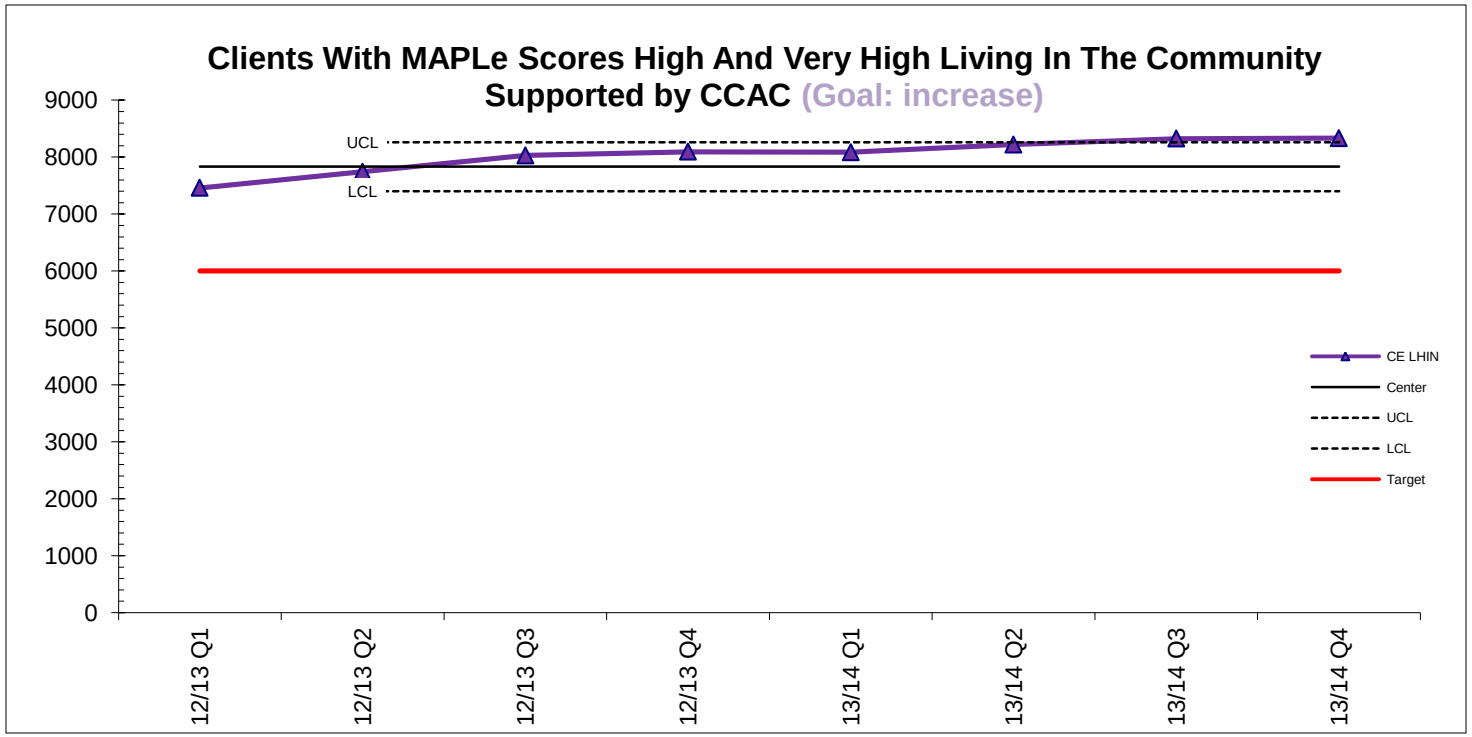
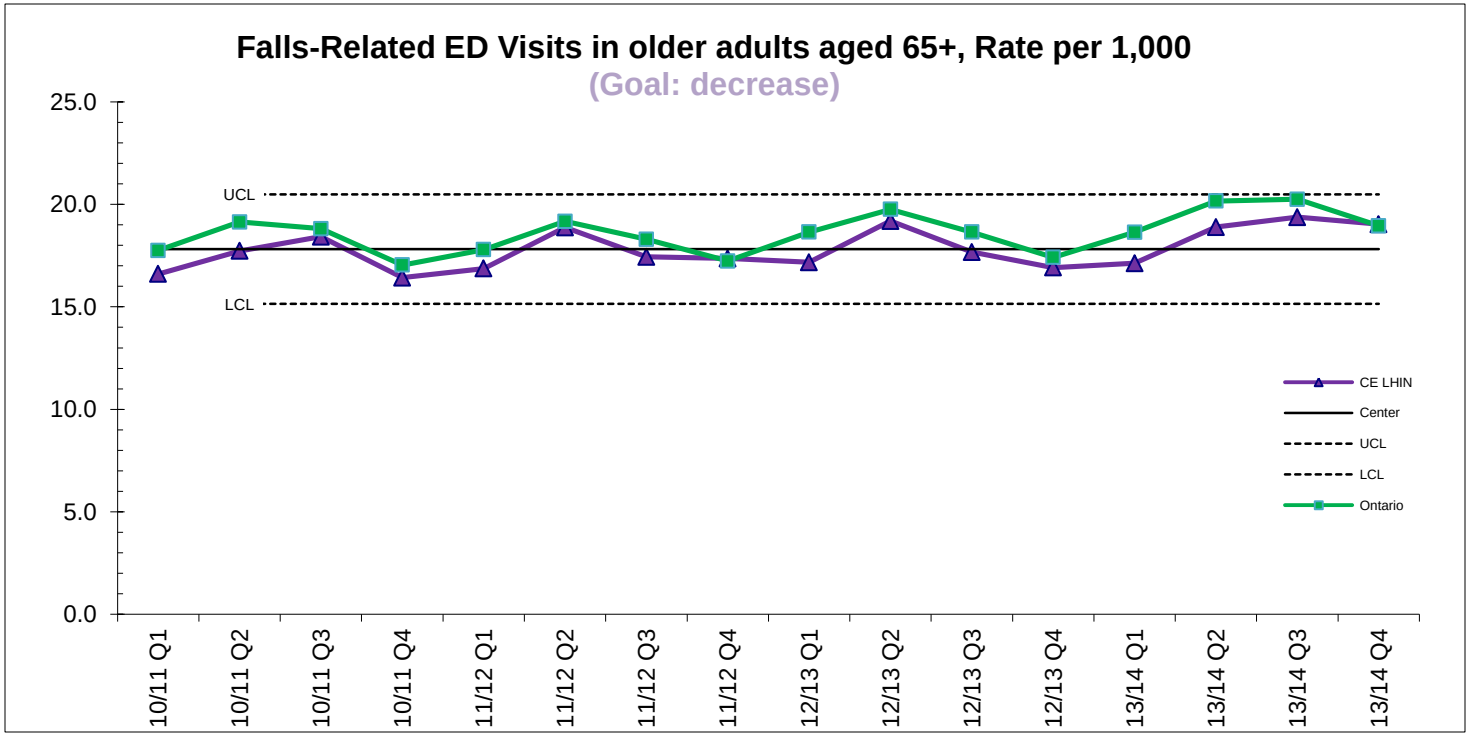
APPENDIX – SUPPORTING METRICS



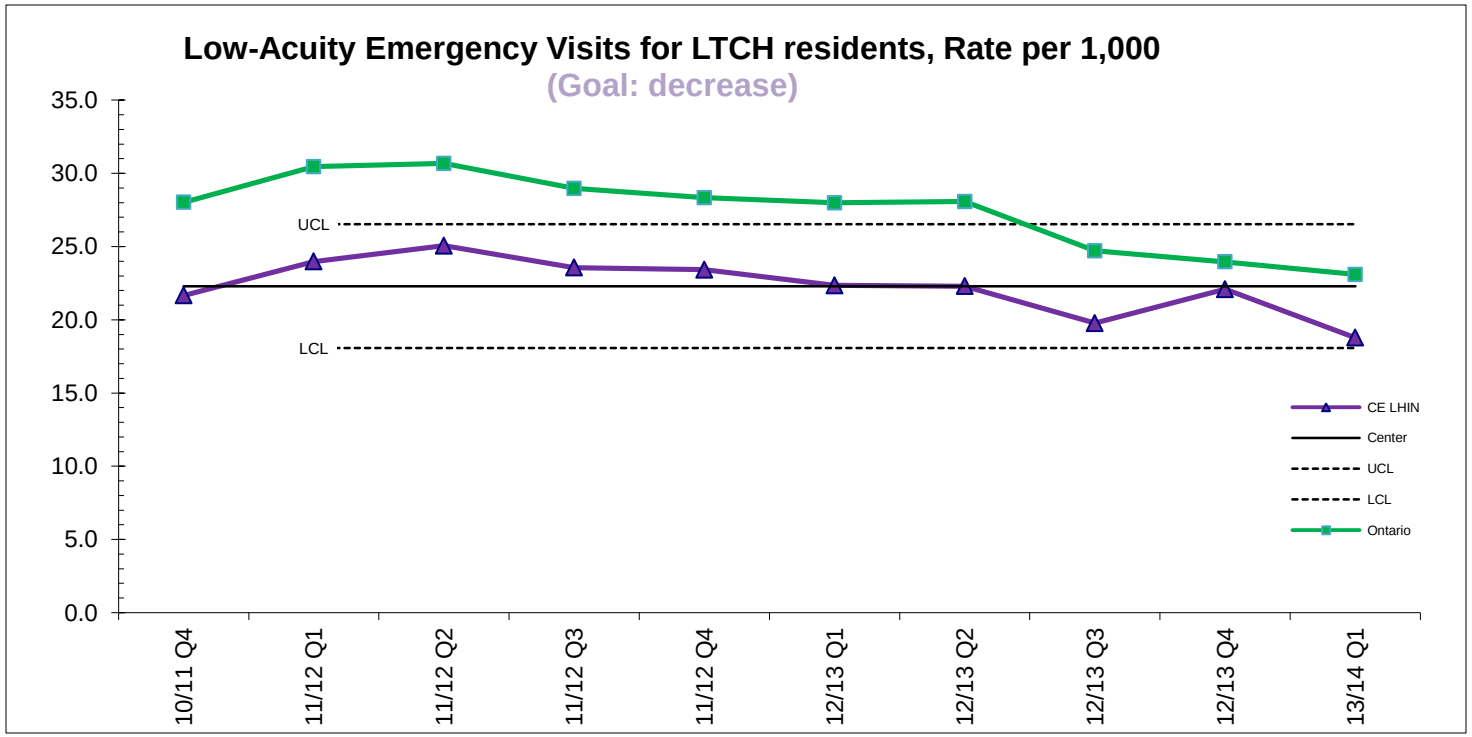
Analysis: In Q4, 2013/14, 90th Percentile Wait Time for Home Care Services (Discharge to First Service) Hospital Setting (all clients) for Central East LHIN is 15 days. There are 3 streams of clients contributing to the current performance: Short Stay Acute (5 days), Short Stay Rehab (21 days) and Long Stay Complex (14 days). The Short Stay Rehab clients contributed to our longer wait. The 90th Percentile wait time across Ontario was 7 days during the same time period.



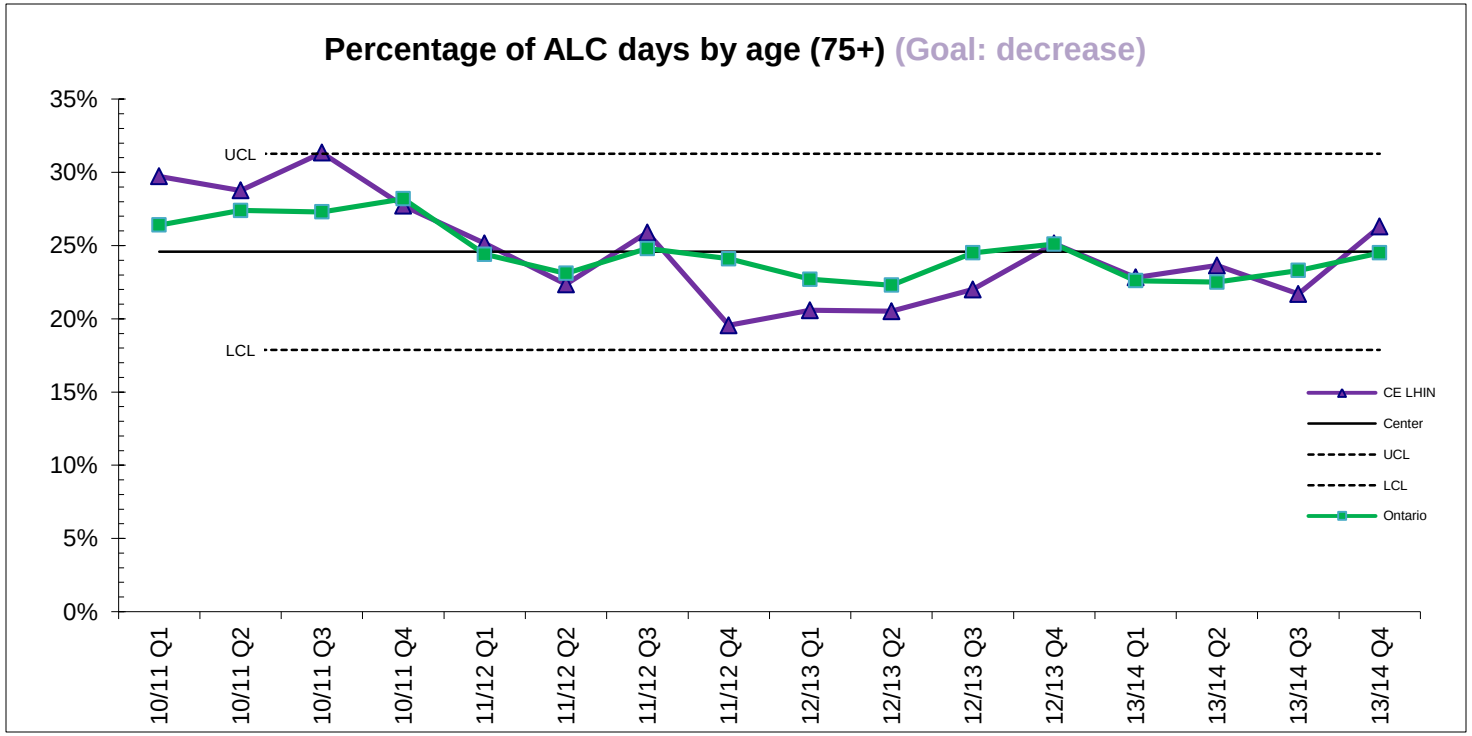
Analysis: The trend of having the highest volume of patients continues in Q4 and for the FY total (which is unique patient count for the year). As of Q4, Central East CCAC patient counts were approximately14% of the provincial total. Between Q1 to Q4 of last fiscal year, the patient counts increased 3% versus the provincial increase of 5%. CECCAC patient count was approximately 4% greater than the CCAC with the second highest volume



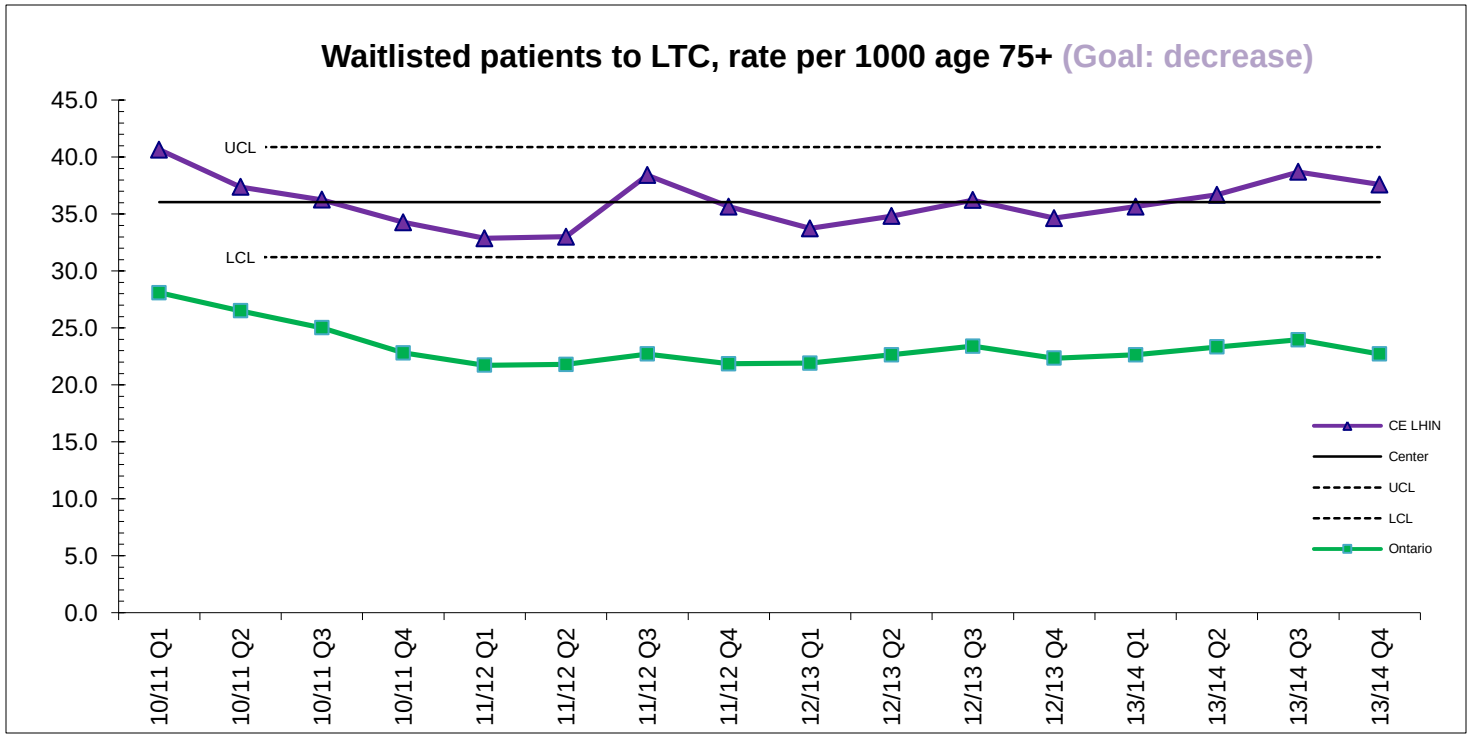
Analysis: The rate of fall-related ED visits in older adults in Central East LHIN is consistent with the provincial rate in Q4, FY 2013/14. This indicator excludes patients living at home with home care and patients living in Long Term Care Homes (LTCH). The goal is to prevent unintentional falls in long term care homes and subsequent visit to the Emergency Department.



Analysis: Central East LHIN rate per 1,000 has been consistently below the Provincial Rate. In Q4, 2013/14, CE LHIN rate decreased to 18.8 per 1,000. Initiatives such as Health Links, Community Funding for FY 2013/14, Hospitals and Community Health Services integrations are expected to reduce ED demand by facilitating ED avoidance, diversion and support individuals upon discharge. The goal is for the residential care population to receive quality care and non-hospital end-of-life care to reduce transfers to the ED. NPSTAT collaboration as a key partner in the CE LHIN Behavioural Supports Ontario strategy which will have a positive impact on ED diversions from LTCH for behavioural reasons.



Analysis: This indicator is measured only when a patient is discharged from the hospital. The numbers will rise during periods when there has been success in discharging a large number of patients designated ALC, or patients who have been in that designation for a long period of time. Further investments have been made in the Assess and Restore (A&R) which will improve screening, assessment, placement, A&R intervention, and finally transition home.



Analysis: In Q4, 2013/14, the rate of individuals on wait lists for LTC per 1000 in the 75+ population dropped to 38%. Across the 14 LHINs, Central East LHIN has the highest rate per 1,000 for FY 2013/14. This disparity has been highlighted by the IHSP Environmental Scan and is one of the key reasons for identifying Seniors as a priority population.

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APPENDIX – ALS-HRS PROGRAMS

ALS-HRS Sites in Central East LHIN and Clients Served to Date

VON:	**Clients Served**
North Durham	59
Gillespie Gardens	63
Scarborough	214
Peterborough	241
Lakefield	25
Havelock	35
Campbellford	39
Cobourg	60
Total	**636**

ALS-HRS Sites in Central East LHIN and Clients Served to Date (Cont'd)

Community Care Durham:	**Clients Served**
Ajax South	137
Whitby/Oshawa	518
Wilmot Creek	90
Total	**745**

ALS-HRS Sites in Central East LHIN and Clients Served to Date (Cont'd)

Care First Seniors	Clients Served
Glen Watford	33
Victoria Park	79
Total	**112**

Community Care Kawartha Lakes	Clients Served
Lindsay	22
Total	**22**

Yee Hong Centre	Clients Served
Scarborough Finch	41
Villa Elegance	42
Total	**83**

2013-2016 IHSP Seniors Aim Update

APPENDIX – ADULT DAY PROGRAM UPDATE

Adult Day (ADP)Projects – Overview/Successes/Lessons Learned

Agency /Program	Clients Served	Successes	Lessons Learned
Community Care City of Kawartha Lakes - Dementia-specific Adult Day Program	Between the opening of the program in early March 2014 to the end of September 2014, CCCKL have supported 13 clients with Alzheimer Disease or a Related Dementia (ADRD) at the Lindsay program	More individualized capacity has been created and appropriate activities based on special needs of clients are being provided. The program is promoting a feeling of independence and accomplishment	With the complexity of responsive behaviors of some clients there are linkages being established with other Community Care organizations and service providers to help address challenges in other ADP locations.
Yee Hong Centre for Geriatric Care – ADP, Alzheimer Program, Memory Training and Activity Centre	ADP – Serving 20 clients/day Alzheimer Program – Serving 18 clients/day Memory Training and Activity Centre – 20 clients/day	The team uses the Mini-Mental State Examination (MMSE) to follow the course of cognitive changes in clients with dementia at admission and regularly. Clients at the Alzheimer Day Program has a slower deterioration than the general dementia population	Through successive training in various techniques such as associative and reductive reasoning, tactile and sensory stimulation, abstract thinking and more, participants will learn how to strategically apply these skills in performing activities of daily living

Adult Day (ADP)Projects – Overview/Successes/Lessons Learned

Agency /Program	Clients Served	Successes	Lessons Learned
Carefirst Seniors and Community Services Association	48 clients/day	Expansion and co-location of the ADP with a community GAIN Clinic site allows Carefirst to develop a Care Coordination Hub for the community of Scarborough	Applying the PACE Model of Care, which is widely adopted by Carefirst, the ADP clients are liaised and are being referred to and received a more comprehensive and integrated services, such as the Assess/Restore program, GAIN clinic and Assisted Living services, as a result
St. Paul's Amoreaux Centre (SPLC)	Serving 20 clients/day	Experiencing increased referrals from other health care providers including CCAC, Hospital GAIN clinics, and GAIN Community Teams	Enhanced collaborative engagement between Day Program and other supportive services available within SPLC through LHIN funded services, partnerships and services agreements (example: Home Support, Meals-On-Wheels, Housing, etc. and Clinical and Primary Care Services such as GAIN, Geriatrician, Geriatric Psychiatry, Physiotherapy, Nurse-led clinics, and Foot care), which helps clients and caregivers to maintain good health and supports independent living in the community

Adult Day (ADP)Projects – Overview/Successes/Lessons Learned

Agency /Program	Clients Served	Successes	Lessons Learned
Oshawa Senior Citizens Centre (OSSC)	36 clients served	Urgent need for specialized adult day program services for adults living in the community is being addressed. The joint effort between OSCC and Faith Place has helped many seniors with complex care needs to participate in this program	With the addition of the Specialized Program, OSCC is better able to meet Day Program clients' needs, in the overall continuum of care.
Victorian Order of Nurses (VON)	YTD – 45 clients served	Additional days of service in Peterborough and Lakefield centres are allowing more clients to be supported in each of those programs. The program at Curve Lake is running successfully and supporting families successfully	Without the availability of this enhanced support at risk seniors might have been at risk of discharge from the ADP programs. Being able to support more clients and caregivers to continue to live at home in their communities through the availability of additional and enhanced respite supports is definitely success