North West LHIN

# Aging at Home Strategy
# Year 1 Service Plan

## Building the Momentum for Change

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Ontario
Local Health Integration Network

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# Aging at Home Strategy: Building the Momentum for Change

## 1.0 Introduction

In August 2007, past Minister of Health and Long-Term Care, the Honourable George Smitherman, launched the provincial Aging at Home Strategy. This strategy is aimed at meeting the health and wellness needs of seniors who require some assistance to live at home independently and reducing the reliance on hospitals and long-term care homes. It represents a $700-million investment, over a three-year period.

While there are concerns about the capacity of the health system to support the growing aging population, there is also a growing appreciation for the desire of most seniors to live independently and with dignity in their own homes and communities. The senior population in Ontario is predicted to double in the next 16 years, increasing reliance on the health care system given the increased health services required later in life. The Aging at Home Strategy reflects a change from traditional health service delivery to a system approach. The majority of seniors are able to live independently, managing their day-to day-activities by themselves; when seniors do require help, approximately 80% of their care is likely to be provided by relatives, friends and volunteers[1].

There is a growing body of literature that stresses the appropriateness and effectiveness of comprehensive, integrated systems of care for seniors. While hospitals and long-term care homes are important resources for seniors in need, services in the community play an important role in maintaining the health and well-being, independence and quality of life for seniors. Furthermore, a mix of community support services may be substantially less expensive than institutional care services. Often considered to be more appropriate choices, community support services are usually seniors' most desired care option.

Since August 2007, the Ministry of Health and Long-Term Care and Local Health Integration Networks (LHINs) have been planning for the implementation of the Aging at Home Strategy. In the spirit of the LHIN mandate, there have been provincially integrated processes initiated to support the development of Ontario's Aging at Home Strategy.

## 1.1 Supporting the Momentum for Change

### North West LHIN Objectives and Priorities

The North West LHIN developed the following Aging at Home Strategy objectives and priorities to align with provincial direction and address local needs. Resources for priority development included the North West LHIN's *Integrated Health Services Plan* (IHSP) and Annual Service Plan (ASP), extensive community engagement activities, consideration of best practices, and analysis of supporting population health and health planning data.

[1] As stated by the Ministry of Health and Long-Term Care in a July '07 presentation to LHIN Board Chairs and CEOs.

## Objectives

The objectives of the North West LHIN's Aging at Home Strategy are:

1. Increase support(s) available for seniors and their caregivers.
2. Increase access to community support services for seniors.
3. Improve access to and decrease waits for long-term care home beds.
4. Increase partnerships and collaborative initiatives for integrated and coordinated care for seniors in the community.
5. Increase capacity to support aging at home for seniors, their families and providers.
6. Decrease the length of stay in hospital for seniors.
7. Establish the Centre of Excellence for Integrated Seniors' Services.

## Directional Priorities

There were three directional priorities that guided the North West LHIN in the service plan development.

### 1) Implement Aging at Home priorities as identified in the IHSP and ASP.

The North West LHIN's IHSP and ASP, in addition to the provincial Aging at Home Strategy, provide direction for addressing priorities. The Aging at Home Service Plan provides the opportunity to review and realign existing resources to better serve seniors and their caregivers.

### 2) Build community capacity and enhance the coordination of community support services.

The Aging at Home Strategy emphasizes collaboration, coordination and building of community capacity. The Service Plan focuses on areas of care management that enhance coordination and integration along the continuum of care, considering both traditional and non-traditional caregivers.

Through recent increased investments in community support services, greater attention has been placed on addressing the needs of seniors in the community, in hospital and in long-term care. This plan aims to build on the initiatives implemented while exploring opportunities to increase capacity across the health care delivery system.

### 3) Explore new models and innovative strategies to support Aging at Home.

Alternative models of care that support seniors to age at home are the primary focus of this strategic initiative. Best practices provide an opportunity for ongoing learning and support decision-making for caregivers and providers. The identification of opportunities to implement new models and/or innovative models that promote prevention and wellness strategies, local community economic development and informal care services have been important considerations in the planning process. As part of the development of this priority, planning includes ways to transfer knowledge about these new models and/or innovative strategies with others, both within the North West LHIN and provincially.

In the North West LHIN, the Aging at Home Strategy represents a financial investment of $3,399,768 over 3 years, to be allocated as follows:

- $1,046,673 (beginning April 1, 2008)
- $878,283 in 2009/10 in additional base funding, for a total of $1,924,956
- $1,474,812 in 2010/11 in additional base funding, for a total of $3,399,768

It is intended that the Aging at Home Strategy will align with the planning priorities of the North West LHIN's *Integrated Health Services Plan* including:

- Access to Care
  - Access to Primary Health Care
  - Chronic Disease Prevention and Management
  - Access to Specialty Care
  - Access to Mental Health and Addictions Services
- Availability of Long-Term Care Services
- Integration of Services Along the Continuum of Care
- Engagement with Aboriginal People
- Ensuring French Language Services
- Integration of e-Health
- Regional Health Human Resources Plan

# 2.0 Aging at Home Strategy – Community Engagement

## Activities to Date - Building the Momentum for Change

Community engagement has been a key component in developing the service plan for the Aging at Home Strategy in the North West LHIN. The North West LHIN has engaged more than 400 individuals and groups to share information about the Aging at Home Strategy and to explore and examine the opportunities and challenges for seniors, their caregivers and communities in Northwestern Ontario. Community engagement sessions included seniors, families, caregivers (formal and informal), community businesses, educators, local leaders, and traditional and non-traditional providers all who want to contribute to make the Northwest a safe place for seniors to age at home. The sessions ranged from formal group discussions, focused individual and small group sessions, written submissions from interested health service providers and service organizations, and correspondence from seniors and their families. In addition, best practices and models of care for seniors from various jurisdictions were explored.

# 2.1 Defining the Need

Information from community engagement activities, as well as the North West LHIN's *Integrated Health Services Plan*, were instrumental in helping to frame the emerging Aging at Home themes.

The themes[2] identified include the need for:

- Integrated and coordinated services for seniors;
- Access to services and programs for seniors;
- Services for Aboriginal Elders;
- Supports for informal care providers;
- Supports to address safety and security issues;
- Services for seniors' day-to-day activities; and
- Valuing and understanding of aging populations and seniors' care.

## Seniors' Services Themes

### 1) Integrated and Coordinated Services for Seniors

During community engagement, health service providers and seniors clearly articulated the need for seniors' services that are integrated, coordinated, connected and able to respond to the changing needs of seniors. The gaps between services and between service providers cause complications and hardships for seniors, their families and caregivers. Ongoing communication and information sharing was identified by seniors and health service providers as essential to ensuring good care. The 'circle of care' for aging at home was identified as an important consideration in ensuring that seniors and their caregivers have access to timely and accurate information. Communication of seniors' health care information to family members and community caregivers in First Nations communities was described as essential to supporting Elders at home.

[2] Not listed in order of priority.

The need to maintain a full continuum of care (i.e. system) perspective and best use of scarce resources was mentioned repeatedly. Community engagement participants looked to other integrated care delivery models such as the Early Years Strategy (for ages 0-6 years) and chronic disease prevention and management strategies as potential models to be adapted for care planning and delivery for seniors. Intergenerational programming, including linkages and partnerships with youth services, was suggested as a means to maximize the use of available resources, to support the cultural shift towards increased respect and value for seniors and to provide early health and wellness education for the seniors and caregivers of the future.

Many people (health service providers, seniors and caregivers) noted that they were not aware of many of the services available to seniors in their own communities. Through better integration/collaboration and increased communication about available services, it was suggested that access to care would be improved, ensuring the right services are available at the right time in response to the changing needs of an aging population.

### 2) Access to Services and Programs for Seniors

Most seniors engaged with the North West LHIN reported that they experience some difficulties in accessing needed services, programs and supports. Inconsistencies in the range of services available for seniors in communities across the Northwest were identified in addition to a significant and growing decline in services available in the community.

Northwestern Ontario's vast geography has been identified as a barrier. With few exceptions, people are traveling to Thunder Bay, Winnipeg or other centres in Ontario to access specialty services. In rural/northern areas, caregivers often travel long distances to visit senior clients in their homes. Additionally, seniors living in small communities may be required to travel long distances for primary and rehabilitative health care services. As well, should a long-term care home be required, seniors may have to move to larger centres, leaving behind the support of their spouses, family and friends. The cost and availability of transportation in the Northwest area makes bridging the distance between the senior and their family a significant financial and emotional burden.

Limited seniors' services were identified as a barrier to seniors seeking services and programs. Supportive housing, respite and convalescent care, community support services, day programs and other alternative care options were repeatedly identified as lacking, limited or prohibited by cost. Seniors and caregivers proposed a system that provides a mix (basket) of services designed to meet individual needs. This service mix was envisioned to be flexible in order to respond to the fluctuating needs of a senior. Community members also suggested that services be clustered to improve access to supports and resources.

> "My home used to be a house; today my home is in a seniors' apartment. Some day my home may be in a long-term care home."
>
> - A Senior

Seniors and their family members noted that seniors are sometimes required to stay in hospital for extended periods and/or move to long-term care homes despite lower level care needs (i.e. Alternate/Appropriate Level of Care). With additional supports in the

community, it was felt that these seniors could remain in their homes safely, with improved quality of life.

Access to primary care and specialty care was identified as important but limited in many of the communities in the Northwest. Seniors reported that limited access to primary care resulted in repeated visits to their local hospital emergency department and/or extended time spent in hospital to address their episodic care needs. Informal caregivers, including working family members looking after parents or older relatives, described difficulties in accessing care services on evenings and weekends and/or having to make multiple trips for care when coordination was lacking. The importance of a team approach (e.g. Family Health Teams) in service coordination was often cited as a means to improving access to services. Access was also reported to be improved through the use of mobile services and telemedicine.

> "Scheduling of seniors' services needs to be coordinated in order to make the best use of our community resources such as doctors' appointments made on days when transportation service is available. This is even more important when having to find someone to drive us out of town for multiple appointments."
>
> - A Senior

Clinical knowledge in gerontology was reported to be limited, across the Northwest. Access to services and resources to assist in the area of mental health and dementia was repeatedly identified as a need. Enhanced use of telemedicine was identified as a means to improve access to specialty services for seniors in the North West LHIN and a resource to link staff with specialists through web-based learning opportunities.

With progress made in caring for those with developmental delays, these individuals are entering middle age and older years with specialized care needs. As parents age, they are experiencing difficulties in caring for children with developmental delays and these children are presenting some seniors' health issues at an earlier age. It was identified that there is a growing need to develop strategies and services for this population in the Northwest.

Difficulties in securing adequate health human resources were also highlighted. In some communities, community nursing services and homemakers are unavailable due to a lack of professionally trained staff and personal support workers. Furthermore, it was noted that the field of gerontology has not been viewed or rewarded as a preferred area of practice and thus fewer health service providers choose this field of practice. With limited availability of physician resources, some communities must rely on locums to fill the service gaps. The use of locums and not having one consistent primary care practitioner was identified as a problem, especially when related to issuing prescriptions, coordination of medications and the management of chronic conditions. The role of nurse practitioners was often suggested as a means to improve access to and continuity of care. Suggestions to manage limited health human resources and to improve access to services included establishing nurse practitioner-led clinics, enhanced home visits and greater numbers of Family Health Teams.

The lack of health human resources was seen to be placing increased burden and reliance on volunteers. With the decreasing population in many Northwestern Ontario communities (particularly youth out-migration and out-migration of those 35-50 years),

the future of volunteerism was questioned. Furthermore, people indicated that seniors are the primary volunteer resource base, affecting sustainability and leading to comments from seniors such as “Volunteering is a major part of my life, but who will take care of me when I need it?”

The lack of transportation services was identified as a barrier for seniors to access services, such as primary care, nutritional services, social and recreational programs. As one senior noted, “Do people think seniors want to stay in their homes and not go out dancing?” Although some transportation services exist, they were reported to be expensive for some individuals and not available in every community. In some cases, seniors reported they were not even aware of the transportation services available in their community.

In June 2008, the Minister of Health and Long-Term Care announced the purchase of 100 vans to assist senior’s transportation in the province; eight new Dodge Caravans were allocated to the North West LHIN. These vans will to help area seniors get to and from medical appointments, wellness programs and recreational activities such as exercise programs. This initiative assists seniors in the Northwest in accessing health and wellness services. The eight vans in the North West LHIN are placed in six communities the region; providing an estimated 11,000 rides for seniors across Northwestern Ontario.

### 3) Services for Aboriginal Elders

The need for improvements in seniors’ services for Aboriginal people was identified by participants, who noted that geographic, language and cultural barriers may inhibit access to services. It was reported that Elders, especially those in remote Northern communities, are seldom able to access housing to meet their needs in their home communities due to the lack of options, such as supportive housing, wheelchair accessible homes and long-term care homes. Often, Elders are required to leave their home communities and move to larger centres in order to receive needed services and programs. It was identified that the need to move to access health services greatly affects the entire community; many are also caregivers for other Elders and are often the primary caregiver for grandchildren. In addition to being isolated from family and friends, Elders also experience cultural and linguistic isolation when they are away from their home community. The inability to access traditional food, speak in one’s mother tongue, or fully comprehend the information provided creates huge stressors and impacts patient safety.

Coordination of services was reported to be very difficult due to various funding body policies; challenges in follow-up care across a distance; and air travel required to and from many of the First Nations communities. For example, timely access to medication is complicated due to distance from pharmacies and reliance on air delivery, often taking months to receive a renewed prescription. The importance of linking traditional healing with modern medicine was identified, emphasizing the need for care providers to coordinate care plans and ensure ongoing communication to minimize adverse events such as drug interactions.

Remote communities have limited in-home Elders’ services. Those providing in-home community supports identified geography and funding constraints as impeding access to services and equipment for seniors. It was reported that much of the home support is directed at providing the essentials, i.e. water and heat (wood) for the Elders.

Collaborative service partnerships, use of technology for service and training and a core basket of services were identified as necessary in helping Elders to remain at home.

### 4) Supports for Informal Caregivers

Many participants in the community engagement process indicated that family members and caring neighbours were the primary supports for seniors in the Northwest. A common experience cited by informal care providers was the lack of awareness of available community support services for seniors both within their own community and in the region. In addition, informal care providers identified the importance of support services such as respite services, with crisis placements when the caregiver is ill; in-home palliative care; day programs; and financial support and guidance in providing care for a loved one.

It was reported that years of caring for aging seniors and lost wages has resulted in financial and physical hardships for many informal providers. With the out-migration of youth in the Northwest, many caregivers are themselves seniors. Family members raised concerns about the sustainability of frail seniors caring for other frail seniors. Family members indicated that community support organizations such as the Alzheimer Society and homemaking services were especially valuable in providing information easing the care burden.

### 5) Supports to Address Safety and Security Issues

The safety and security of seniors was identified as being very important to the residents of the North West LHIN. Seniors identified adverse weather and lack of transportation as potential safety risks. Geographical isolation and emotional distance from family members were also described as a safety concern. Frail seniors were identified at greatest risk of injury and isolation. It was reported that obtaining assistance to install safety equipment in homes was difficult for seniors due to the lack of financial and/or human resources. Seniors and caregivers indicated that home maintenance services and home help programs would be an important resource to assist seniors to age safely at home. Finally, falls prevention programs were repeatedly highlighted as essential to support seniors in their homes.

### 6) Services for Seniors' Day-to-Day Activities

Services that provide assistance to seniors for day-to-day independent activities of daily living (IADL) were repeatedly identified as a key resource that would help seniors to age at home e.g. help with paying bills; meal preparation; grocery shopping; homemaking tasks; snow removal; volunteer driving; friendly visiting and minor home maintenance. These supports would promote greater independence and keep seniors safely living in their homes. In addition, assistance with medication management including reminders, refilling prescriptions and ensuring appropriate doses and mix of medication were reported to be a high priority for seniors. Recreational and social activities were identified as important to the overall health and wellness of seniors and to support seniors to remain in their homes. Friendly visits and calls to seniors were identified as being important for health promotion and illness prevention. Individuals who reported having access to volunteer and community support services identified these resources as essential to remaining at home.

### 7) Valuing and Understanding of Aging Populations and Seniors' Care

As the baby boomers population continues to age, there will be a greater public focus on the senior population. Education of health care professionals related to healthy aging and caring for an aging population was identified as increasingly important to support seniors to age at home. Identification of economic opportunities related to seniors and interest in age friendly communities, were identified as some key considerations that will affect attitudes towards seniors. Many seniors spoke with pride of their value and role in society, while other seniors described devaluing experiences. Community members reflected on their role and their communities' responsibilities to ensure that older members of the population are supported and valued.

## 2.2 Exploring Opportunities and Innovation

The following opportunities were identified during the Aging at Home planning process and community engagement activities; these opportunities will be incorporated into our planning for senior's services.

### 1) Maximizing Health Human Resources

Increasing and expanding the number of interprofessional teams in the Northwest was suggested as a way to improve access to health services, allowing seniors to visit the most appropriate health professional(s), while freeing other professionals to see clients. Family Health Teams, Community Health Centres and Aboriginal Health Access Centres were cited many times as providing improved access to primary health care. The importance of the role of pharmacists as part of the care team was reported numerous times as was the inclusion of those working in mental health and addiction services.

The role of nurse practitioners (NPs) in supporting seniors' care was discussed in all communities. The experience of receiving care from nurse practitioners was reported to be positive, with adequate time available during appointments to discuss health and wellness needs. Seniors and their families felt that the availability of nurse practitioners may decrease the reliance on physicians, enabling physicians to have additional time to see clients for services outside of the scope of a nurse practitioner. Suggestions for improved access to nurse practitioners included having a nurse practitioner-led clinic (that could be specific to seniors or available to the general public), having NPs complete in-home assessments and follow-ups, and increasing the number of NPs in Family Health Teams.

The services of nurse practitioners, other allied health professionals, community support service agencies and public health were described as valuable in enhancing prevention and wellness strategies for seniors. Exercise programs, falls prevention programs, accessible immunizations and nutrition education were cited as examples of wellness services that could be provided to seniors.

### 2) Collaboration of Care

While speaking with health service providers, families, caregivers, seniors and community members, the relationships and collaboration that happen in communities and between communities throughout the region was seen as a true strength. In addition to being something people were very proud of, this type of collaboration was also described as presenting important opportunities for innovation and integration.

Collaboration is seen as a necessity and inherent value in the Northwest. There are a number of innovative collaborations happening in the Northwest, including:

- Addictions providers in the City of Thunder Bay working together to ensure that 'no door is a wrong door' to service;
- Ambulance, police, health service providers, volunteers and spiritual care collaborating across the Northwest to ensure that palliative care is available and supported in our communities;
- Collaboration with municipalities to ensure that seniors' driveways and walkways are cleared of snow; and
- Collaboration with local businesses to have goods delivered to seniors' homes.

Through sharing of resources and partnerships (traditional and non-traditional), the establishment of collaborative community planning tables was reported as an opportunity to enhance existing services, identify and address gaps, reduce service duplication and improve coordination of care.

### 3) Services Closer to Home

Innovative strategies for providing services closer to home were seen as a strength in the Northwest. Examples cited included mobile health services and telemedicine. During community engagement for the *Integrated Health Services Plan* and the Aging at Home Strategy, the Ontario Breast Screening Coach, CNIB Eye van and the new NorWest Community Health Centre mobile unit were identified as models for providing services close to home. Mobile services are an effective and efficient method of making the most of limited resources as they increase the range and quality of health services for people living across the Northwest. Although it was acknowledged that not all services will be available in every community or be appropriate as a mobile service, suggested potential mobile services for seniors included primary health care, seniors' day programs, foot care, and specialized services such as physiotherapy and occupational therapy. Mobile services were also considered as a potential resource for elders living in more remote areas of the region.

> "Seniors need a health system that reaches out to them. Going into someone's home environment also improves the safety of seniors living at home…it can provide important clues as to what is really needed and what could help."
>
> - A Provider

The Ontario Telemedicine Network is an example of innovation developed in the North. With all of the communities in the Northwest (including remote First Nations via Keewaytinook Okimakanak (KO) Telehealth) having access to telemedicine, communities recognize the great potential and service provided by telemedicine. In addition to improving access to specialists for assessment and follow-up, telemedicine is

used to link health service providers with experts for training and advice; provides opportunities for ongoing education and training; offers group support and activities to those in isolated communities (e.g. cardiac rehabilitation); provides a means to communicate between communities for collaboration opportunities; and enables Elders to stay connected with family and friends.

The expansion of telemedicine in the Northwest including access to a greater range of services, greater number of available access times (i.e. increased number of telemedicine units) and expansion of current programs is seen as a way to significantly improve access to many services. Priorities for telemedicine expansion were identified as telehomecare, access to psychiatry and specialized mental health services, and activities that would decrease the isolation of seniors.

An **innovative idea** that was mentioned several times during community engagement sessions across the Northwest was the idea of an "Older Years" program. Seniors suggested that just as with those aged 0-6 years, seniors require specialized programming, navigation and direct contact with a caregiver. As one senior reported, "In Ontario we ensure that no child is left behind...I don't want to be left behind or forgotten either." Those suggesting this integrated model of care delivery felt that benefits would include:

- Case management/navigation for every senior; the senior or senior's family could determine when this service was needed.
- A friendly phone call and possible follow-up visit from a nurse within 48 hours of discharge from hospital.
- Linkages to services likely to be relevant to seniors, i.e. day centres, seniors' centres, senior exercise programs, etc.
- Linkages between the primary point of contact in the model (i.e. case manager) and all other service providers.
- Supports and education for those caring for seniors.
- Health promotion and illness/injury prevention programs for seniors.

### 4) Wellness and Education

Keeping the senior population healthy was deemed to be of great importance. Seniors, families and health service providers identified the need for partnerships to promote a healthy aging population. Partnerships included, but were not limited to, health service providers, public health, chambers of commerce and local businesses, housing, municipalities, education and numerous other parties.

Education of caregivers, health service providers and the general public on healthy living and issues specific to seniors was seen to be very important. Areas of focus include general facts, information on where to go for service or how to access additional information.

Linkages with Confederation College, Lakehead University and the Northern Ontario School of Medicine were identified as opportunities to prepare future health service providers to address the needs of our aging population, through curriculum, clinical placements and presentations.

# 3.0 Aging at Home Strategy – Planning

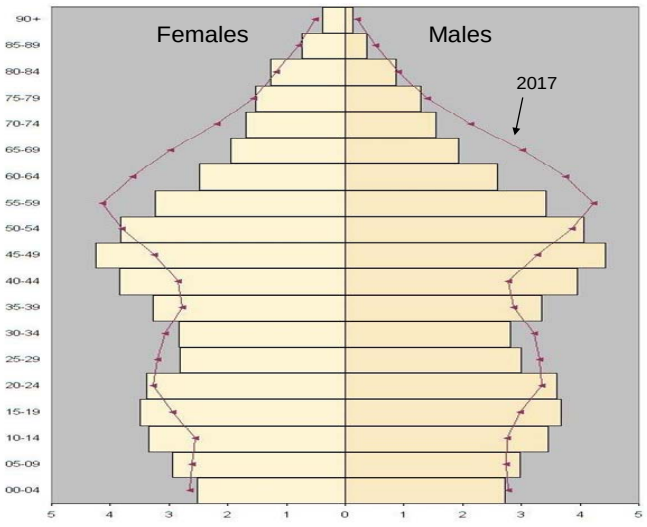
## 3.1 Environmental Scan

The population of the Northwest is aging faster than the province as a whole. Compared to the provincial population, the Northwest has a slightly higher proportion of people 65 years or older. The lack of new immigrants, slow population growth and continued youth out-migration contribute to the older age of Northwestern Ontario's population. Youth out-migration is now at the highest level ever. From 1996-2001, the population in Northwestern Ontario aged 55 years and over increased by 5.1%. During the same period, the population of youth dropped significantly (-7.2%) and the population of people aged 25-54 also declined (-3.4%).

This demographic profile suggests that there will be future challenges related to formal and informal care giving for seniors, as fewer people from the younger cohorts[3] will be available for these roles. Furthermore, this youth out-migration represents a loss of potential formal care providers. Securing skilled caregivers is increasingly a challenge for many communities and seniors in the Northwest.

The following exhibit shows the population structure of the North West LHIN. The purple line denotes the population projection for 2017, which shows that there will significant shift towards an older population in the next ten years. While there may be a slight increase in population in the 25-34 year age group, there is predicted to be a large decrease in the percentage of population that is in the 35-54 year age group.

**Exhibit 2.0 Projected Age-Sex Population Distribution (2007 and 2017)**




Source: 2001 Census

The population of the North West LHIN is decreasing, with an expected 4.4% decline expected by the year 2031. The population of seniors will continue to grow over this time

[3] Youth Out-Migration in Northern Ontario – 2001 Census Research Paper Series: Report #2, Training.

period by 77.4% in the 65-69 year age group between 2007 and 2031; 105.4% in the 70 – 74 year age group and 80.3% in the 75 – 79 year age group. Significant growth is also projected for people 80 years of age and older. Projections indicate that by 2031 the percentage of the North West LHIN population over the age of 65 will be 25.6%. (See Table 1 for details.)

**Table 1 Population Project Comparison 2007 and 2031 with Percentage Increase**[4]

| Age | 2007 | 2031 | % Increase |
|---|---|---|---|
| 65-69 | 9,100 | 16,145 | 77.4% |
| 70-74 | 7,624 | 15,656 | 105.4% |
| 75-79 | 6,633 | 11,959 | 80.3% |
| 80-84 | 5,028 | 8,176 | 62.6% |
| 85-89 | 2,599 | 3,817 | 46.9% |
| 90+ | 1,240 | 1,805 | 45.6% |
| **Total Pop** | **235,167** | **224,786** | **-4.4%** |

In addition to the declining population, the Northwest also has the lowest life expectancy among males and females in the province and Northwest residents report higher than average rates of chronic disease. Arthritis afflicts approximately 17.2% of the population of Ontario, while it is reported in approximately 21.4% of the population in the Northwest. Heart disease is reported as 16.1% in the 65-74 age group in Ontario, while affecting 26.7% of the same age group in the Northwest. With a high burden of chronic disease, it is expected that there will be challenges to support seniors aging at home in the North West LHIN.

Aboriginal people, who make up a large and growing proportion of the population, are developing chronic diseases earlier in life. In addition, this population has a high incidence of diabetes. Many of the support programs and services that are common in larger communities such as community respite, transportation, supportive housing and Alzheimer day programs do not exist in many of the northern/rural communities. Admission to a nursing home is often the only option for seniors, who might be better supported to age at home. This has significant implications for requirements for long-term care services and the future health care needs of the seniors.

Access to services is an ongoing challenge in the North West LHIN. Many seniors outside of Thunder Bay must travel great distances to access specialty services. As road conditions are less than optimal for several months of the year and the drive to services is often long and isolated, many seniors choose not to travel.

In addition, services for seniors across the continuum of care are not consistently available across the North West LHIN. Cultural and linguistic requirements (e.g. for the Aboriginal and Francophone populations) may present a barrier for seniors accessing services. As well, there is an identified and documented shortage of home support services and supportive housing for seniors across the Northwest. Several reports[5,6,7] have suggested that appropriate investments in community supports and supportive

[4] 2006 Population Estimates, Ontario Ministry of Finance, accessed through PHPDB.

[5] "Integrated Service Plan for Northwestern Ontario", Report of the Special Advisor, Tom Closson, June 2005.
[6] "A Study of Alternative Care in the City of Thunder Bay", Northwestern Ontario District Health Council, 2004.
[7] "Supportive Housing in Northwestern Ontario: A Needs Assessment", Northwestern Ontario District Health Council, 2004.

housing could actually reduce the need for long-term care home beds and allow seniors to remain in their homes for longer periods.

The use of technology has helped to improve access to services. A number of specialists use the Ontario Telemedicine Network (OTN) to conduct appointments with their patients. There is only one geriatrician to serve this vast region, and through the use of telemedicine, his capacity to serve clients in the region is greatly enhanced. Many other specialists also use this technology, which increases access and reduces the need for seniors to travel to access services. An innovative cardiac rehabilitation program is offered to seniors in small communities in Northwestern Ontario through telemedicine.

## 3.2 Aging at Home Activities

### 1) Advisory Teams: Supporting Change and Integration in the Health System

The North West LHIN has sought the involvement of local health service providers and residents of Northwestern Ontario in order to establish effective collaborative relationships essential to improving outcomes and achieving results for our health care system. As part of this ongoing collaborative process, the North West LHIN has established a System Integration Committee to provide advice to the North West LHIN senior leadership team on innovation, change and integration in the health system. Linked to this Committee are five Advisory Teams that provide advice to the North West LHIN on planning and implementation of comprehensive services within the context of the specific IHSP priorities. Communities of Interest, consisting of people from across the Northwest with various backgrounds, support the work of the Advisory Teams.

The Seniors' Services Advisory Team has been established and has begun to assume its role as a resource/support for the planning of seniors' services for the Northwest's health care system. The membership of this Team includes health service providers as well as interested community residents. The Seniors' Services Advisory Team has participated in a workshop in the Balance of Care methodology, has examined best practices for seniors' services and provided the North West LHIN with critical feedback in the development of the Aging at Home Directional Plan and the Service Plan. This Team will continue to be a key resource in moving the Aging at Home Strategy forward.

### 2) Building for Change

On November 21, 2007, the North West LHIN and St. Joseph's Care Group co-hosted a visioning exercise with Dr. Paul Williams, Co-Director of the Canadian Research Network for Care in the Community. Health service providers, seniors and interested community members were exposed to provincial, national and international models and best practices in the delivery of integrated seniors' services. This visioning exercise also included a presentation from the Innovation Centre in Thunder Bay which stimulated thinking about innovative and non-traditional approaches to community development opportunities that can support seniors to age at home in their community.

### 3) Investing in Seniors:

#### The Interface of Chronic Disease and Aging at Home in the North West LHIN

The North West LHIN has a high prevalence of chronic illness. Asthma, hypertension, arthritis, diabetes and heart disease all occur at levels pronouncedly higher than the provincial average. As chronic conditions are more likely to emerge in later years, the implications for seniors' health are significant.

Improvements in the prevention and management of chronic conditions are taking place. Capacity to support self-management of chronic illness has been greatly expanded through education sessions sponsored by the North West LHIN. Over 300 providers have attended sessions thus far, and further training will take place in the near future. Supporting seniors to manage their conditions in the community when they are well will effectively prevent unnecessary admissions to acute care that often are precursors to long-term care home admissions.

The establishment of Family Health Teams with a mandate to better manage chronic illness will be instrumental in supporting older adults to sustain manageable levels of health and therefore remain in the community. As the incidence of chronic illness increases with age, the proactive approach of the Family Health Teams will be especially important for seniors.

In March 2008, the North West LHIN hosted the Chronic Disease Prevention and Management (CDPM) Self-management Master Trainer Program provided through Stanford University. Building self-management capacity is a focused strategy for the North West LHIN. This self-management approach is aimed at supporting and educating seniors to better manage their chronic illnesses independently while remaining in their home communities. Twenty-eight health service providers from across the North West participated in this week-long training program; an investment which has the potential to reach every senior in Northwestern Ontario.

### 4) Alternate Level of Care (ALC)

One of the persistent system-wide challenges facing seniors relates to the need for services to be provided in the most appropriate setting. Alternate Level of Care (ALC) issues exist when an individual (most often a senior) occupies a bed in an acute care setting when he/she no longer requires acute care services. While the term reflects the situation most prevalent in acute care, seniors wait for appropriate levels of care in chronic complex care, rehabilitation and long-term care settings. Impediments to facilitate appropriate levels of care to meet client needs in the most appropriate setting include: lack of community support services, lack of available supportive housing units, and the inability to access higher intensity services that help seniors maintain independence in activities of daily living while at home.

A comprehensive range of care and service options need to be available in the community to supply services that reflect the needs of seniors. This continuum of care needs to be transparent to those requiring services. The North West LHIN is advancing strategies related to Aging at Home that will help address the ALC pressures in the following areas:

Provide support for seniors in instrumental activities of daily living through:

- Home maintenance;,
- Home help (shopping support, meal preparation and housekeeping);

Provide functional support programs for seniors in activities of daily living such as:

- Congregate dining;
- Enhancements to Meals on Wheels;
- Enhancements to supportive housing;
- Support for First Nation people to exercise at home through telerehab linkages;
- Respite services where gaps exist in the community;
- Early referral and linkages for individuals with dementia; and
- Geriatric mobile unit which will be used to assess home bound individuals re: management of their activities of daily living.

Aging at Home initiatives for Year 2 must focus on addressing ALC and ED pressures and planning is currently underway.

### 5) Service Coordination

Seniors and providers alike have identified that there is confusion about what services are available in their community and where to access services or programs outside of their home community. Inventories of available resources are not readily available, nor are they regularly updated and there is no one single point of access that links available resources or services for seniors across the Northwest.

The 'Balance of Care' key assumption identified by Dr. Paul Williams at a visioning session held in the North West LHIN indicated that individuals are less likely to require institutional care where appropriate, managed home and community care packages are accessible. Alternatively, individuals are more likely to require institutional care where appropriate packages of care are not accessible. "At risk" individuals are least likely to be able to navigate the system on their own. Community support services play an important role in maintaining health, well-being, independence and quality of life for seniors. Intensive case management can reduce costs and promote access to care while using minimal level of services to maintain the individual at the highest possible functional status.

Recently a single point of access to learn about available resources was established in Northwestern Ontario, through the implementation of a '211' call centre. Funded by the United Way, this initiative has been quite successful in many other communities across the province. Current '211' efforts are focused on educating providers and the public about this service.

### 6) Home Support Services

The need for home support services that help maintain functional independence and quality of life for seniors was identified by seniors and health care providers. Home support services in the Northwest vary from community to community; limited services are available in most communities. The North West LHIN intends to work with community partners to promote opportunities that build additional capacity for home support services through an integrated system of care.

# 4.0 Aging at Home Strategy - Service Plan

Seniors and their caregivers living in communities across the Northwest will benefit from the implementation of the Aging at Home Strategy. Increased access to a range of services will help maintain independent activities of daily living and support healthy aging at home. By increasing opportunities and offering enhanced care packages for seniors, hospitals and long-term care homes will have greater capacity to respond to those seniors who require access to specialized care across our region. In addition, enhancements to home care and community support services will serve seniors well through improvements to care coordination, increased collaboration and where possible integration of resources at the local community level.

## 4.1 Service Plan Overview

The North West LHIN Aging at Home Service Plan is built on the provincial Aging at Home Strategy directional priorities of maintaining seniors' independence and safety in their homes and communities, innovation, integration, partnerships and sustainability. The following chart provides an overview of priority activities to be addressed by the North West LHIN over the next three years.

Populations of the North West LHIN who may benefit from the Aging at Home Strategy include individuals and their families or caregivers who:

- Want to help seniors continue to remain independent and safe in their own homes;
- Risk experiencing an episode of illness that requires additional supports to remain at home;
- Are inappropriately admitted to hospital or long-term care because of insufficient community supports or lack of alternative services;
- Are waiting in hospital for a more appropriate level of care;
- Require behavioural support services and access to respite services.

| North West LHIN Aging at Home Strategy – Service Plan | | |
|---|---|---|
| **2008/09** | **2009/10** | **2010/11** |
| ▪ Further explore and identify innovative models and strategies as options for the North West LHIN that support seniors to age at home. | ▪ Implement 1-2 innovative models or strategies across the North West LHIN that build on the theme of Aging at Home. | ▪ Expand implementation of the innovative models more broadly across the North West LHIN that build on the theme of Aging at Home. |
| ▪ Increase knowledge transfer and promote best practices through Aging at Home-related forums. | ▪ Leverage additional resources to promote implementation of best practices more fully across the North West LHIN. | ▪ Identify best practices in seniors' service delivery across the North West LHIN and celebrate successes. |
| ▪ Identify opportunities for partnership and integrations of services in the community that will enhance coordination of care across the continuum. | ▪ Work with partners to implement integrations of community and support services that enhance coordination of care across the continuum with access as a priority. | ▪ Align resources to support continued integration of services. |
| ▪ Host sessions with business partners to promote innovation and enhancement of services for seniors across the North West LHIN. | ▪ Create an inventory of new services that are developed in response to the challenge for innovative community solutions. | ▪ Evaluate the success and sustainability of initiatives that have been implemented. |
| ▪ Develop an evaluation framework to measure improvements in service delivery for seniors in the North West LHIN. | ▪ Work with research and educational partners to collect baseline data using the evaluation framework. Develop a report on findings. | ▪ Produce report on evaluation of the three-year strategy based on performance measures identified. |

## 4.2 Planning Year 1: Initial Priorities and Proposals

Priorities for the North West LHIN Aging at Home Strategy were identified through a number of processes including community engagement, review of relevant background material and literature on best practices and/or an environmental scan. Identification of key themes related to seniors' services as well as consultation and validation with experts in the field, health service providers and the North West LHIN Seniors' Services Advisory Team also helped to determine the Year 1 priorities.

### Request for Proposal Process

A request for proposal process was used to gather proposals that addressed one or more of the initial key Aging at Home Strategy priorities in the North West.

The call for proposals was issued on May 12, 2008, with a closure date of May 30, 2008. The focus of this call was to:

1. *Reduce Length of Hospital Stay*
2. *Decrease Unnecessary Admissions to Long-Term Care and Hospital*
3. *Address Health and Safety of Seniors*
4. *Provide Community Supports that Maintain Independence of Seniors within Communities across the Northwest*
5. *Establish Partnerships and Collaborative Initiatives*
6. *Support Innovation, Community Economic Development and Non-Traditional Partnerships*

An internal review team independently reviewed 52 eligible proposals and scored each proposal independently using the decision-making framework. The final recommended funding allocations were based on Year 1 Aging at Home priorities and the decision criteria. The final recommendations were presented to the North West LHIN Board of Directors and the Ministry of Health and Long-Term Care for approval.

#### Early Opportunity

The North West LHIN used a decision making framework to help determine those proposals that best met the Year 1 Aging at Home priorities.

The following outlines the decision criteria used to review Aging at Home proposals.

**Strategic Fit**
*Alignment with: IHSP; Annual Service Plan; Ministry Strategic Directions; Ministry-LHIN Accountability Agreement; and provider system role (mandate and capacity)*

| |
|---|
| **Population Health**<br>*Contribution toward improvements in: health status; potential population impact; and health promotion & disease prevention* |
| **System Values**<br>*Contribution towards: client focus; partnerships; project scope; community engagement; innovation; equity; and operational efficiency.* |
| **System Performance**<br>*Contribution toward improvements in: sustainability and quality.* |

While the decision-making framework is in early stages of implementation, the North West LHIN Aging at Home Strategy has benefited from the use of this decision criteria.

## 4.3 Implementation

Community engagement sessions and data have highlighted the challenges and opportunities available to support the implementation of the Aging at Home Strategy in the Northwest.

As evidenced in all the community engagement sessions, one of the strengths of communities in the Northwest is the ability to come together and harness limited resources in order to improve quality of life for residents. Community members have welcomed the Aging at Home Strategy, identifying with the Strategy's core principles and stated goals, including the opportunity to support seniors' independence. The following recommended first year strategies reflect this spirit and commitment to caring for seniors.

A summary of Board approved proposals for Year 1 can be found below (additional information, including funding, is available in Appendix A).

**Program Name: Respite Service for Seniors in the District of Thunder Bay: A Pilot Project**
**Organization: Wesway**

This innovative pilot project will provide a self-managed respite care program for family caregivers of frail seniors in the District of Thunder Bay. This program will help to address the limited respite care services available to seniors and their families living in the outlying communities of the Thunder Bay District. Respite care is essential for dedicated family caregivers who require temporary breaks. Without supports, family members look to hospital or long-term care services for support. The goal of this service is to help frail seniors remain in their homes as long as possible.

This pilot project will serve 32 seniors with an average of 8 hours of respite per week. This respite service model is designed to be flexible, accommodating the particular strengths and needs of each family. The services will be delivered throughout the District of Thunder Bay, including communities of Red Rock, Nipigon, Geraldton, Longlac, Schreiber, Terrace Bay, Marathon and Manitouwadge.

This respite program will be linked closely with North West CCAC services.

**Project Name: Smooth Transitions: A Home Discharge Program**
**Organization: Saint Elizabeth Health Care**

Adapted from the Home at Last Program, this program is designed to help seniors in Thunder Bay who are without adequate caregiver support and ineligible for CCAC services, to return home and settle safely after an emergency department visit or hospital stay. Smooth transitions will help facilitate timely discharge from Thunder Bay Regional Health Services Centre. Services will include transportation from hospital to home, settlement and follow-up. Settlement services include ensuring adequate supplies and current prescriptions in the home, safety check and assessment and referral, if required, for ongoing community support services. This program has the potential to provide short-term enhanced services to assist seniors in successfully transitioning from hospital to home.

The overall objectives of Smooth Transitions are to reduce the length and numbers of hospital stays, address seniors' safety needs and to provide and facilitate community supports to help seniors maintain independence.

**Program Name: Principles of Physical Rehabilitation: A Training Workshop for Personal Support Workers in Remote First Nations Communities**
**Organization: Northwestern Ontario Regional Stroke Network (NWORSN)**

This innovative service will enable the delivery of two workshops on the principles of physical rehabilitation and "hands on" training for home and community care providers in 15 remote First Nations communities from 3 Tribal Councils, Keewaytinook Okimakanak (KO), Shibogama and Windigo. While the program will focus on the common impairments and functional limitations of persons living with stroke, the learning's from these sessions are transferable to persons living with chronic disease. Upon completion of this training, community service providers will have increased ability to support in-home and community rehabilitation programs for people living in remote communities.

With this training and the effective use of videoconferencing technology, it is anticipated that seniors will be able to stay in their home community, reducing hospital admissions and providing community supports to help maintain independence and safety at home.

NWORSN will partner with KO Telemedicine to facilitate communication and collaboration with the Tribal Councils.

**Program Name: First Link: An Innovative Approach to Linking Individuals Diagnosed with Alzheimer's Disease or a Related Dementia and their Caregivers to a Community of Coordinated Learning, Services and Support**
**Organization: Alzheimer Society of Thunder Bay**

First Link will facilitate a referral and early intervention program that links seniors diagnosed with Alzheimer's disease or related dementia and their family members/caregivers to coordinated learning, services and support from the point of diagnosis and throughout the continuum of the disease. Through enhanced partnerships with diagnosing primary care physicians and other primary care providers, First Link will assist seniors and their families in understanding and management of Alzheimer's disease and related dementia.

The First Link program will serve seniors and their families living in the Thunder Bay District. It is anticipated that 150 new clients per year will receive counselling, information and referral and ongoing education services.

First Link will promote the health and safety of seniors and provide community supports that maintain the independence of seniors.

**Program Name: Programs for Community Living-Marathon**
**Organization: Wilson Memorial General Hospital**

This innovative program will provide functional and coordinated support services for seniors in the Marathon area. Gaps in service will be delineated, with the goal of developing and delivering innovative care through collaborative community efforts and resource sharing. Seniors at risk of losing their independence will be assessed in coordination with primary care providers to develop a function plan that will address non-medical needs for aging at home. Seniors have access to medical requirements but have very limited access to services considered essential to maintaining independence at home including meals, grocery shopping, housekeeping, seasonal chores and home repair. The program will provide access to multiple services through a single access point.

Programs for Community Living will assist in decreasing unnecessary hospital and long-term care admissions, promote health and safety of seniors in the Marathon area and provide community supports to help maintain independence.

This program will be built and maintained through the development of traditional and non-traditional partnerships and community economic development initiatives.

**Program Name; Seniors Maintaining Active Roles Together (SMART) Program**
**Organization: Victorian Order of Nurses**

The SMART program will offer physical activity as a positive health intervention through the delivery of exercise programming, reaching isolated, home bound, sedentary seniors living in the North West LHIN area. This volunteer facilitated, evidenced based delivery model will be offered in individual and group settings. The aim of this program is to improve seniors' mobility, flexibility and strength. Clients of the program have reported increase in functional mobility, a reduction in feelings of isolation and decrease in the number of falls.

This program will assist in promoting seniors' health and safety and offers community support that help seniors maintain independence.

**Program Name: Programs for Community Living: Terrace Bay/Schreiber**
**Organization: McCausland Hospital**

This innovative program will provide functional and coordinated support services for seniors in Terrace Bay and Schreiber area. Gaps in service will be delineated, with the goal of developing and delivering innovative care through collaborative community efforts and resource sharing. Seniors at risk of losing their independence will be assessed in coordination with primary care providers to develop a function plan that will address non-medical needs for aging at home. Seniors have access to medical requirements but have very limited access to services considered essential to

maintaining independence at home including meals, grocery shopping, housekeeping, seasonal chores and home repair. The program will provide access to multiple services through a single access point.

Programs for Community Living will assist in decreasing unnecessary hospital and long-term care admissions, promote health and safety of seniors in the Terrace Bay/Schreiber area and provide community supports to help maintain independence.

This program will be built and maintained through the development of traditional and non-traditional partnerships and community economic development initiatives.

**Program Name: North Shore MedExpress**
**Organization: Manitouwadge General Hospital**

This program will provide two medical transit buses that will link seniors in Manitouwadge and Geraldton with specialized health services in Thunder Bay. The North Shore MedExpress service is designed to offer long distance transportation services for seniors needing access to specialist care in Thunder Bay. The service will be offered a minimum of three times a week. The vehicle will be designed to take regular seated passengers, wheel chair passengers and one stretcher. This program will become self-sustaining after one year.

This program will be facilitated through a partnership of care provider organizations linked along the Highway 17 and Highway 11 corridors in Northwestern Ontario.

North Shore MedExpress service is designed to decrease unnecessary hospital admissions, promote the health and safety of seniors and provide community supports to help seniors maintain independence.

**Program Name: Rural Geriatric Primary Care Outreach Program**
**Organization: Mary Berglund Community Health Centre**

The Rural Geriatric Primary Health Care Outreach Program will provide comprehensive and continuous health care services for homebound seniors in Ignace and the outlying communities of Dinorwic and Savant Lake through a Geriatric Health Mobile Unit. Each community will receive a weekly day visit, with homebound seniors receiving in-home visits. Unit services will include nurse practitioner care as well as other health services including health promotion, rehabilitation, chronic disease management and social work services. Acute episodic illnesses will be assessed and treated. Seniors recently discharged from hospitals will also benefit from this community care service.

This outreach program is designed to help seniors maintain independence, promote health and safety and decrease unnecessary admissions to hospital and long-term care.

**Program Name: LHIN-Wide Fall Injury Prevention Program for Seniors in Northwestern Ontario**

Planning is underway for a falls prevention program for seniors in the North West LHIN. In Year 1 the program focus is on communities with high ALC and ED pressures related to falls, with expansion throughout the region in the subsequent two years.

This innovative program will include prevention, improved management and evaluation of falls in the elderly. There will be an early emphasis on education for seniors and their caregivers.

It is anticipated that this program will reduce the incidence of falls in the elderly and when they do occur, management will be improved.

# 5.0 Moving Forward

In addition to extensive community engagement, the North West LHIN has undertaken many activities to plan for and support the goals and objectives of the Aging at Home Strategy.

## 5.1 Aging at Home Projects

The North West LHIN's Aging at Home Year 1 Service Plan will continue to build on innovative strategies identified through scanning best practices in other jurisdictions and through community engagement. Within the North West LHIN, our partners are starting to explore and develop opportunities to better integrate services. Examples of some North West LHIN funded initiatives are outlined below.

### 1) Safety Resources for Seniors

Seniors and their family members have indicated that they are not always aware of available resources. It is recognized that seniors are at greater risk of accidents and other preventable events, which is often exacerbated by their isolation. The North West LHIN has supported the development of a Seniors' Safety Guide for Kenora and Rainy River District Seniors. This guide developed and distributed by the District Mental Health Services for Older Adults Program (Fort Frances) in partnership with the North West Community Care Access Centre (CCAC) and the Northwestern Health Unit, is designed to promote the health and safety of seniors through education and self-management.

### 2) End-of-Life Care

Access to palliative care services is difficult for seniors living in rural and remote northern areas. The North West LHIN has supported the North West CCAC in the creation of a tool box for integration activities in rural, community-based end-of-life care. This tool box is designed to improve access to a range of palliative care services as well as improve service coordination in Emo and the Rainy River District. Once developed, this service coordination process is expected to be a resource for communities across Northwestern Ontario. In addition, to support palliative care across the Northwest, St. Joseph's Care Group was funded to establish a 24/7 hotline service as well as a mentorship/education/ practicum for health professionals in the long-term care sector.

### 3) Care Coordination

Community Support Services and the Northwestern Independent Living Services, in partnership with other health services providers, are developing a common community referral tool. This new referral tool will improve access to and coordination of services for seniors and their families that will result in improved quality of care; greater coordination of service; and better use of existing services. The Fort Frances Family Health Team is working to develop educational and health promotion materials to assist with a coordinated, consistent approach to chronic disease management in the Rainy River District.

### 4) Train the Trainer Projects

In addition to the Stanford self-management training hosted by the LHIN, funding has been provided for three 'train the trainer' projects to:

- Train and supervise a number of certified fitness instructors and volunteers to teach/assist with Multiple Sclerosis and Parkinson's Disease exercise programs;
- Train primary caregivers in evidence-based approach to management of arthritis; and
- Train fitness facilitators (via instructional DVD) to safely deliver community-based exercise programs to persons living with a stroke.

### 5) Centre of Excellence for Integrated Seniors' Services

Access and availability of long-term care services was identified as a priority in the IHSP and integral to the provision of seniors' services. With the return of 300 municipal beds from the City of Thunder Bay to the province, the North West LHIN and St. Joseph's Care Group, along with community partners, are planning a Centre of Excellence for Integrated Seniors' Services (CEISS). The announcement of the CEISS was made August 31, 2007 by the Honourable George Smitherman. This Centre will include 336 long term-care home beds of which 64 beds will be regional, specialized behavioural beds; 132 new supportive housing units; enhanced community support services for 120 new clients; and increased CCAC services for 30 additional clients.

The concept for this project and its range of services was born through numerous community engagement sessions, where seniors reported that they wanted to age at home with appropriate community supports in place to assist them. The specialty beds will be an important regional resource for individuals with dementia and related behaviours. They will provide a safe and therapeutic environment to meet the care needs of these individuals based on best practice.

The CEISS project offers more choices for seniors and promotes their independence by offering an enhanced package of services across the care continuum. Seniors with minimal to moderate care needs can remain in the community either in their own home with increased community support services or in a supportive housing unit. The aggregation of seniors' services co-located at one site creates operating efficiencies, while making life more convenient for the residents of the facilities. The CEISS will be home to many seniors, all who have varying health care needs and will bring provider expertise together at one site. This type of environment creates an excellent learning milieu and offers great potential for research initiatives related to care of the elderly. The CEISS's critical mass and focus on excellence will enhance the region's ability to attract and retain a well-educated workforce, contributing to the region's knowledge community.

A Steering Committee has been established to guide this project and is composed of partners from St. Joseph's Care Group, the City of Thunder Bay, District Social Services Administration Board, Community Support Services, North West Community Care Access Centre, the Ministry of Municipal Affairs and the North West LHIN. A project charter drives the agenda of the monthly meetings while strategically building capacity across the sectors on the determinants that define a Centre of Excellence. Several working groups have been established and include: community

supports, supportive housing, communications, and behavioural beds. Further working groups will be established relevant to communication with residents and the development of an evaluation framework that includes system indicators and performance measurement. The CEISS Plan for the next three years is presented below.

| North West LHIN Aging at Home Strategy – CEISS Plan | | |
|---|---|---|
| **2008/09** | **2009/10** | **2010/11** |
| ▪ Enhancement to existing supportive housing units in Thunder Bay. | ▪ Enhancement to existing supportive housing units in Thunder Bay. | ▪ Enhancement to existing supportive housing units in Thunder Bay completed.<br>▪ Opening of the 132 new supportive housing units. |
| ▪ Increased community supports (to serve 15 additional CCAC clients). | ▪ Increased community supports (to serve 30 additional CCAC clients). | ▪ Increased community supports (to serve 30 additional CCAC clients) implemented. |
| ▪ 60 additional community support service clients. | ▪ 120 additional community support service clients. | ▪ 120 additional community support service clients implemented. |
| | | ▪ Closure of the (300) City of Thunder Bay long-term care beds by 2011. |
| | | ▪ Opening of 336 beds at the new Centre of Excellence by 2011. |

## 5.3 Performance Measures and Outcomes

The following is an initial selection of outcomes and performance measures that will be used to evaluate the North West LHIN Aging at Home objectives. These measures will be further refined and revised, based on continued discussions with various stakeholders. The performance measures will assist in the evaluation of the success of the Aging at Home Strategy.

| North West LHIN Aging at Home Strategy – Service Plan | | |
|---|---|---|
| **Objectives** | **Outcomes** | **Performance Measures/indicators** |
| **Increase support(s) available for seniors and their caregivers.** | ▪ Supports exist for seniors and caregivers.<br>▪ Maintain seniors at home. | ▪ Increase in number of seniors accessing existing programs.<br>▪ Increase in senior and caregiver satisfaction rates. |
| **Increase access to community support services for seniors.** | ▪ Timely access to Community Support Services.<br>▪ Fewer seniors require hospitalization or emergency services. | ▪ Measure wait times for service.<br>▪ Increase in number of seniors accessing respite services.<br>▪ Decrease in unnecessary hospitalization and emergency department visits |
| **Improve access to and decrease waits for long-term care home beds.** | ▪ Senior transfers to the appropriate setting, occurs in a timely manner. | ▪ Increase in percentage of seniors receiving their home of choice.<br>▪ Wait time to home of choice is decreased.<br>▪ Increase in referrals to community support services. |
| **Increase partnerships and collaborative initiatives for integrated and coordinated care for seniors in the community.** | ▪ Innovative approaches/ strategies/ models for seniors to access low cost integrated services existing across the North West LHIN. | ▪ Measure number of innovative programs implemented.<br>▪ Measure number of partnerships involving non-health funded providers. |
| **Increase capacity to support aging at home for seniors, their families and providers.** | ▪ Greater understanding and capacity to support Aging at Home Strategies. | ▪ Increase in number of seniors accessing services to remain at home. |
| **Decrease the length of stay in hospital for seniors.** | ▪ Seniors length of stay in hospital is reduced. | ▪ Decrease in ALC days per senior.<br>▪ Decrease in hospital ALC days.<br>▪ Increase in percentage of ALC seniors discharged home.<br>▪ Decrease lengths of stay for seniors in hospital. |
| **Establish the Centre of Excellence for Integrated Seniors' Services** | ▪ Capacity in gerontology will be increased through the creation of enhanced learning and research opportunities.<br>▪ Staff in long-term care homes will have enhanced | ▪ A full range of health services across the continuum available.<br>▪ Quality clinical placements for students in health professional programs in place. |

| | | |
|---|---|---|
| | opportunities to provide evidence-based care.<br>▪ Dementia clients with responsive behaviours will receive quality care in a long-term care environment.<br>▪ Critical mass of services on one site will improve recruitment and retention of health care professionals in Thunder Bay. | ▪ Decrease in wait times for people waiting in acute care hospitals and community for access to long-term care. |

# 6.0 Policy/Legislative Enablers

The primary barriers to service, as identified by seniors and caregivers, relate to fees for various services, rules governing access to home care services and the varying eligibility requirements for homemaking services.

It is anticipated that there will be several policy and/or legislative/regulatory implications that may restrict or limit the North West LHIN's ability to implement an optimal Aging at Home Service Plan. Work is underway between the provincial LHIN's and the Ministry of Health and Long-Term Care to identify policy, legislative and regulatory changes that would improve the provision of coordinated services for seniors to live at home independently.

The following policy and/or regulatory changes would assist the North West LHIN in implementing the Aging at Home Strategy:

- Flexibility in funding to enable funds to flow with the senior across service organizations;
- Eliminate line by line budgeting in Community Support Services (CSS) in order to facilitate the delivery of a flexible basket of services;
- Continue to build greater flexibility into service maximums for CCAC services to enable higher service levels for those in need;
- Continued flexibility in the criteria for personal support and homemaking within CCAC services:
- Develop alternate physician remuneration structures that support home visits to seniors by physicians and physicians working with interprofessional teams;
- Allow more flexible supportive housing options; and
- Change supportive housing service policy to allow for funding of different models of care including cluster care.

# 7.0 Conclusion/Summary

This Service Plan was developed through discussions with community stakeholders, seniors, their family members and health service providers. The themes identified in this plan were repeatedly validated in sessions across the Northwest. As well, the North West LHIN Seniors' Services Advisory Team provided valuable input in the development of this plan. This plan provides an overview of the direction the North West LHIN will take in implementing its Aging at Home Strategy. More work is required to develop and implement the Service Plan over the next three years.

Ensuring people have access to services in the most appropriate setting is key to attaining efficiencies in the health system. The goal is to have a full spectrum of services available to people across the continuum of care to improve the care for seniors, supporting quality of life and aging at home in the most appropriate place. This will allow flexibility in where services are delivered regardless of whether this occurs at home in the community, in a supportive housing setting, in a long-term care home setting, or in an alternate setting such as rehabilitation, complex continuing care or acute setting.

In summary, the North West LHIN's Aging at Home Strategy will support initiatives that:

- Reduce length of hospital stay (reduce ALC days);
- Prevent and/or delay hospital admissions;
- Prevent unnecessary long-term care admissions;
- Promote integrated and coordinated community services; and
- Promote innovative solutions to keep seniors healthy.

For Year 1 of the Aging at Home Strategy, the North West LHIN Board of Directors has approved 10 initiatives that will focus on:

1. Reducing Length of Hospital Stay

2. Decreasing Unnecessary Admissions to Long-Term Care and Hospital

3. Health and Safety of Seniors

4. Community Supports the Maintain Independence of Seniors within Communities Across the North West

5. Partnerships and Collaborative Initiatives

6. Innovation, Community Economic Development and Non-Traditional Partnerships

These initiatives will provide health care services for seniors and their caregivers living in the North West; helping seniors live healthy, independent lives in the comfort and dignity of their own homes.

The North West LHIN will continue to work with local partners, with the Ministry of Health and Long-Term Care and with other LHINs to achieve an integrated system of community based services for seniors.

# Appendix A

Summary of Aging at Home Year 1 Initiatives and North West LHIN Year 1 Priorities

| First Year Strategies | Reduce Length of Hospital Stay | Decrease unnecessary LTC and Hospital Admissions | Health and Safety of Seniors | Community Supports that Maintain Independence of Seniors | Partnerships and Collaborative Initiatives | Innovative, Community Economic Development, Non-Traditional Partnerships | Funding Year 1 | Funding Year 2 | Funding Year 3 |
|---|---|---|---|---|---|---|---|---|---|
| Respite Services for Seniors in the District of Thunder Bay | | X | X | X | | X | $182,100 | $293,100 | $0 |
| Smooth Transitions: A home Discharge Program | X | X | X | X | | | $261,589 | $459,552 | $0 |
| Principles of Physical Rehabilitation: A Training Workshop for Personal Support Workers in Remote First Nations Communities | | X | X | | X | X | $10,000 | $10,000 | $0 |
| First Link | | | X | X | | | $67,500 | $67,500 | $0 |
| Programs for Community Living-Marathon | X | X | X | X | X | X | $43,075 | $55,150 | $47,650 |
| Seniors Maintaining Active Roles Together (SMART) Program | | | X | X | | | $31,858 | $21,904 | $0 |
| Programs for Community Living-Terrace Bay/Schreiber | X | X | X | X | X | X | $43,075 | $55,150 | $47,650 |
| North Shore MedExpress Services | | X | X | X | | | $207,141 | $23,142 | $0 |
| Rural Geriatric Primary Care Outreach Program | | X | X | X | | X | $19,300 | $19,300 | $19,300 |
| Falls Prevention Program NW LHIN Wide | X | X | X | X | X | X | $181,035 | TBD | $0 |