North West **LHIN**

Aging at Home Strategy
Year 2 Service Plan

Continuing the Momentum for Change

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Ontario
Local Health Integration Network

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Aging at Home Strategy Year 2
Continuing 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]

[1] As stated by the Ministry of Health and Long-Term Care in a July 2007 presentation to LHIN Board Chairs and CEOs.

2.0 North West Local Health Integration Network (LHIN) Objectives and Priorities

The North West LHIN developed 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. Table 1 identifies the IHSP planning priorities, themes from seniors' services the Aging at Home Strategy directional priorities and objectives.

Table 1 North West LHIN Aging at Home Strategy: Planning Framework

North West LHIN IHSP Planning Priorities	North West LHIN Seniors Services Themes	North West LHIN AAH Directional Priorities	North West LHIN AAH Objectives
▪ 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	▪ 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.	1. Implement Aging at Home priorities as identified in the IHSP and ASP. 2. Build community capacity and enhance the coordination of community support services. 3. Explore new models and innovative strategies to support Aging at Home.	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.

3.0 North West LHIN Aging at Home Strategy Financial Investment

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

$1,046,673 (beginning April1, 2008);
$920,158 in 2009/10 in additional base funding, for a total of $1,924,956; and
$1,474,812 in 2010/11 in additional base funding for a total of $3,399,768.

An additional $3.4 M has been allocated over three years to support the establishment of the Centre of Excellence for Seniors Services (CEISS Project).

As part of the Year 1 call for proposals, the commitments identified in Table 2 exist for the Aging at Home Strategy Year 2 Service Plan. Appendix I contains the project schedule for the Aging at Home Strategy Year 2 Service Plan

Table 2: Aging at Home Strategy Year 1 Initiatives and Investments Committed for Year 2

Aging at Home Strategy Year 1 Initiatives	Investment
Respite Services	$ 293,100
Smooth Transitions	$ 459,552
Rehab Training	$ 10,000
First Link	$ 67,500
Community Living (Marathon)	$ 55,150
Community Living (Terrace Bay/Schreiber)	$ 55,150
SMART Program	$ 21,904
North Shore MedExpress	$ 23,142
Geriatric Primary Care	$ 19,300
Total:	**$ 1,004,798**

In accordance with Ministry of Health and Long Term Care (MOHLTC) guidelines, twenty percent of the LHINs Aging at Home Strategy funding is to be allocated to innovation strategies. Initiatives proposed in the Aging at Home Year 1 Service Plan provided 14% in innovation credits. The Year 2 and 3 Service Plans focus on achieving the outstanding 6% in innovation credits.

4.0 Aging at Home Strategy Planning Process

4.1 Community Engagement

Community engagement has been a key component in developing the service plans for the Aging at Home Strategy in the North West LHIN. The North West LHIN has engaged 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.

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 (SSAT), which includes health service providers as well as interested community residents, participated in a workshop in the Balance of Care methodology, examined best practices for seniors' services and provided the North West LHIN with critical feedback in the development of the Aging at Home Strategy Directional Plan and the Year 1 Service Plan. The SSAT continues to be a key resource to the Aging at Home Strategy and provided input for the Aging at Home Year 2 Service Plan.

4.2 North West LHIN Demographic Profile

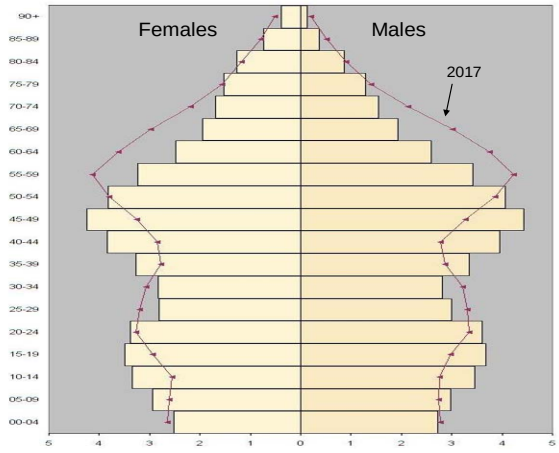
The North West LHIN is home to 235,046 (2006) people or 2.0% of the population of Ontario; almost half of the population lives in the City of Thunder Bay. The population of the Northwest decreased by 1.2% between 2001 and 2006, markedly different from the population of Ontario as a whole which increased by 6.6% during this period. The Northwest had the highest unemployment rate (8.3% compared to 6.4% for Ontario

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[2] 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 1.0 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 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 3 for details.)

Table 3 Population Project Comparison 2007 and 2031 with Percentage Increase[3]

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%**

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

[3] 2006 Population Estimates, Ontario Ministry of Finance, accessed through PHPDB.

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. 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.

Cost drivers associated with the large geography and small population of the North West include:

- The long travel time to remote communities reduces the time available to provide clinical service;
- Residents of remote areas and First Nations are required to travel large distances to access primary and specialty services;
- Economies of scale are not possible to the same degree, given smaller populations in communities often large distances apart;
- Cost of non-urgent transfers poses financial challenges.

Compared to the rest of Ontario, the North West LHIN also has:

- The largest geography (47% of the province);
- A slightly higher proportion of people 65 years and older;
- The highest percentage of Aboriginal people;
- A life expectancy that is the lowest in the province;
- The percentage of deaths before age 65 is the highest in Ontario;
- The Potential Years of Life Lost (PYLL) is the highest in Ontario;
- Residents report their health as “Excellent” or “Very Good” at rates that are significantly lower (51.0%) than the province as a whole (57.4%);
- A significant proportion of residents (29.4%), compared to 24.6% provincially) report being limited in their activities because of a physical or mental condition or health problem which lasted or is expected to last longer than six months;
- Residents smoke more and consume higher quantities of alcohol than the provincial average; and
- Rates of obesity are higher than elsewhere in the province.[4]

4.3 Emergency Department/Alternate Level of Care (ED/ALC) Overarching Plan 2009/10

A major factor causing long emergency room wait times is the high number of alternate level of care (ALC) patients occupying acute care hospital beds. ALC patients are unable to be discharged because the appropriate level of care they require is not always available.[5] While ALC reflects the situation most prevalent in acute care, seniors wait for appropriate levels of care at home in the community, in chronic complex care, rehabilitation and long-term care settings.

[4] North West Local Health Integration Network Annual Business Plan, 2009-2012.

[5] Ontario Ministry of Health and Long-Term Care. *News.* May 30 2008.

The North West LHIN ED/ALC strategy was developed based on comprehensive community engagement with stakeholders, analysis of relevant data and initiatives that focus on system-wide gaps and challenges across the Northwest. The advice of the North West LHIN ALC Steering Committee, established in November 2007, has also informed the North West LHIN ED/ALC Strategy. The North West LHIN Board of Directors supports this strategy.

The North West LHIN's Overarching Plan 2009/10 provides an overview of the North West LHIN ED/ALC Strategy and its impact on emergency department (ED) wait times and alternate level of care (ALC). The Plan also provides high level information about the types of initiatives that the North West LHIN is undertaking to address these issues. The percentage of ALC days for 2009/2010 is 13%.

The North West LHIN ED/ALC Strategy addresses and integrates the priorities of the MOHTLC, including the Aging at Home Strategy, and targets initiatives that focus on:

- **Direct** (Patient is either already in ED or ALC. The patient being discharged or moved from acute to transition care setting);
- **Divert** (Patient is high to medium risk of presenting in ED if supports/services not provided or maintained); and
- **Preventative** (Patient presents low to medium risk of presenting in ED if supports/services not provided or maintained).

The Aging at Home Strategy Year 2 Service Plan must allocate 50% of the funding in the following manner:

Table 4: Impact of Aging at Home Investments on ED/ALC 2009/10

Aging at Home Strategy 2009/10 Investment Category	Direct	Divert	Preventative
	50%	35%	15%

Initiatives being advanced through the North West LHIN Aging at Home Strategy will help address the ED/ALC pressures in the following areas:

- Proceeding with the development of the Center of Excellence for Integrated Seniors Services scheduled to open in 2010/2011;
- Creating as a pilot project transitional beds in available retirement homes in Thunder Bay to provide surge capacity;
- Creating transitional supportive housing capacity across the North West region
- Supporting enhancements to community support services across the North West region;
- Exploring e-Health initiatives that support expedited discharge from hospital and improve patient flow.
- Implementing a wounds management program and a falls management program that will divert and prevent unnecessary ED visits.

4.4 Setting the Balance of Care in Northwestern Ontario

During 2008 a study on the balance of care in Northwestern Ontario was completed by Community Care and Health Human Resources (CIHR).[6] *Balance of care* is an approach that aims at determining the most appropriate mix of institutional and community resources at the local level to meet the needs of an aging population. A key assumption of balance of care is that individuals are less likely to require institutional care where appropriate, managed home and community care packages are accessible. Also, individuals are more likely to require institutional care where appropriate packages of care are not accessible.

Throughout the North West LHIN seniors and providers alike have identified that there is confusion about services 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. Furthermore there is no one single point of access that links available resources or services for seniors across the Northwest.

"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.

The preliminary findings of *Setting the Balance of Care in Northwestern Ontario (2008)*[7] *indicate that:*

- Health care needs[8] are higher in Thunder Bay as compared to the rest of the Northwest Region;
- Most people (regardless of location or place waiting) have high instrumental activity of daily living needs (IADL); this appears to be driving the waiting list for long term care more than heavier care needs;
- A large proportion of people waiting for long term care in Thunder Bay are in hospital, whereas people in the rest of the region are mostly in the community;
- Rural communities tend to have healthier people on the long term care waiting list compared to urban communities (Thunder Bay) likely due to a lack of community-based options;
- The Rurality Index of Ontario (RIO)[9] for Thunder Bay, Region West and Region East suggest that rural residents face a greater chance of becoming waitlisted for long term care beds while still relatively healthy due to a lack of community-based options.

[6] *Setting the Balance of Care in Northwestern Ontario*. (June 20, 2008; December 18 2008). Kerry Kuluski and A. Paul Williams, Community Care and Health Human Resources, Department of Health Policy, Management and Evaluation, University of Toronto.

[7] Note that the final report for this study was not available at this time but is expected to be released in the near future.

[8] Health care needs were defined as the top five disease diagnoses by Region.

[9] The RIO is a variable made up of man factors including distance to closest basic and advanced referral centres; population; physician numbers, and the presence of an acute care hospital. he higher the RIO score, the greater the rurality.

The preliminary findings of the study *Setting the Balance of Care in Northwestern Ontario* (2008) determined that up to 50% of clients residing outside of Thunder Bay, on the current long term care wait list, could be supported at home if services appropriate to support their needs are in place. The findings of this study helped to inform the focus on expanding access to services that provide activities of daily living in accordance with the assessed needs of the clients, found in the Aging at Home Strategy Year 2 Service Plan.

4.5 Proposal Process

In May 2008 the North West LHIN released a call for proposals *Innovative Alternatives that Promote Aging at Home*. The submitted proposals were assessed according to impact in achieving the objectives and priorities outlined in the North West LHIN's *Aging at Home Strategy Directional Plan and Aging at Home Strategy Service Plan,* including:

- Reduction in length of hospital stay;
- Decrease of unnecessary admissions to long-term care homes and hospital;
- Health and safety of seniors;
- Community supports that maintain the independence of seniors;
- Partnerships and collaborative care initiatives; and
- Innovation, economic development and non-traditional partnerships.

A variety of activities contributed to the preparation of the Aging at Home Strategy Year 2 Service Plan. Proposals submitted in response to the May 2008 proposal call were further reviewed and assessed in relation to their impact on reducing ED/ALC pressures. Aging at Home Strategy Year 1 initiatives were reviewed to identify opportunities for expansion and/or replication. A review of seniors' services helped to determine the service gaps throughout the North West LHIN. Contributing to this review were findings from community engagement sessions conducted during the summer of 2008 throughout the North West. Ongoing meetings were held with health services providers and presentations were made to the North West LHIN Board of Directors and Seniors' Services Advisory Team. These activities provided a base of information for the development of the Aging at Home Strategy Year 2 Service Plan. In December 2008 the North West LHIN Board of Directors approved the initiatives proposed for the Aging at Home Year Strategy 2 Service Plan.

5.0 Aging at Home Strategy Year 1 in Review

The Aging at Home Strategy Year 1 initiatives, with the exception of First Link in Thunder Bay, will continue as pilot projects in Year 2. First Link, which is part of a province wide program of the Alzheimer's Association and has proven outcomes, was moved to base funding for 2009/10. The following table provides a brief summary and the implementation status of the Aging at Home Strategy Year 1 initiatives.

Table 5 Aging at Home Strategy Year 1 Service Plan (2008/09)[10]

AAH Strategy Year 1 Initiatives	Health Service Provider	Status
Respite Service for Seniors in the District of Thunder Bay: A Pilot Project	Wesway	Program began in late fall 2008
Smooth Transitions: A Home Discharge Program	Saint Elizabeth Health Care	Program began December 2008
Principles of Physical Rehabilitation: A Training Workshop for Personal Support Workers in Remote First Nations Communities	Northwestern Ontario Regional Stroke Network (NWORSN)	Workshop conducted November 2008; Second workshop planned for June or September 2009
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	Alzheimer Society of Thunder Bay	Program began fall 2008 Official launch February 2009
Programs for Community Living-Marathon	Wilson Memorial General Hospital	Program began September 2008
Seniors Maintaining Active Roles Together (SMART) Program	Victorian Order of Nurses	Program began Fall 2008
Programs for Community Living: Terrace Bay/Schreiber	McCausland Hospital	Program began November 2008
North Shore MedExpress	Manitouwadge General Hospital	Program will begin February 2009
Rural Geriatric Primary Care Outreach Program	Mary Berglund Community Health Centre	Program began Fall 2008

[10] A detailed description of Year 1 initiatives is available in the Aging at Home Strategy Year 1 Service Plan. This document is available at: www.northwestlhin.on.ca .

6.0 Aging at Home Strategy Year 2 Service Plan

The initiatives proposed for the Aging at Home Strategy Year 2 Service Plan focus on expanding access to services that provide activities of daily living in accordance with the assessed needs of the clients; the plan has been framed in accordance with targets, established by the MOHTLTC, that measure the impact of Aging at Home initiatives on ED/ALC.

The following table provides a summary of the proposed initiatives, the responsible health service providers, the target groups and the impact of the proposed initiative on ED/ALC.

Table 6 Aging at Home Strategy Year 2 Service Plan (2009/10)

AAH Strategy Year 2 Initiatives	Health Service Provider	Target Group	ED/ALC Impact
Transitional Beds in Retirement Homes in the City of Thunder Bay	Thunder Bay Regional Health Sciences Centre	Client is already in ED, or ALC patient is being discharged or moved from acute to transitional setting	Direct
Transitional Enhanced Supportive Housing in the City of Thunder Bay	St. Joseph's Care Group	Client is already in ED, or ALC patient is being discharged or moved from acute to transitional setting	Direct
		Clients at low to medium risk of presenting in ED	Preventative
Community Living and Independent Activities of Daily Living in Dryden	Patricia Gardens	Clients at high risk of presenting in ED; are receiving service from CCAC or in acute care	Divert
		Clients at low to medium risk of presenting in ED	Preventative
Community Living in Red Lake	Kenora District Homes for the Aged	Clients at high risk of presenting in ED; are receiving service from CCAC or in acute care	Divert
		Clients at low to medium risk of presenting in ED	Preventative
Supportive Housing in Sioux Lookout	Kenora District Homes for the Aged	Clients at high risk of presenting in ED; are receiving service from CCAC or in acute care	Divert
		Clients at low to medium risk of presenting in ED	Preventative
Expansion of First Link in Kenora/Rainy River Districts	Alzheimer's Society of Kenora	Clients at low to medium risk of presenting in ED	Preventative
Independent Activities of Daily Living in Machin	Municipality of Machin	Clients at low to medium risk of presenting in ED	Preventative
Gardening for the Aging at Home in Gull Bay First Nation Community	Gull Bay First Nation Community	Clients at low to medium risk of presenting in ED	Preventative

A brief description of each proposed Aging at Home Strategy Year 2 initiative follows.

Transitional Beds in Retirement Homes in the City of Thunder Bay

This initiative is proposed as a pilot project that will create 20 to 30 transitional beds, within a retirement home setting, for alternate level of care patients who are currently located at Thunder Bay Regional Health Sciences Centre (THRHCS). The transitional care will provide surge capacity to address alternative care pressures at Thunder Bay Regional Health Sciences Centre (TBRHSC). Personal care services and accommodations will be provided 24 hours a day, seven days a week. This initiative will build a rapid response to escalating ALC pressures in the hospital and have a direct impact on reducing the number of ALC patients in hospital at TBRHSC during the pilot (see the Detailed Service Plan in Appendix A).

Transitional Enhanced Supportive Housing in the City of Thunder Bay

The Centre of Excellence for the Integrated Seniors Services (CEISS) project includes 132 new enhanced supportive housing apartments. This initiative will provide a transitional supportive housing environment for clients who are frail and elderly and at risk of deteriorating health status and becoming ill. Enhanced supportive housing will help prevent emergency department visits or long term care facility placement until the CEISS opens in 2010/11. The clients remain in a community setting with support services appropriate to their needs. This initiative will have a direct impact on ED/ALC (see the Detailed Service Plan in Appendix B).

Community Living and Independent Activities of Daily Living in Dryden

This pilot replicates initiatives implemented as part of the Aging at Home Strategy Year 1 Service Plan. This initiative will provide functional and coordinated support services for seniors in the Dryden area. Gaps in service will be addressed, with the goal of developing and delivering innovative care through collaborative community efforts and resource sharing. The initiative will provide homemaking, yard maintenance, and access to multiple services through a single access point.

Dryden is a community at high risk of ED/ALC. Clients at high risk of presenting in ED if supports/services are not provided or maintained (i.e. receiving services from the Community Care Access Centre) will be diverted from presenting at the emergency department or becoming ALC. Clients at low to medium risk if supports/services are not provided or maintained (i.e. live in their own homes, are aging and require support appropriate to their needs in order to maintain their health status for as long as possible) will be prevented from placement in long term care (see the Detailed Service Plan in Appendix C).

Community Living in Red Lake

This pilot replicates initiatives implemented as part of the Aging at Home Strategy Year 1 Service Plan. This initiative will provide functional and coordinated support services for seniors in the Red Lake area. Gaps in service will be addressed, with the goal of developing and delivering innovative care through collaborative community efforts and resource sharing. The initiative will provide access to multiple services through a single access point.

Red Lake is a community at high risk of ED/ALC. Clients at high risk of presenting in ED if supports/services are not provided or maintained (i.e. receiving services from the

Community Care Access Centre) will be diverted from presenting at the emergency department or becoming ALC. Clients at low to medium risk if supports/services are not provided or maintained (i.e. live in their own homes, are aging and require support appropriate to their needs in order to maintain their health status for as long as possible) will be prevented from placement in long term care (see the Detailed Service Plan in Appendix D).

Supportive Housing in Sioux Lookout

Sioux Lookout has been identified as a community at high risk of ED/ALC. This initiative will expand the support for independent activities of daily living already provided through the supportive housing program. The initiative focuses on two target groups: clients at high risk of presenting in ED if supports/services are not provided or maintained (i.e. receiving services from the Community Care Access Centre) will be diverted from presenting at the emergency department or becoming ALC; clients at low to medium risk if supports/services are not provided or maintained (i.e. live in their own homes, are aging and require support appropriate to their needs in order to maintain their health status for as long as possible) will be prevented from presenting in the ED or becoming ALC (see the Detailed Service Plan in Appendix E).

Expansion of First Link in Kenora/Rainy River District

First Link is an innovative referral and early intervention program that links the person with Alzheimer's disease or a related dementia (ADRD) and their family members/caregivers to coordinated learning, services and support from the point of diagnosis and throughout the continuum of the disease. This program was established in the District of Thunder Bay in Year 1 of the Aging at Home strategy and is being expanded in the west in Thunder Bay District and to the Kenora/Rainy River Districts in Year 2.

First Link will support and educate individuals and families confronting Alzheimer's disease in the Kenora/Rainy River District, with the mission of preventing unnecessary admissions to hospital and/or long-term care, promoting health and safety, and increasing independence. The target population of First Link includes people living with ADRD across the Kenora/Rainy River District including a broader reach into the First Nation communities in this area. Services will be translated into Ojibway and Ojicree as an outreach to the First Nation communities. The First Link initiative is preventing unnecessary visits to the emergency department and reduce/prevent placement on the long-term care wait list (see the Detailed Service Plan in Appendix F).

Independent Activities of Daily Living in Machin

This initiative will provide enhanced community support services and invest in independent activities of daily living in Machin. Machin is located just outside of Dryden, Ontario and 16.4%[11] of the population is over 65 years of age. The population to be served is frail seniors 65+ who have complex medical conditions and need additional support services to stay at home in the community. These clients are at risk of becoming ALC if admitted to hospital. The preliminary findings of the study *Setting the Balance of Care in Northwestern Ontario* (2008) suggests that up to 50% of the clients currently on

[11] 160 people out of a total population of 978.

the long-term care wait list outside of Thunder Bay could be cared for in the community if services were available (see the Detailed Service Plan in Appendix G).

Gardening for the Aging at Home in Gull Bay First Nation Community

The Gull Bay First Nation is located 180 km north of Thunder Bay and has a population of about 400 people. The community store does not provide fresh vegetables or fruit. The overall objective of this initiative is to increase physical exercise and to improve local access to nutritionally adequate food by developing a sustainable food system. Many factors that impact the health and safety of seniors including increased physical activity will be promoted through the community gardening activities. This initiative for community gardening provides early prevention to risk of ED/ALC (see the Detailed Service Plan in Appendix H).

7.0 Aging at Home Strategy Monitoring and Evaluation

The planning process for the Aging at Home Strategy Year 1 Service Plan included the development of preliminary outcomes and performance measures that will be used to evaluate the North West LHIN Aging at Home Strategy objectives (see Table 7).

Additional monitoring and evaluation activities, as the process for the Aging at Home Strategy Year 2 moves forward, include two projects that are common to several LHINS. In relation to *First Link* the North West LHIN is collaborating with the Alzheimer Society of Ontario and other LHINs in the development of indicators to evaluate the four common core elements of First Link. Included in the core elements is tracking outcomes of First Link's impact on ED/ALC. First Link in Thunder Bay an Aging at Home Strategy Year 1 initiative was moved to base funding for Year 2. Expansion of the First Link program to the Kenora/Rainy River Districts is proposed for the Aging at Home Strategy Year 2. In relation to *SMOOTH Transitions* a provincial level program logic model and evaluation framework developed for *Home at Last*, will be available for evaluation purposes. The North West LHIN is continuing to monitor the Year 1 initiatives.

Table 7 Aging at Home Strategy Monitoring and Evaluation

North West LHIN Aging at Home Strategy Monitoring and Evaluation		
Objectives	**Outcomes**	**Performance Measures/indicators**
Increase support(s) available for seniors and their caregivers.	▪ Supports exist for seniors and caregivers. ▪ Maintain seniors at home.	▪ Increase in number of seniors accessing existing programs. ▪ Increase in senior and caregiver satisfaction rates.
Increase access to community support services for seniors.	▪ Timely access to Community Support Services. ▪ Fewer seniors require hospitalization or emergency services.	▪ Measure wait times for service. ▪ Increase in number of seniors accessing respite services. ▪ 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. ▪ Wait time to home of choice is decreased. ▪ 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. ▪ 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 Strategy.	▪ 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 ▪ Decrease length of stay for seniors in hospital.

Objectives	Outcomes	Performance Measures/indicators
Establish the Centre of Excellence for Integrated Seniors' Services	▪ Capacity in gerontology will be increased through the creation of enhanced learning and research opportunities. ▪ Staff in long-term care homes will have enhanced opportunities to provide evidence-based care. ▪ Dementia clients with responsive behaviours will receive quality care in a long-term care environment. ▪ Critical mass of services on one site will improve recruitment and retention of health care professionals in Thunder Bay.	▪ A full range of health services across the continuum available. ▪ Quality clinical placements for students in health professional programs in place. ▪ Decrease in wait times for people waiting in acute care hospitals and community for access to long-term care.

8.0 Conclusion/Summary

The Aging at Home Strategy reflects a change from traditional health service delivery to a system approach. The goal is to have a full spectrum of services available to seniors across the continuum of care that supports quality of life and aging at home in the most appropriate place.

According to MOHLTC[12] 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 (2007). *Setting the Balance of Care in Northwestern Ontario* (2008) findings indicate that individuals are less likely to require institutional care where appropriate, managed home and community care packages are accessible.

The Aging at Home Strategy Year 1 Service Plan included ten initiatives that focused on:

- Reducing Length of Hospital Stay;
- Decreasing Unnecessary Admissions to Long-Term Care and Hospital;
- Health and Safety of Seniors;
- Community Supports the Maintain Independence of Seniors within Communities Across the North West;
- Partnerships and Collaborative Initiatives;
- Innovation, Community Economic Development and Non-Traditional Partnerships.

The Aging at Home Year 2 Service Plan has been framed in accordance with targets, established by the Ministry of Health and Long Term Care that measure the impact of Aging at Home initiatives on ED/ALC. The focus of the North West LHIN's ED/ALC Strategy, which includes Aging at Home, is:

- Proceeding with the development of the Center of Excellence for Integrated Seniors Services scheduled to open in 2010/2011;
- Creating as a pilot project transitional beds in available retirement homes in Thunder Bay to provide surge capacity;
- Creating transitional supportive housing capacity across the North West region
- Supporting enhancements to community support services across the North West region;
- Exploring e-Health initiatives that support expedited discharge from hospital and improve patient flow.
- Implementing a wounds management program and a falls management program that will divert and prevent unnecessary ED visits.

Initiatives funded by the Aging at Home Strategy 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 while at the same time alleviating the pressure on ED/ALC.

[12] As stated by the Ministry of Health and Long-Term Care in a July 2007 presentation to LHIN Board Chairs and CEOs

The North West LHIN will continue to work with the Seniors' Services Advisory Team, 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.

9.0 Appendix

Appendix A Aging at Home Year 2 Detailed Service Plan for Transitional Beds in Retirement Homes in the City of Thunder Bay

Appendix B Aging at Home Year 2 Detailed Service Plan for Transitional Enhanced Supportive Housing, City of Thunder Bay

Appendix C Aging at Home Year 2 Detailed Service Plan for Community Living and Independent Activities of Daily Living in Dryden

Appendix D Aging at Home Year 2 Detailed Service Plan for Community Living in Red Lake

Appendix E Aging at Home Year 2 Detailed Service Plan for Supportive Housing in Sioux Lookout

Appendix F Aging at Home Year 2 Detailed Service Plan for Expansion of First Link in Kenora/Rainy River District

Appendix G Aging at Home Year 2 Detailed Service Plan for Independent Activities of Daily Living in Machin

Appendix H Aging at Home Year 2 Detailed Service Plan for Gardening for the Aging at Home in Gull Bay First Nation Community

Appendix I Aging at Home Strategy Year 2 Project Schedule