WHY NOT NOW?
A Bold, Five-Year Strategy for Innovating Ontario’s System of Care for Older Adults
March 2012

Long Term Care Innovation Expert Panel
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**LTC Innovation Strategy**

**long·term·care home** – a facility licensed by the Ontario Ministry of Health and Long Term Care (“the Ministry”) that provides 24 hour nursing and personal care and services in a secure home-like setting for adults with assessed high needs who can no longer live independently in the community.

**in·no·va·tion** - a process through which economic or social value is extracted from knowledge—through the creation, diffusion, and transformation of ideas—to produce new or improved products, services, or processes (Conference Board of Canada, 2011)

**strat·e·gy** - a plan or method for obtaining a specific goal or result; a combination of ends (goals) and means (policies).
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BETTER CARE, BETTER ACCESS, BETTER VALUE

There is no room for short term thinking in long term care. That is why, in June 2010, the Ontario Long Term Care Association (OLTCA) commissioned the Conference Board of Canada (CBoC) to investigate the innovation potential of Ontario’s 634 long term care homes. In a report released last year, the Conference Board of Canada recommended that the residential long term care sector develop a comprehensive innovation strategy to address growing demand, sector constraints and health system sustainability. OLTCA convened a panel of experts to:

• Consult with key stakeholders on possible content and priorities for an innovation strategy
• Promote a focused and informed strategic discussion on the future of long term care and aging policy in Ontario
• Help build consensus on a vision for long term care (LTC) within an integrated health care system
• Make recommendations for innovation to enable long term care to fulfill its promise as a partner in the health care system.

The Long Term Care Innovation Expert Panel addressed several areas ripe for innovation including:

• Service organization and delivery
• Health human resources
• Facility planning, architecture and design
• Devices, equipment and technology and
• Funding, financing and regulation

The Panel met several times between April and November 2011 to deliberate and hear presentations and submissions from a variety of stakeholders including representatives from residents and families, professional associations, researchers and organizations active in mental health and addictions, end of life care, dementia, injury prevention and other areas.

The Panel met again in February 2012 to finalize its recommendations. The result is this document. It outlines a vision for Ontario’s system of care for older adults and residential long term care’s place within it. It makes the case for change by clarifying long term care’s value proposition, and proposing alternate models for reorganizing services and making the system of care for older adults with complex health needs more cost-effective and easier to access and navigate. Finally it recommends a 3-pronged strategy for innovation and system transformation.

LTC INNOVATION: A PROACTIVE RESPONSE TO GROWING CONSUMER EXPECTATIONS AND SYSTEM NEEDS

1. Reengineer Long Term Care
   • Improve long term care placement and flow
   • Develop new service, funding and business models
   • Rebrand to reflect new sector orientation

2. Build Capacity for Transformation
   • Strengthen the care team
   • Harness technology
   • Rebuild for the Future

3. Enable User-Driven Innovation
   • Retool education and training
   • Invest in applied research
   • Remove policy and regulatory barriers
Long Term Care’s Value Proposition

Access + Quality Care

The Expert Panel supports the shift to community care and recognizes that a growing number of people will want to receive care in their community. It also recognizes that this shift will be difficult to achieve without the contribution of the long term care sector. But to do its part, the sector will need to diversify and innovate.

Ontario’s long term care homes are well positioned to dramatically improve flow and access to needed high quality care for frail seniors and older adults with multiple chronic conditions while generating cost-savings for the health care system. This can be done by:

- Streamlining the assessment and placement process and making it easier for consumers to navigate and plan their own care
- Rebalancing the LTC bed mix to provide more short stay, respite and convalescent care thereby relieving pressure on hospitals, home care and frail Ontarians and their families
- Reserving long-stay beds for persons with the heaviest care needs and building capacity to look after higher need residents through new models of service delivery
- Undertaking comprehensive service planning that works across LHIN boundaries and is responsive to emerging demand for, and supply of aging care ‘places’ and ‘spaces’ in a wider variety of settings including supportive housing, retirement living and day/night programs
- Leveraging the redevelopment of 35,000 LTC beds to meet emerging consumer preferences and system needs, including the needs of rural communities
- Moving to a financial and regulatory framework that incents and rewards system-wide improvements in access, quality, cost and consumer satisfaction

The Panel makes over 60 recommendations that will ensure that Ontario’s health care system is well-positioned to provide high quality, cost effective care to the aging population of the future. It also recommends that:

- A task force composed of sector leaders and representatives from government, LHINs and system partners be created to advise on key elements of strategy implementation
- Health Quality Ontario provide an independent assessment of progress made

6 MODELS FOR LTC TRANSFORMATION

- **Post-Acute Model** – specializes in short-term skilled nursing and intensive rehabilitation for medically complex and injured or disabled older adults returning to the community following a hospital admission
- **Specialized Stream Model** - provides higher level of care for special needs populations including persons with late stage dementia, severe mental illness and addictions, and those at end of life
- **Hub Model** - takes advantage of LTC expertise and investments in physical plant by centralizing seniors care and services in rural and northern communities
- **Integrated Care model** - enables ‘continuums’ with an enrolled population, or vertically integrated providers in a defined geographic area, to develop a variety of integrated home and community support services and receive incentives for managing chronic conditions, reducing ED visits, etc.
- **Designated Assisted Living model** – bridges the gap created by long term care’s shift to higher acuity residents
- **Culture Change Model** – revitalizes traditional nursing home

For a description of these models go to page 41.
The proposed LTC innovation strategy will:

- Simplify consumer choice and improve coordination and access to quality care
- Spur innovation in care organization and delivery
- Dramatically increase support for caregivers and access to services for those at highest need
- Strengthen the evidence-base in elder care
- Shift care and resources to the most appropriate and cost-effective setting
- Reduce wait times and free up hospital beds occupied by patients who do not need to be there
- Reduce the need for new long term care beds
- Increase productivity and cost-savings that could be reinvested elsewhere
- Improve resident, caregiver and staff satisfaction

**Key Recommendations for Building a High-Performing System of Care for Older Ontarians with Complex Health Needs**

**ACCESS**

- Explore service delivery models that improve utilization of existing LTC bed capacity and optimize lengths of stay using evidence-based care pathways
- Move to a referral-based admissions process from hospital to a post-acute or specialized short-stay program in long term care to improve system flow
- Consider a wait time guarantee for a ‘place’ in long term care that could include a long or short-stay bed or a space in a day, night or outreach program
- Support cost-effective care delivery in a wider range of assisted living settings
- Provide patients and families with access to a consumer-friendly assessment tool to help them determine the likelihood of long term care placement, assess options and plan ahead

**QUALITY**

- Set targets for improvement in areas with potential to generate the greatest value in the system of care for older adults such as palliative/end of life care, prescription drug utilization, stroke and diabetes management, and dementia care

For the complete list of recommendations go to page 66.
• Adopt a ‘no home left behind’ policy that will ensure performance is consistently high across providers
• Build advanced nursing capacity in every home and create a long term care medical specialty in recognition of the skills required to care for an aging population
• Create a comprehensive province-wide cooperative education initiative in aging care along with bridging programs and prior learning assessment to attract and retain staff and enable those already in the sector to upgrade their skills
• Ensure service-based funding considers optimal staffing mix for different groups of residents along with outcomes of care

COST
• Expand the range of non-financial incentives available to LTC providers, including earned autonomy for those that consistently exceed performance benchmarks
• Develop alternate LTC physician and nurse practitioner reimbursement models to provide incentives for mentoring LTC staff and students and achieving key care outcomes targets such as reducing hospital transfers
• Develop capital financing models that enable greater choice in accommodation and amenities while preserving provider viability
• Undertake costing study and develop performance targets and incentives for new short stay programs in collaboration with the sector
• Retain a flow-through system of accounts for nursing and personal care so the public is assured there is no profit from direct care in LTC

INNOVATION
• Move to an outcomes based performance and accountability framework that allows providers more discretion to determine how care is provided while holding them accountable for reporting on and meeting agreed upon results
• Create an aging care and services innovation cluster to accelerate development, validation and adoption of needed technologies for Ontario and the global marketplace
• Establish a central clearinghouse for technology in aging care at MaRS to assist consumers and providers to share information and post-market research
• Fast-track plan to upgrade the sector’s clinical information infrastructure in collaboration with Canada Health Infoway and e-Health Ontario
• Add innovation to Health Quality Ontario quality framework for public reporting.

“We should recognize and reward staff and homes that make the resident experience a priority.”
Donna Fairley, Ontario Association of Residents’ Council, Presentation to Expert Panel

“LTCHs are a final destination for many seniors. The…sector emphasizes permanent placement …and provides programs and capacity aligned with this purpose. While permanent placement may be appropriate for some, for many others the ability to transition through LTC to access a temporary restorative program (e.g. convalescent care), and then move home or to other community settings may be a more appropriate option.”
Dr David Walker, 2011

“New innovation patterns are emerging that push companies to listen to their customers, collaborate with competitors in smart ways and assume greater social and environmental responsibility. Innovation must respond to users’ needs, which often requires involving and empowering them … at early stages in the product or services development phase.”
European Commission Enterprise & Industry Directorate General, 2009
Anticipated Outcomes of Implementing LTC Innovation Strategy

Access

- 36% increase in LTC capacity created through modest improvements in LTC occupancy and length of stay and a rebalancing of bed types
- 41,000 more older adults able to access residential short stay spaces, including post care convalescent care, specialized units and assess and restore programs
- A fourfold increase in respite care spaces to address the temporary, intermittent care or end of life care needs of over 19,000 community-dwelling frail older Ontarians and their families

Quality

- 5 million hours redirected from documentation and administration to front-line care.
- A high performing system of care for older Ontarians with complex health needs that is the best in Canada
- An integrated consumer-focused long term care system with outcomes in palliative care, dementia care and transitional care that are among the best in the world

Cost

- $1.15 billion in avoided capital costs to the Government of Ontario to build 9,465 new LTC beds required by 2016 and an estimated $454 million annually thereafter in avoided operating costs
- Targeted investments to strengthen community and residential care capacity to deliver better care closer to home
- Cost savings as a result of efficiencies and quality improvements in care delivery, prescription drug utilization and reduced ED transfers and readmissions

Innovation

- A thriving elder care innovation cluster that is producing products and services for the $55 billion global aging care market and generating high-value jobs and economic prosperity for Ontarians

“CCAC simply does not have sufficient capacity to both reduce hospital census levels to the targets preferred by the hospitals while at the same time keeping the community wait times within the wait time target of 90 days…Any delay in the placement of clients in LTC does have the potential for reducing the client’s LOS in LTC thus effectively increasing capacity…[but] it is only when the LOS reaches 2 years that the current capacity is sufficient to come close to meeting the community wait time targets currently in place.”

Jonathan Patrick, University of Ottawa, 2011

“For transformation to happen we need cross-continuum solutions that build capacity at the organizational and sector levels – and we need to use partnerships and integration as levers for innovation.”

Anne Marie Malek, Panelist
The scenario below envisions the creation of step-down units in LTC for hospital patients in need of convalescent or other post acute care. It also envisions the creation of step-up units in respite or other short stay beds for long term care or community care residents who require end of life care, specialized assessment or intensive supports for a temporary period of time. Two options for modeling short stay convalescent and other specialized programs are provided in order to show the impact of varying average lengths of stay on the number of individuals served. Appendix H presents alternate scenarios. More complex capacity planning models and extensive sector consultation would be required to determine the reapportioned bed ratios and ensure care pathways and lengths of stay for expanded short stay programs in long term care optimize care for different groups of patients and assist with discharge planning and successful transition back ‘home.’

"Many OECD countries have developed the capacity of LTC institutions to receive LTC patients once they no longer need acute care in hospitals, in order to free up costly hospital beds."

OECD, 2011
Why Not Now?

A message from the co-chairs of the Long Term Care Innovation Expert Panel

Long term care is known for many things, innovation is not usually one of them. The aim of the Long Term Care Innovation Expert Panel was to develop a consumer-oriented strategy that would unleash the innovation potential of the sector while generating value for the healthcare system.

The Panel was set up following the release of a Conference Board of Canada (CBoC) report on the state of the sector and options for renewal. The CBoC’s blunt message:

*Long-term care is struggling to meet current requirements and is ill-prepared for the challenges that will emerge over the next two decades. Unless significant steps are taken to prepare the sector to operate more effectively within an integrated system of care for older adults, Ontarians will be left with an unsustainable system that fails to provide the care they require in their final years.*

Between April and November 2011, our 22 member panel listened to experts and stakeholders and engaged in focused discussions on service organization and delivery, health human resources, technology, building design and funding, financing and regulation. We heard about the many challenges facing the sector and the many opportunities to make things better. We did not hear a lot of brand new ideas or well-costed options that dramatically challenged current thinking or way of doing things. But we heard that experimentation and small improvements, some radical, many incremental, could generate value for the system.

The truth is: there is no magic bullet or regulatory solution to all the perceived ills in long term care, or healthcare. But there are pockets of excellence here, and internationally. And we can learn from our own and others’ experiences, we can develop a vision that will inspire transformative change and confidence in the system; we can focus effort by developing actionable goals. In short, we can innovate but it requires commitment, creativity and an enabling environment.

The Expert Panel believes that by working collaboratively with other system partners, Ontario’s long term care providers have the potential to become the innovation engine for the best elder care system in the world—a system that is integrated, sustainable and puts the ‘consumer’ first. It is a conviction shared by all those who took the time to respond to our call for presentations and submissions. This document presents our collective best thinking. It proposes a bold and ambitious strategy for innovation and integration of long term care. The challenge is: are we – providers, government and system partners—ready and willing to change?

*Change is inevitable but the choice to innovate is ours. Why not start now?*
This innovation strategy was developed by the Long Term Care (LTC) Innovation Expert Panel following:

- In-depth interviews with over 30 leaders in government, academia, health care and long term care in Ontario and other jurisdictions carried out by the Conference Board of Canada
- Data and background research compiled by staff and independent consultants
- Submissions from a wide range of stakeholders who responded to an open call posted on the Ontario Long Term Care Association website and promoted widely
- Presentations and discussions led by the panelists themselves.

The strategy builds on “Elements of an Effective Innovation Strategy for Long Term Care in Ontario,” a Conference Board of Canada report commissioned by the Ontario Long Term Association (OLTCA) in 2010 to launch a conversation on the future of aging care and services and long term care’s place within the out-of-hospital continuum of care.

OLTCA convened the Panel following a period of rapid and unprecedented change. There was concern about the capacity of long term care to absorb change, and more importantly, concern that these changes were not transformative enough to produce vastly different outcomes. As one panelist observed: “long term care is perfectly structured to do what it has always done and to get the results it has always gotten. Tinkering at the margins is not going to change things.”

The Conference Board of Canada defines innovation as “a process through which economic or social value is extracted from knowledge through the generation, development and implementation of ideas to produce new or significantly improved products, processes and services.” It also notes that much really useful innovation is incremental, not radical.
The challenge for the Panel was distinguishing between what was ‘tinkering’ and what was truly—incrementally or radically - innovative and worth highlighting. In making its choices, the panel was guided by the following principles:

- **Accountability and Transparency**: does the proposed course of action improve accountability and transparency?
- **Consumer Choice**: does the proposed course of action promote informed consumer choice?
- **Flexibility**: does the proposed course of action enhance the ability of providers or system to anticipate and adapt to changing needs?
- **Sustainability**: is the proposed course of action cost-effective? Can it be sustained over the long term?
- **Evidence**: is the proposed course of action informed by evidence or does it help to grow the evidence-base? Is implementation amenable to evaluation and course correction?
- **Results/Outcomes**: does the proposed course of action focus on ‘ends’ and leave the ‘means’ as fodder for innovators?

Although not all recommendations achieved unanimous support, there was broad consensus on the contents of this document and the proposed path for sector - and health system - renewal.

The Expert Panel believes strongly that long term care needs to address the value proposition for the delivery of health care services in the province of Ontario: access, quality and cost. The proposed 3-pronged strategy for innovating long term care focuses on delivering value to all stakeholders in the system.

Much of the content is not new. Indeed, several sections echo the recommendations of ER/ALC Expert Panel Chair, Dr. David Walker. The strategy is also consistent with the Drummond Report and Ontario’s Action Plan for Health Care. What is new is the innovation lens applied to a sector with untapped potential to address the needs of a growing number of Ontarians: older adults with complex health needs and their families.
Services

In many jurisdictions, ‘long term care’ refers to care offered in a range of settings including an individual’s home. In Ontario, long term care refers to care provided in facilities licensed under the *Long Term Care Homes Act, 2007*. Long term care homes (LTCHs) provide care, services and accommodation in a secure environment to people with high assessed needs who require complex health care and personal support and can no longer live independently in the community. Government-funded LTCH services include:

- Clinical assessment and care planning
- Nursing and personal care with 24 hour supervision
- Regular and emergency medical care by an on-call physician
- Treatment and medication administration and management
- Assistance with activities of daily living such as dressing, bathing, eating, walking and toileting restorative and palliative care, dementia care and specialized services such as behavioural supports and peritoneal dialysis
- Required programs such as continence care, falls prevention, skin health and pain management
- Spiritual care, and social and recreational programs
- Short-term respite and convalescent care (in a limited number of homes)
- Room and board, including meal service and special diets, housekeeping and laundry services (resident co-payments cover most of these costs)

Community care access centres are responsible for assessment and long term care placement. Clients have a choice of up to five homes and must consent to placement.

**ASSESSMENT & ADMISSION TO LONG TERM CARE**

MAPLe, or Method for Assigning Priority Levels, is a standardized measure that helps Community Care Access Centre (CCAC) case managers determine appropriateness for admission to long term care and assists with priority setting and wait list management. It assigns clients based on a scale of 1 (low need) to 5 (very high need). High MAPLe levels indicate problems with cognition, behaviours and/or independent functioning. In 2011, 82% of LTC placements were at high to very high risk of adverse health outcomes (MAPLe 4 and 5) and the remaining 18% were at moderate risk (MAPLe 3).

Sources: MOHLTC, 2003 and OACCAC, 2011.

**FACT:** 83% of residents admitted to LTC in 2010/11 had ‘high’ or ‘very high’ care needs compared to 72% in 2007/08. (Source: OACCAC, 2011.)
KEY FACTS

Bed Capacity
- 634 long term care homes across Ontario
- 77,863 beds, 97% of which are long stay beds
- 3/4 of all beds in the healthcare system

Ontario LTC Home Ownership Profile

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<tr>
<th></th>
<th>BEds</th>
<th>HOMES</th>
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<tbody>
<tr>
<td></td>
<td>Proprietary</td>
<td>Municipal</td>
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<tr>
<td>Non-Profit</td>
<td>25%</td>
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<tr>
<td>Municipal</td>
<td>16%</td>
<td>77%</td>
</tr>
<tr>
<td>Eldcap*</td>
<td>0.3%</td>
<td>1%</td>
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*The Elderly Capital Assistance Program (EldCap) provides services to long-term care residents in units that are collocated within hospitals, or are near hospitals, in small northern communities. EldCap beds under the EldCap program are licensed and are subject to the LTC program requirements, as funded through a hospital’s global budget at a higher per diem than other long-term care beds.

Source: Long Term Care Home System Report, July 2011, MOHLTC

LTC Residents
- Residents admitted, assessed or discharged: 111,777
- Average age: 83, Younger than 65 years: 6.7%, Female: 68.5%
- 42% of admissions come from hospital
- 76% are totally dependent or require extensive assistance with activities of daily living
- 56% show signs of health instability, including end stage disease
- 58% have dementia diagnosis; 29% have severe cognitive impairment
- 45% show aggressive behavior


Discharge Destination by Setting & Jurisdiction, 2010/2011

<table>
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<tr>
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<th>CCC Ontario</th>
<th>LTC Ontario</th>
<th>LTC Manitoba</th>
<th>LTC BC</th>
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</thead>
<tbody>
<tr>
<td>Total Discharged</td>
<td>21574</td>
<td>36184</td>
<td>2302</td>
<td>6201</td>
</tr>
<tr>
<td>Proportion of All Residents</td>
<td>80.8</td>
<td>32.4</td>
<td>29</td>
<td>23.1</td>
</tr>
<tr>
<td>Died in Facility (%)</td>
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<td>45.9</td>
<td>70.8</td>
<td>78.6</td>
</tr>
<tr>
<td>Discharged to Acute/Other Hospital (%)</td>
<td>14.9</td>
<td>21.5</td>
<td>4.8</td>
<td>3.6</td>
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<tr>
<td>Discharged Home (%)</td>
<td>30.8</td>
<td>19.8</td>
<td>1.7</td>
<td>3.6</td>
</tr>
<tr>
<td>Discharged to Residential Care (%)</td>
<td>22.9</td>
<td>12.7</td>
<td>22.3</td>
<td>13.4</td>
</tr>
</tbody>
</table>

Source: CCRS Quick Stats Tables 2010/11, CIHI.
Resources

- Ontario spends approximately $3.4 billion annually on long term care homes. This accounts for 7.5% of the provincial health budget.
- Direct care staffing levels average 2.9 hours per resident per day and vary depending on funding available from provincial and municipal governments and charitable donations.
- As of July 1, 2011, homes received $153 per resident per day (prpd) from the provincial ministry of health. This amount, which includes a resident co-payment, varies based on acuity.
- Homes receive a premium for semi-private (up to $8 prpd) and private accommodation (up to $18 prpd). Those that provide peritoneal dialysis (17 homes) or convalescent care (438 beds) receive an additional resident per diem ranging from $33 to $70.


Utilization

As of July 2011:

- 99% of Ontario’s long term care beds were occupied.
- 19,000 Ontarians were waiting for LTC placement.
- 2/3 of clients placed in long term care were in the high needs category, 28% were in the crisis category.
- 36% of residents were placed in the home of their first choice.
- Average wait time to LTC placement was 76 days but varied widely by LHIN region (from 40 days in Central West LHIN to 169 in North West LHIN), home classification and ownership, and preference ranking (lower wait times for those who were admitted to their 2nd or 3rd choice of home). Wait time for placement also varied by residence, with those in hospital waiting a median of 64 days and those in the community, 132 days.

FACT: As of July 2011, 67 mostly older homes were below 97% occupancy, the threshold below which homes lose full funding. This trend is likely to continue as consumers become more selective and families more assertive regarding choice of care setting. Homes operating below the 97% threshold have difficulty retaining staff to meet care needs in the home and staffing to full capacity to meet surges in demand. (Source: OLTCA, 2011.)

FACT: Municipalities contribute over $300 million annually to top up funding for approximately 16,500 municipal long term care beds in operation across the province. (Source: Association of Municipalities of Ontario, 2011.)

FACT: There are 13 life and health insurers in Canada that offer individual LTC insurance plans. As of 2009, providers covered 397,000 Canadians and paid out $13.4 million in benefits under these plans. (Source: Canadian Life and Health Insurance Association, 2011.)

FACT: Spending on the continuum of long term care accounted for 1.5% of GDP on average across 25 OECD countries in 2008 and is expected to increase significantly in the decades ahead. (Source: OECD, 2011, p. 37.)
Ontarians in the high or very high risk (MAPLe 4 & 5) category waited approximately 3 months for a bed. Clients waiting for placement in an ethnic or religious home and those in the highest need categories applying from the community had a highest wait times for long term care.

Sources: MOHLTC, 2012 and OACCAC, 2011.

System Performance

- Over half of all hospital alternate level of care (ALC) patients, including over three quarters of long wait patients, are waiting for LTC. Of the remaining cases, one quarter is waiting for convalescent care, palliative care and assisted living.

- Hospital length of stay for persons with dementia is more than double the Organisation for Economic Co-operation and Development (OECD) average where more are cared for in community settings, including residential care.

- The LTC sector performs relatively well on several system-level indicators but opportunities for improvement exist with respect to preventable injuries that result in transfer to hospital, discharges to hospital for end of life care, and workplace safety.

- LTC is taking in more complex residents compared to three years ago but length of stay is still relatively long compared to other jurisdictions.


For additional background information on the sector, including accountability and quality in long term care, see Appendices D and E.
STRATEGIC CONTEXT

Trends

- Rising demand for care as a result of the growing number of persons over the age 75 with complex chronic conditions and age-related disability and disease such as dementia.
- More diverse and educated consumers exhibiting strong preference for independent living, autonomy and choice.
- Declining proportion of working age population able to contribute to tax base and workforce, both formal and informal.
- Smaller families and greater mobility weakening traditional family ties and social supports.
- Rising number and influence of empowered caregivers.
- Growing importance of social networks and virtual communities.
- Shift toward person-centred care with more emphasis on choice, autonomy and dignity, and promotion of social interaction, communication and partnership among staff, management, patients/residents and families.
- Continuing efforts to curb health care spending through diversion and controls on access to expensive parts of the system particularly hospitals and long term care homes.
- Emerging demand for different types of premium accommodation and services within congregate settings.
- Further segmentation of residential care supply and demand based on ability to pay.

Challenges

- Lack of integrated systems, poor coordination of admissions to long term care and overly complex rules related to eligibility and choice are resulting in bottlenecks, duplication, longer wait times and negative resident and family experience.
- Regional variability in assessment and referral processes, access to specialized resources and technology infrastructure.
- Not enough current and new physicians, nurse practitioners, registered nurses or other health professionals trained to care for growing population of older, frailer residents with complex conditions, behaviours, and severe mental illness and addictions.
- Negative image of sector and low confidence in its ability to provide high quality of care consistently across programs and providers.
- Regulatory burden reinforces ‘culture of compliance,’ diverting time from clinical care to regulatory administration and documentation.

FACT: Preliminary data from the Canadian Longitudinal Study on Aging reveals that half of Ontarians aged 45-64 and one third of those 65-85 reported providing assistance to another person in 2009. One in six Ontarians aged 45-64 reported managing another person’s care needs or assisting with personal care, medication or other medical care. (Source: Dr. Parminder Raina, Panelist)

FACT: Expenditures on home care and institutions vary widely among OECD countries. Variation reflects differences in care needs, the comprehensiveness of formal systems, and family caring cultures. (Source: OECD, 2011.)

FACT: The Ontario ministry of health funds 174 minutes of direct care per LTC resident per day. Homes participating in the CAN-STRIVE study reported spending an average of 75 minutes per day on resident-specific direct care and care coordination activities. The remaining time was spent on non-resident specific tasks such as charting and reporting. (Sources: Hirdes et al., 2011 and Ontario Ministry of Health and Long-Term Care 2011.)
Recent changes to long term care funding agreements and the licensing system have created uncertainty and reduced access to capital for redevelopment of older homes.

Opportunities

- Families and residents are demanding better and more timely information about care options and a system that is more responsive and easier to navigate.
- 35,000 long term care beds are due for redevelopment.
- Some providers (municipalities, small hospitals, small independents) are being forced to reconsider their role in long term care.
- 3 new LTC centres of learning, research and innovation are creating the platform for workforce renewal and rapid development and application of new technologies and leading practices.
- The culture change to resident-driven care and quality improvement initiatives such as Health Quality Ontario’s Residents First project are redefining the service delivery model, creating capacity for quality and momentum for innovation in the sector.
- ‘Hub and spoke’ structure and competitive RFP process provide a potential model for organization and rapid roll out of province-wide programs.
- Ontario’s regional geriatric programs offer evidence-based specialized support and could be expanded to serve Northern Ontario.
- A recent review of long stay ALC patients concluded that enhanced community capacity, including targeted transitional care and more resource-intensive home care services, will be required to address higher care needs in the community.
- Long term care is enabling more and more people to be returned to the community and some providers are early leaders in the delivery of specialized programs.
- Long term care has competencies required by the health system.

“People see long-term care as a failure of themselves, their family and the health-care system. The main goal is always to keep them out of long-term care homes, rather than saying how can we make them attractive interesting places to be and work.”
Pat Armstrong, researcher (in S. McLean, 2010)

“The average length of stay for dementia and Alzheimer’s patients in acute care has decreased by 23 days on average across OECD, between 1994 and 2008, showing that it is possible to deliver more appropriate care at lower cost.”
Francesca Colombo, 2011
Long Term Care’s Core Competencies

1. Long term care successfully integrates medical and social models of care, offering a flexible holistic option for adults with very high physical, social, psychological and personal needs, many of whom are at the end of life or can no longer live independently in the community.

2. Long term care has extensive experience and expertise in interdisciplinary team delivery of chronic care for seniors based on a restorative philosophy that maximizes function and dignity.

3. Long term care provides services at a guaranteed price and knows how to maximize limited resources.

### Long Term Care Areas of Expertise

<table>
<thead>
<tr>
<th>Existing</th>
<th>Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerontology</td>
<td>Chronic disease management</td>
</tr>
<tr>
<td>End of life care</td>
<td>Assess &amp; restore</td>
</tr>
<tr>
<td>Dementia care; Behaviour management</td>
<td>Geriatric mental health</td>
</tr>
<tr>
<td>Medication management</td>
<td>Infection control &amp; prevention</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>Quality improvement methods &amp; tools</td>
</tr>
<tr>
<td>Continence Care</td>
<td>Data analysis</td>
</tr>
<tr>
<td>Wound care</td>
<td>Interprofessional practice</td>
</tr>
<tr>
<td>Restorative approach to care</td>
<td>Communication</td>
</tr>
<tr>
<td>Resident-centred care</td>
<td>Mentoring &amp; leadership</td>
</tr>
<tr>
<td>Team-based care delivery</td>
<td>Lifelong learning; applied research</td>
</tr>
<tr>
<td>Regulatory environment</td>
<td>Culture change</td>
</tr>
<tr>
<td>Financial management</td>
<td>Technology</td>
</tr>
</tbody>
</table>

Source: Adapted from C Bisanz and D Rubin, 2010
OUR VISION FOR ONTARIO’S SYSTEM OF CARE FOR OLDER ADULTS
Ontarians should be supported to remain in the community for as long as possible. This requires creating age-friendly communities, providing a range of supportive housing and retirement living options and developing new models of care. It also requires ensuring that high quality residential long term care is accessible to those who need it when they need it.

The Expert Panel has an inclusive vision for Ontario’s system of care for older adults; one based on the belief that the system should:

- **Promote health** and well-being
- **Empower** older Ontarians to make informed choices and take control of their lives and their care, even if it means acceptance of increased risk to the individual
- **Be seamless** and easy to navigate from the perspective of the consumer and the provider
- **Provide access** to a range of high quality accommodation and services that address the hierarchy of needs and promote quality of life
- **Be responsive** to evolving consumer needs, wants and preferences
- **Support caregivers** to carry out their roles effectively
- **Be affordable** for consumers and taxpayers
- **Be regulated** in a manner that promotes innovation and continuous quality improvement.

These principles should guide system transformation and long term care innovation.

**Maslow’s Hierarchy of Needs**

- **Physiological**
  - Air, Food, Water, Shelter, Sleep, etc.

- **Security**
  - Personal Safety, Comfort, Physical Resources, Property, Family, Health, Social Stability

- **Social**
  - Love, Belonging, Affection, Relationships, Sexual Intimacy

- **Esteem**
  - Confidence, Achievement, Personal Worth, Recognition, Respect

- **Self-Actualization**
  - Personal Growth, Fulfillment, Creativity, Spontaneity

“The unfortunate aspect of ageing is that it is treated as a disease and in many countries services are developed based on this mindset.”

Greg Shaw, Panelist

“The Danish government made a philosophical shift in the way elderly people were housed and cared for through the de-institutionalization of seniors back into the community... Ontario too may be ready for a philosophical shift that places seniors’ quality and variety of care as central to an aging at home policy. Low-income seniors who often experience greater health risks and vulnerability due to their inability to privately purchase the care they need would gain safety, comfort, independence and the right to choose the housing and care that best suits their specific needs.”

Allison Jones, 2007
Moving to a continuing care model will require a significant shift in policy and funding. The Panel heard about a number proven and promising innovations in Canada and elsewhere. Some focus on integrated approaches to the organization and delivery of services; others on integrated approaches to housing. All call for older adults and their families to become active partners in the health system and addressing needs comprehensively. Investments in home and community care are needed but an enabling - and nimble - regulatory environment is also important.

Detailed recommendations for reform of the broader continuing care system were beyond the scope of the Expert Panel’s work. Nevertheless many of the submissions and presentations to the Panel (see Appendix) contained evidence and ideas for change and could be a resource to Ontario’s reform efforts. There is also a burgeoning body of comparative analyses emerging from ANCIEN (Assessing Needs of Care in European Nations) and the OECD LTC project, with summative reports set for release in 2012.

While the Panel did not undertake an in-depth comparison of alternate approaches, snapshots of Australia’s blended residential and community planning model, and Denmark’s long term care system, which integrates social care, health care and housing, are included in the Appendix to illustrate the types of policy choices and investments that may be required in Ontario. The Australian Productivity Commission also completed an exhaustive review of that country’s aged care system. The rigour with which it approached its task and the conclusions it drew are worthy of consideration.

The Continuum of Care for Older Adults

<table>
<thead>
<tr>
<th>Self Management</th>
<th>Consumer-Directed Care</th>
<th>Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Promotion &amp; Awareness</td>
<td>Home Care</td>
<td>Assisted Living</td>
</tr>
<tr>
<td>Informal Supports</td>
<td>Preventive Visits</td>
<td>Homemaking</td>
</tr>
<tr>
<td>Volunteer Programs</td>
<td>Homemaking Services</td>
<td>Personal Care</td>
</tr>
<tr>
<td>Regular Housing</td>
<td>Adapted Housing</td>
<td>Reablement</td>
</tr>
<tr>
<td>Short Stay Housing</td>
<td>Congregate Housing</td>
<td>Community &amp; Outreach Services</td>
</tr>
</tbody>
</table>

"It is the integration of medical, health, supportive, community and residential/institutional care into one system that is the essence of the continuing care model and is why it is such a good fit to the actual needs of people with ongoing care needs such as the elderly and people with disabilities."

Neena Chappell & Marcus Hollander, 2010

FACT: In nearly all OECD countries, 50-75% of all formal LTC is provided in home care settings, including care for persons with dementia. (Source: OECD, 2011.)
WHY LONG TERM CARE WILL BE A RESOURCE TO HEALTH SYSTEM TRANSFORMATION

- Long term care is well-positioned to lead health system change in the care of older adults.
- LTC is based on a sustainable private/public funding model that is affordable, equitable and sensitive to market rigour and consumer choice.
- The sector has a significant presence: 78,000 beds (and an equivalent number of workers) in 634 communities across Ontario.
- Homes are embedded in the social and economic fabric of local communities which vary greatly depending on socio-demographic profile, size, location and economy.
- There is a mix of public, nonprofit and private ownership and a healthy balance of collaboration and competition among providers.
- There is a limited number of provider organizations enabling economies of scale and capacity to rapidly duplicate and replicate programs and practices across the sector.

Ontario’s LTC providers offer a range of services beyond long term care including community support services; home care; rehabilitation, complex continuing care and acute care; geriatric clinical consulting services; retirement living and supportive housing; land development/real estate and shared purchasing and operations management. This creates untapped opportunities for innovation and system transformation.

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Acute Care</th>
<th>Post Acute</th>
<th>Total</th>
<th>Total ALC Beds</th>
<th>% ALC Beds Occupied by Patients Waiting for LTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterloo Wellington</td>
<td>12</td>
<td>27</td>
<td>39</td>
<td>126</td>
<td>31</td>
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<td>Hamilton Niagara</td>
<td>57</td>
<td>100</td>
<td>157</td>
<td>446</td>
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<tr>
<td>Haldimand Brant</td>
<td>34</td>
<td>1</td>
<td>35</td>
<td>130</td>
<td>27</td>
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<tr>
<td>Mississauga Halton</td>
<td>77</td>
<td>185</td>
<td>262</td>
<td>522</td>
<td>50</td>
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<tr>
<td>Toronto Central</td>
<td>104</td>
<td>28</td>
<td>132</td>
<td>321</td>
<td>41</td>
</tr>
<tr>
<td>Central</td>
<td>38</td>
<td>24</td>
<td>62</td>
<td>128</td>
<td>48</td>
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<tr>
<td>Central West</td>
<td>41</td>
<td>90</td>
<td>131</td>
<td>198</td>
<td>66</td>
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<tr>
<td>Erie-St.Clair</td>
<td>76</td>
<td>76</td>
<td>152</td>
<td>276</td>
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<tr>
<td>North East</td>
<td>121</td>
<td>161</td>
<td>282</td>
<td>438</td>
<td>64</td>
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<tr>
<td>Central East</td>
<td>35</td>
<td>74</td>
<td>109</td>
<td>170</td>
<td>64</td>
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<tr>
<td>North West</td>
<td>114</td>
<td>125</td>
<td>239</td>
<td>358</td>
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<tr>
<td>South West</td>
<td>167</td>
<td>133</td>
<td>300</td>
<td>485</td>
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<td>Champlain</td>
<td>66</td>
<td>16</td>
<td>82</td>
<td>140</td>
<td>59</td>
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<tr>
<td>North Simcoe Muskoka</td>
<td>70</td>
<td>61</td>
<td>131</td>
<td>195</td>
<td>67</td>
</tr>
<tr>
<td>South East</td>
<td>1012</td>
<td>1101</td>
<td>2113</td>
<td>3953</td>
<td>54</td>
</tr>
<tr>
<td>Total Beds</td>
<td>14645</td>
<td>12693</td>
<td>27,338</td>
<td>27,338</td>
<td></td>
</tr>
</tbody>
</table>

Source: OHA, 2012

ALC Patients in Acute & Other Inpatient Care Waiting for LTC Bed by LHIN Region, December 2011
OUR VISION FOR LONG TERM CARE
The long term care sector will be an integral partner in a sustainable health care system as a provider of high quality integrated person-centred care, services and accommodation for older adults and a source of innovation on care and services for an aging population.

There are some who believe that long term care is the ‘iron lungs of gerontology’ and has no place in a healthcare system that is increasingly community-based, technology-enabled and consumer-driven. The Expert Panel rejects this view. Long term care is a vital partner in an integrated health care system. But the traditional ‘nursing home’ must – and will - undergo a fundamental transformation over the next decade.

The ‘long term care home’ of the near future will be:

- A **hub for community-based elder care** and geriatric research and education
- A **nurturing clinical setting** for those in need of continuing, convalescent, restorative, respite and end of life care and non-residential outreach and support programs
- A **magnet for students, researchers, caregivers and healthcare professionals**
- A **place where innovation thrives** and ‘next’ practices for seniors care originate
- A **preferred place to work**, live and receive care.

In the process, long term care’s role will be reinvented. It will cease to be a place of last resort. It will cease to be ‘long term’ care for all but those residents with complex health needs who cannot be cared for in other settings. It will provide ‘convalescent care,’ ‘transitional care,’ ‘restorative care,’ ‘cyclical care,’ ‘intermittent care,’ ‘continuing care,’ ‘end of life care,’ ‘integrated seniors care.’ In short, long term care will become not only a cost-effective resource for older adults with complex needs and their families, but also a collaborative leader working with other partners to create a better, more accessible, more sustainable health care system.
LONG TERM CARE’S VALUE EQUATION

Ontario’s long term care homes are well positioned to dramatically improve flow and access to needed high quality care for frail seniors and older adults with multiple chronic conditions while generating cost-savings for the health care system.
Ontario’s population is aging and the fastest growing groups are the very old and those with multiple chronic conditions. Indeed, the number of Ontarians aged 75+ will rise from 865,000 in 2010 to almost 2.2 million in 2036, while the group aged 90+ will triple in size according to the Ministry of Finance. Although today’s older adults are healthier than previous generations, age-related disability and frayed capacity of family caregivers to meet competing demands and rising care needs will place unsustainable pressures on the health care system. Indeed, this is happening already.

The latest Ontario Hospital Association ALC survey shows that 14% of Ontario’s 27,000 hospital beds are occupied by patients who could be more appropriately cared for elsewhere. Over half – some 2,000 patients on any given day - are waiting for long term care. The challenge is that long term care has its own ALC problem with one in five current residents assessed as having relatively low care needs. Many of these residents could be accommodated in supportive housing, retirement homes or other assisted living options but Community Care Access Centres place them in long term care because such supports may not be accessible or available in their community.

The Expert Panel supports the shift to community care. It also recognizes that this shift will require an increase in service and caregiver capacity that will be difficult to achieve without long term care’s contribution. Due to the demographic profile of aging boomers, there is a window of opportunity in the next decade to transform the system. That is why the Panel is recommending that providers and policymakers set a goal to reduce overall length of stay (LOS) in long term care.

A simulation study carried out by University of Ottawa researchers suggests a reduction from the current 3 years to 2 years or less is needed to ensure timely access to care. Although Home First and targeted community investments are increasing discharge rates and delaying LTC admissions, such a reduction will require careful consideration of unintended impacts and may be difficult to achieve in the short term. An alternate approach would require modest improvements in long stay utilization, along with a rebalancing of bed types and service and accommodation mix offered by LTC providers. In addition to significantly improving system capacity, these measures could avoid the need to build additional long term care beds in Ontario over the next five years.

To improve flow, the Expert Panel also recommends that Ontario review current approaches to LTC admission and wait list management and consider a wait time guarantee for a ‘place’ in long term care which could include a long- or short-stay bed, or a space in a day, overnight or outreach program. This would enable older adults to remain in their community as long as possible, and ALC patients to move into the LTC system with a guaranteed

“Most ALC patients (63%) had high health-care and support needs, making them likely candidates for LTC. However, more than a third (35%) had moderate care needs and could be cared for at home, but still ended up waiting for LTC … The percentage of these ALC patients waiting for LTC varied by as much as 20% across Ontario’s Local Health Integration Networks (LHINs).”

The Change Foundation, 2011, p. 1

WALKER REPORT RECOMMENDATIONS
The LHINs should support the specialized and differentiated use of LTC capacity as a transitional place of stay on a short-term basis, while providing support for patients with highly complex needs on a more permanent basis. LHINs and LTC homes make this capacity central to the sector’s mandate through Accountability Agreements. The ministry support creation of special units/programs in the community and LTC homes for seniors with special needs.
placement in their preferred home within a set timeframe. Referral-based admission to a short-stay program in long term care would also provide more appropriate care pathways for those with heavy care needs unable to return home following a hospital admission.

**FACT:** A 33% reduction in the average length of stay in LTC is required in order to reduce wait times for placement to close to the target 90 days. (Source: J Patrick, University of Ottawa, 2011.)

**FACT:** Between 77% and 86% of clients placed in long term care between July 2010 and June 2011 had high to very high assessed care needs (MAPLe 4 and 5), depending on LHIN region. Provincially, 99% of admitted LTC residents were in MAPLe categories 3 or above. (Source: OACCAC, 2011.)

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**WHY THE LONG LTC WAITS?**

Mismatch between supply and demand
Poorly designed system:
- Too much complexity or too many queues
- Inefficient scheduling
- Excess steps and avoidable delays
- Poor use of human resources
- Doing the right thing at the wrong place
- Traffic jams
- People who should not be on the waiting list

Source: S Kreindler, 2008

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Time to Placement in LTC in Year Following Introduction of Long Term Care Homes Act (LTCHA), Ontario, July 2010 – June 2011

- > 18 Months: 14%
- 12-18 Months: 7%
- 9-12 Months: 5%
- 6-9 Months: 9%
- 3-6 Months: 16%
- 1-3 Months: 25%
- < 1 Month: 24%

*Excludes Toronto Central CCAC, transfers from other LTCs.
Source: OACCAC, December 2011
**FACTORS ASSOCIATED WITH LONGER LENGTH OF STAY IN NURSING HOMES**

- Female gender
- Lower Income
- Younger age on admission
- Higher cognitive functioning
- Lower levels of physical impairment

Source: N Lievesley et al., 2011

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**IMPACT OF LENGTH OF STAY ON LTC LONG STAY DEMAND, CAPACITY & COST, 2016**

<table>
<thead>
<tr>
<th></th>
<th>STATUS QUO</th>
<th>SCENARIO 1</th>
<th>SCENARIO 2</th>
<th>SCENARIO 3</th>
<th>SCENARIO 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay</td>
<td>3.1 Years</td>
<td>2.75 Years</td>
<td>2.5 Years</td>
<td>2.25 Years</td>
<td>2 Years</td>
</tr>
<tr>
<td>Estimated Number of Residents Served per Year (76,073 long stay beds)</td>
<td>99,607</td>
<td>102,692</td>
<td>105,437</td>
<td>108,784</td>
<td>112,968</td>
</tr>
<tr>
<td>Demand Gap by 2016</td>
<td>12,393</td>
<td>9,308</td>
<td>6,563</td>
<td>3,216</td>
<td>-968</td>
</tr>
<tr>
<td>Estimated New LTC Beds Required by 2016</td>
<td>9,465</td>
<td>6,895</td>
<td>4,735</td>
<td>2,249</td>
<td>-652</td>
</tr>
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</table>

**COSTS**

**Capital**

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<thead>
<tr>
<th></th>
<th>STATUS QUO</th>
<th>SCENARIO 1</th>
<th>SCENARIO 2</th>
<th>SCENARIO 3</th>
<th>SCENARIO 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-time (per non-profit home)</td>
<td>$250,000</td>
<td>$3,721,049.97</td>
<td>$4,336,839</td>
<td>$2,978,447</td>
<td>$1,414,590</td>
</tr>
<tr>
<td>Ongoing (per bed per day x 25 years)</td>
<td>$13.30</td>
<td>$1,148,733,676</td>
<td>$836,771,963</td>
<td>$574,676,831</td>
<td>$272,938,322</td>
</tr>
<tr>
<td>Total Capital Costs Avoided (Saved)</td>
<td>$1,152,454,726</td>
<td>$841,108,802</td>
<td>$577,655,278</td>
<td>$274,352,912</td>
<td>($79,520,385)</td>
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</tbody>
</table>

**Operating**

<table>
<thead>
<tr>
<th></th>
<th>STATUS QUO</th>
<th>SCENARIO 1</th>
<th>SCENARIO 2</th>
<th>SCENARIO 3</th>
<th>SCENARIO 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Costs per bed</td>
<td>$48,300 (2011)</td>
<td>$457,159,500</td>
<td>$333,028,500</td>
<td>$228,700,500</td>
<td>$108,626,700</td>
</tr>
</tbody>
</table>

Note: This model uses forecasted demand by 2016 in Walker report (2011) and assumes no change in the number of long stay beds or occupancy (99%). Under these conditions, only in Scenario 4 would supply exceed demand, enabling a significant reduction in wait times or reallocation of resources.
Caring for clinically complex older adults is challenging. The Expert Panel believes that long term care has expertise to build on and share with other partners in the health care system in areas such as wound care, falls prevention, dementia care and complex chronic disease management in the frail elderly. But the sector’s potential is severely hampered by limited access to diagnostic equipment, timely data and specialist expertise. The result: unnecessary transfers to hospital and unacceptable delays or discontinuities in care. The Expert Panel believes the time has come to create a more cost-effective system of care for older adults with complex health needs including those for whom long term care is the best option. Ontario needs to build advanced practice nursing capacity in every home, speed up the shift to technology-enabled care, eliminate non value-added regulatory requirements and processes that take time away from residents and families, and move to primary care and LTC funding models that incent coordinated care.

Ontario is increasingly focused on quality, performance and accountability. Human resources practices must strengthen core competencies and support a culture of learning and continuous improvement. The Expert Panel strongly believes that the sector must move away from prescriptive staffing, regimented work environments and punitive approaches that discourage initiative, critical thinking and creative problem-solving. This requires a shift from a focus on compliance to a focus on the customer – the resident, the family, and the taxpayer.

The introduction of the interRAI family of clinical assessment tools has provided a base for measuring, tracking and benchmarking performance across time, providers and sectors. These instruments - soon to be complemented by staff, consumer satisfaction and ministry inspection surveys - are supporting quality improvement and enabling the development of new funding methodologies more sensitive to care needs and organizational performance. The Expert Panel is cognizant of the amount of time required to complete these assessments, concerns related to coding, clinical relevance and usefulness, and barriers to accessing up-to-date data for benchmarking and quality improvement. Nevertheless, it supports the use of validated assessment instruments not only because they lead to better care but also because they have the potential to improve policy and regulation and result in a fairer, more appropriate allocation of resources across clients and care settings. It also supports regular review and refinement of these assessment tools to ensure they continue to advance professional practice, and ongoing monitoring and education to ensure they are completed correctly. Additionally, there is an urgent need to implement tools and measures that better assess the care experience of residents and families, including the degree to which they feel valued, respected and listened to.
Over the past decade, there has been unprecedented investment in research on aging in Canada. While some of studies have informed policy and practice, significant gaps in knowledge remain in areas such as clinical practice guidelines for older adults, LTC regulation, funding policy, human resources, productivity and technology. The Expert Panel recommends growing the evidence base in elder care and accelerating its translation into practice by targeting investments to where the potential for user-driven innovation and system improvement are greatest and opportunities for development of niche markets in aging care exist.

**FACT:** The average cost of a normal acute hospital stay for persons with dementia is $14,176. (Source: Patient Cost Estimator, 2009–2010, CIHI.)

**ASSESSMENT TOOLS**

interRAI is an international collaborative of researchers and clinicians established 25 years ago to develop a valid tool to assess the clinical and resource intensity needs of nursing home residents in the US for funding and care planning purposes. The RAI MDS 2.0 was the first of a series of tools to emerge from the group. The interRAI suite now includes the latest generation RAI MDS, the Long Term Care Facilities Instrument (LTCF), along with tools specially designed to address the needs of home care, palliative care, acute and post-acute care, mental health and the resident experience. Although the tools have been validated and provide a common platform for cross-sectoral clinical and administrative decision-making, concerns have been expressed about clinical relevance, specificity and administrative burden. The US has recently moved to RAI MDS 3.0 updated by a team from RAND and Harvard University. In national trials the tool took 45% less time to complete and rated highly in terms of validity, reliability and integration of the resident voice. As the lines between sectors and settings of care blur, the need for integrated but more flexible assessment tools will grow. This presents an opportunity for researchers, clinicians and policymakers to engage in a thoughtful discussion about improvements and future direction. (Sources: www.interrai.org and Saliba & Buchanan, 2008.)
OPPORTUNITIES FOR LTC TRANSFORMATION: 4 AREAS RIPE FOR COST-SAVING INNOVATION

Palliative Care – Many Ontario LTC residents are discharged to hospital for end of life care, an expensive and less than optimal option for residents and families. Australia, the UK and the US have models that could be adapted for use here. An evaluation of the UK Gold Standards Framework in Care Homes, which helps people live well until the end of life, found the program improved care and reduced transfers to hospital by more than 50% (to 9.4%). Opportunities exist to strengthen end of life care in long term care building on networks and research under way in Ontario.

Prescription Drug Use – Wide variation exists in prescribing practice related to the care of older adults, including those in long term care. UK research suggests that 70% of antipsychotic prescriptions for persons with mild behavioural problems provide no benefit and had negative effects ranging from dizziness, falls, social withdrawal, accelerated cognitive decline, preventable hospital admissions and in some cases, death. Stopping inappropriate prescribing of anti-psychotics was estimated to reduce drug costs by £55 million annually. One third of Ontario long term care residents are on antipsychotic medication. It is likely that the behaviours of these residents could be better managed through more appropriate, less costly interventions.

Chronic Disease Management – According to the Ontario Renal Network only 17 LTCs (3%) offer peritoneal dialysis. Yet one quarter of LTC residents have diabetes, 9% have renal failure and incidence is rising among older adults. Last year, Ontario spent $4.5 million transporting LTC residents to dialysis care in hospital. It is unclear how many residents would be eligible for hemodialysis, or peritoneal dialysis in LTC although opportunities for improved access and care likely exist. Another area where opportunity for improvement exists is stroke care. It affects a growing number of older adults, many of whom have difficulty accessing appropriate rehabilitation services in a timely way.

Dementia Care – The Ontario Behavioural Support System (BSS) has the potential to improve care and reduce costs but it is in the early stages of development. Specialized post-acute care for persons with dementia could reduce hospital length of stay and enable these patients to remain in the community longer. A more comprehensive approach to early diagnosis and support for persons with dementia and family caregivers - including expanded access to respite and day and night programs, reablement or intermittent care in LTC, along with specialized caregiver education - could reduce ED visits, delay admission to long stay beds and reduce the need for significant system expansion over the next 25 years.

DOES QUALITY IMPROVEMENT SAVE MONEY?

Research by Øvretveit (2009) and others suggests that quality improvement reduces cost when:

- Providers bear more of the costs for poor quality
- Quality and related costs are routinely measured as part of management and payment systems
- The cost of training and education is financed and linked to savings
- Quality improvement costs are spread over time and between partners

“Evidence of an effective change + Effective implementation method + Supportive environment and infrastructure = Improved quality.”

Øvretveit, 2009
Public health and health promotion measures are crucial to reducing the burden of disability and disease over the medium to long term. In the near term, significant cost savings can be achieved through improvements in quality. Cost avoidance is also possible through more appropriate utilization of health services – including long term care. The Expert Panel anticipates that within two years only residents with high or very high needs – including many patients now designated ALC – will be admitted to long stay long term care beds, with consequent reductions in LTC length of stay and cost per episode of care. Enabling the sector to look after residents with much higher care needs will require more staff and a different skill mix. Long term care is a low cost provider compared to inpatient care but it cannot look after residents who would have been admitted to complex continuing care units in the past on $152 a day.

Investments will need to be made with money that would otherwise have been spent on new LTC beds, as well as savings generated by quality improvement within the sector (see text box opposite) or reallocations from other areas. The Expert Panel recommends that the LHINs re-examine interim beds in hospitals and invest in transitional supports and care for high-acuity patients in appropriately resourced community settings. It recommends that Ontario’s assisted living policy be refined to enable more older adults to access publicly funded services in a broader range of settings. It also recommends that providers across the continuum adopt Lean process improvement methods to eliminate waste and develop creative new ways of delivering better care for less money.

There is no doubt that Ontarians want to remain in their community as long as possible. There is also no doubt that community care costs significantly less than long term care, mostly due to the large proportion of costs shifted to families and patients themselves. This trade off is cost-effective as long as service delivery is relatively efficient, and there are adequate community and in-home supports, including family caregivers, to keep seniors well and out of hospital. It is less cost-effective when high-level care is required over an extended period of time or when support systems break down.

In 2011, one in five caregivers of home care clients living in the community, and nearly 40% of caregivers of clients admitted to hospital showed signs of acute distress. A recent analysis of CCAC service utilization by Doody and colleagues showed that 10% of home care clients account for nearly 50% of total expenditures. Some of these clients could be more cost-effectively cared for in a broader range of congregate living environments or specialized group programs. The capacity of family caregivers could also be significantly improved through education and training and better access to respite care programs – all of which long term care homes have the infrastructure and expertise to provide. Indeed, many are already doing so.
OPPORTUNITIES FOR LTC TRANSFORMATION: THE CASE OF CONVALESCENT CARE

An independent evaluation commissioned of the LTC Convalescent Care Program found high satisfaction with outcomes but identified 4 areas for improvement:

Admissions
• Insufficient information on client goals, cognitive abilities, potential for improvement and caregiver issues
• Lack of access to diagnostics, lab results and physiotherapy and occupational therapy assessments
• Incomplete medication and physician order information
• Time-consuming and labour intensive process for home to track down missing information
• Advance planning to accommodate weekend and holiday admissions
• Administratively burdensome documentation and assessment requirements
• Adequacy of assessment tools for patient population
• Clients not well informed about physician and physiotherapist availability and types of personal supplies and costs for which they would be responsible

Human Resources
• Lack of dedicated core staff
• More specially trained wound care staff and access to psycho-geriatric nurses and specialized mental health services
• Availability of social work, counselling and therapy services (occupational therapy, physiotherapy, speech therapy, orthopaedic therapy), with consideration to using physiotherapy aids and restorative care workers
• Higher physician workload and patient expectations of physician availability but CCC billing code rates and restrictions do not support key activities such as team and family conferences or increased medical care and admission and discharge planning.

LTC Environment
• Intermingling of beds and residents created frustration at having to share areas with more fragile LTC residents with severe impairments
• Lack of access to private rooms with higher level amenities (in-room TVs/entertainment, phone and internet access, balcony)
• Food preparation and selection
• Access to recreational/social activities geared to needs of convalescent residents who are generally younger than the long stay population

System Integration
• Transportation and escorts to medical/specialist appointments outside of LTC costly and administratively burdensome
• Medication coverage for patients ineligible for the Ontario Drug Benefit Program a challenge
• Specialized equipment (e.g., adaptation of wheelchairs and mobility devices, special mattresses, bariatric needs, topical pressurized oxygen therapy) and supplies (e.g., wound care, IV therapy)
• Access to lab services (e.g., INR) and mobile diagnostic services (e.g., x-rays, CT scans), particularly on weekends and after regular business hours.

Expanding post-acute convalescent care in long term care will require changes to how care is organized and delivered.

“There should be different parameters set up for convalescent care residents … as a convalescent I did not relate to the much older population of the home.”

Convalescent Care Program Evaluation respondent (Source: Evaluation of the New Convalescent Care Program Final Report, July 2008.)
SUMMARY

For the growing numbers of older Ontarians who wish to remain in their communities but are finding it increasingly difficult to do so, aging at home is more vision than reality. Long term care is a limited resource appropriate for those requiring high-level nursing care and personal support. In the near future, it could also become a setting of choice for growing numbers in need of transitional care and specialized services. The sector has untapped capacity in areas key to system transformation, including assisted living and the care of the frail elderly and persons with dementia. Service capacity in these areas could be cost-effectively expanded with the redevelopment of 35,000 LTC beds over the next few years. Creating value through better access, quality and cost is possible.

The Expert Panel has identified priorities for action that if implemented will:

• Spur innovation in care organization and delivery
• Dramatically increase support for caregivers and access to services for those at highest need
• Strengthen the evidence-base in elder care
• Shift care and resources to more appropriate settings along the continuum
• Improve flow, increase productivity and generate cost-savings that could be reinvested elsewhere

The innovation strategy that follows describes how these improvements will be achieved.
VALUING LONG TERM CARE: A 3-POINT STRATEGY FOR TURNING VISION INTO REALITY

1. Reengineer Long Term Care to Meet Consumer Expectations and System Needs
   - Improve placement and flow
   - Develop new service, funding and business models
   - Rebrand to reflect new service orientation

2. Build Capacity for Transformation
   - Strengthen the care team
   - Harness technology
   - Rebuild for the future

3. Enable User-Driven Innovation
   - Retool education and training
   - Invest in applied research
   - Remove policy and regulatory barriers

Anticipated Outcomes
   - Decreased LTC length of stay and wait times
   - Increased LTC capacity and productivity
   - Improved resident outcomes and consumer satisfaction
   - Improved safety and quality of work life
   - Reduced hospital ALC days, ED transfers and avoidable admissions
   - Improved health system sustainability

“Strong management is critical for greater innovation in our economy and our prosperity.”

Roger L Martin, Chair, Institute for Competitiveness and Prosperity, March 2009
STRATEGY 1
REENGINEER LONG TERM CARE TO MEET CONSUMER EXPECTATIONS & SYSTEM NEEDS

Ontarians want a health care system that is safe, effective and there when they need it. They want better communication and integration. They want to have their voice heard and choices respected. In short they want to be partners in the system. Few know a lot about long term care and what they have heard is generally not positive. Changing that view is not only in the interest of providers, it is in the interest of government, system partners and those who work and live in long term care. It starts with taking immediate action on fixable irritants that impede flow. It continues with developing business and service models that will enable the sector to better serve groups with very specialized needs. It concludes with rebranding long term care from ‘the final step,’ or ‘a place of last resort’ to ‘a care setting of choice.’

“A home just doesn’t take in a resident, it takes in a family as well. Families are faced with ongoing loss. They require information on the system and the day to day care the home provides. They need to be reassured that the system and home are attuned to quality of care and of life. Communication is a positive way of creating a family/staff partnership.”

Phyllis Hymmen, Concerned Friends of Ontario Citizens in Care Facilities, Presentation to Panel

LONG TERM CARE HOME PLACEMENT AND FLOW ARE A SOURCE OF CONCERN TO ALL STAKEHOLDERS. BETTER SYSTEMS AND MORE APPROPRIATE PLACEMENT COULD REDUCE WAIT TIMES AND DRAMATICALLY IMPROVE CONSUMER EXPERIENCE AND PERCEPTION OF LONG TERM CARE. A 2009 CHANGE FOUNDATION/OACCAC REPORT DOCUMENTED 160 STEPS IN THE MOVE FROM HOSPITAL TO LONG TERM CARE. THE PROCESS INVOLVED 36 FORMS, 7 STAFF AND 15 HAND-OFFS - EXCLUDING THE ADMISSION ASSESSMENT AND RESOURCE MATCHING PROCESS WITHIN THE HOME ITSELF. A MORE RECENT REPORT PREPARED FOR THE ERIE ST CLAIR LHIN FURTHER DOCUMENTED THE CHALLENGES EXPERIENCED BY ALC PATIENTS AND FAMILY MEMBERS AND RECOMMENDED AMONG OTHER THINGS THAT:

- Long term care homes be integrated into the education process with families and case managers
- Staffing models be developed that allow the same service providers to provide care in and out of hospital so as to ensure continuity of care and familiarity with staff
- More precise information on individual LTCH wait times be made available
- Patient assessments be reviewed to reduce duplication and increase information sharing.

FACT: North York General Hospital and Central CCAC dramatically reduced the number of steps required to discharge an ALC patient resulting in a 46% reduction in the number of days waiting for LTC placement and a 150% improvement in the availability of equipment for community-bound patients. (Source: The Change Foundation, 2010)

“IT IS IMPORTANT THAT [WE] MOVE BEYOND SOLELY DISCUSSING MEDICAL DIRECTIVES AND BEGIN TO INCORPORATE DISCUSSION AROUND SOCIAL, SPIRITUAL, AND PSYCHOLOGICAL CARE NEEDS OF THE RESIDENT AND FAMILY. THIS WILL HELP RESIDENTS AND FAMILIES TO BETTER UNDERSTAND THE SCOPE OF CARE THAT LTC HOMES MAY PROVIDE … AND IT WILL ALSO ALLOW STAFF TO LEARN MORE ABOUT [END OF LIFE] CARE GOALS OF THE RESIDENT AND FAMILY.”

Quality Palliative Care in LTC Alliance Submission to the Expert Panel

Phyllis Hymmen, Concerned Friends of Ontario Citizens in Care Facilities, Presentation to Panel
### Ontario’s LTC Wait List: Examples of Poor System Design

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>EXAMPLES</th>
</tr>
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| Too much complexity or too many queues | • 5 home choices  
  • 8 wait list categories  
  • 14 accommodation classes  
  • 2 gender categories  
  • 8 ranking rules  
  • Separate interim bed, special unit and short stay (convalescent) lists  
  • Additional considerations: capacity of home to meet care needs; roommate matching, ability to pay for preferred accommodation, religious and ethnic home admissions |
| Insufficient Scheduling | • Placement rules discourage pre-planning  
  • No consistent approach to home tours or information about LTC |
| Excess steps and avoidable delays | Assessments and admission/discharge processes carried out in Hospital, CCAC and LTCH. Any variation in capacity or process steps contributes to delays, for example:  
  • Incomplete forms  
  • Family members out of town or family disagreement  
  • Change in client condition  
  • Delayed response from case manager, LTC home, client  
  • Uncertain/unknown wait list position of client  
  • Difficulty arranging home tours  
  • Lack of information about LTC that is relevant to client decision-making  
  • Assessments not available to home; information out of date |
| Poor use of human resources | • Health professionals doing clerical work  
  • Nursing, social work & CCAC case manager role duplication |
| Doing the right thing at the wrong place | • Unnecessary or duplicate assessments  
  • Inappropriate admissions to ethnic and religious homes |
| Traffic jams | • Structural 14 day wait on placement  
  • CCAC assessment capacity  
  • Consumer choice  
  • Inability to discharge from hospital or to another home  
  • Home closed to admissions due to outbreak  
  • System not designed for 24/7 admissions to long stay beds; for new residents, move to LTC is life altering decision  
  • Lack of LTC resources (physical, human, financial) to meet needs of specialized populations |
| People who should not be on the waiting list | • Client does not want to go to LTC but has no where else to go  
  • Clients with severe mental illness; history of violence  
  • Wait list errors (duplicate names, client dies, needs change, etc) |

“The LTC Homes have struggled with the paperwork involved in the rapid turnover of [convalescent care] patients…Their work is made more difficult by the fact that applications often arrive with important information missing…the hospitals [also] expressed frustration at the delays caused by having to complete what they felt was an overwhelming amount of paperwork.”

Ontario Ministry of Health and Long Term Care, 2008
The Expert Panel supports these changes and further recommends that:

- Individuals and families have access to a consumer-friendly assessment tool to help them determine the likelihood of future long term care placement, assess options and plan ahead
- Assessment and patient navigation capacity be strengthened and expanded to key community settings including family health teams
- Placement processes and information be streamlined and standardized across the province and paper-based referrals eliminated
- Comprehensive up-to-date assessment data be available to the homes on referral, and transferred electronically on admission, transfer and discharge
- Consumer choice be retained for accessing long stay and respite beds from community settings, and a referral-based admissions process be implemented for access from hospital to specialized programs and convalescent and other short-stay beds
- A LTC wait time guarantee be considered for a ‘place’ in LTC that could include a long or short bed or a space in a day, night or outreach program
- A real-time standardized navigation and placement satisfaction survey be introduced to stimulate all stakeholders to build a better system.

Transformation is only possible if residents, families, system partners and providers begin to see improvements in areas that matter to them. Implementing these recommendations would:

- Increase consumer knowledge of care and placement needs
- Improve the resident and family experience
- Reduce wait time to LTC placement
- Free up acute, CCC and rehab bed capacity
- Eliminate duplicate documentation and data entry
- Release staff time from administration to direct care
- Improve continuity of care

“I want help getting accurate information that I can understand at the right time and place, including viable options, so my family and I can make the right decision for us. I want to feel confident that people care and to be treated with fairness and respect… I don’t want to make a decision out of fear, inadequate care, or surprises”

The Change Foundation, 2009

“Family Caregivers don’t always self-identify, but when they do connect to each other they share a high level of community, often using social networks to share insights, stories and concerns with one another.”

Don Fenn, Panelist

**FACT:** Although individuals have up to 5 choices, over half of those on the LTC wait list (including those in the crisis category) choose only one home. (Source: OACCAC, December 2011.)
LTC PLACEMENT: WHAT FAMILIES & PATIENTS NEED

1) More information. Family caregivers do not feel they have enough information on individual home wait times, location, services or features, experiences of others or process for scheduling home tours. For some, home visits are not a positive experience. Many would like more help with respect to exploring all private and public pay options available including retirement living, home care, and community services.

2) Less complex LTC placement process. Matching a client to a bed takes into account priority level for admission based on the legislation and local hospital utilization policies, bed characteristics and ability to pay, fit with other residents (e.g., gender, behaviours) and capacity of the home to meet special needs (e.g., bariatric, smoking, spousal accommodation). Most applicants do not know their position on the list or anticipated wait time for placement. Those in hospital have difficulty identifying care goals or hospital discharge rules. Greater transparency and better communication would reduce confusion and stress.

3) Better preplanning. Many older persons are reluctant to accept outside assistance or consider options that would require them to leave home. Caregivers see LTC admission as a failure or abdication of responsibility; many provide care until they can no longer cope and end up in the Emergency Department. Most are unable to identify viable options for care and feel guilty about considering them. A neutral third party such as physician can help trigger discussions about care but placement rules that remove residents from wait lists if they do not accept placement are a barrier.

4) Consideration of quality and cost. Patients are concerned about the quality of care in long term care and feel that hospital care is superior; a perception reinforced by regular but unnecessary vital sign checks, greater access to physicians and nurses and other aspects of the hospital environment. Family members, on the other hand, understand the challenges of remaining in hospital and the potential for negative outcomes such as de-conditioning, depression, weight loss, medication errors and infection. However, they want their family member to be close to home, safe, comfortable and treated with kindness and respect. Many worry about continuity of care, including consistency in staff, and are reluctant to accept temporary placements. The cost of mobility aids and assistance, medications, and the LTC co-payment, is also a concern for some patients and families.

Sources: The Change Foundation, 2010 and Erie St Clair LHIN, 2011

“Allowing hospitalization to be the event that causes discussions and decisions to occur within families is a failure to implement adequate, systematic methods of encouraging preplanning.”

The Change Foundation, 2009
Achieving rapid system change is difficult without considering alternate service and business models. In the Ontario long term care sector there is only one model: 24 hour nursing and personal care for long stay residents. This model is not flexible enough to meet the needs of government, system partners or consumers. It is also becoming unsustainable for small operators.

The Expert Panel believes the sector is well-positioned to relieve system pressures by pursuing greater specialization and integration. It proposes six models for enabling sector transformation:

- **Post-Acute Skilled Nursing Model**
- **Specialized Stream Model**
- **Hub Model**
- **Integrated Care Model**
- **Designated Assisted Living Model**
- **Culture Change Model**

The **Post-Acute Model** focuses on skilled nursing care and assess and restore programs. Homes that adopt this model would specialize in short-term intensive nursing and rehab care for medically complex and injured or disabled older adults following a hospital stay. Care is provided by a professional team of nurses, occupational therapists, physiotherapists, speech language pathologists, audiologists, etc. with a focus on stabilizing or improving the person’s condition and enabling their return to the community. This model would be most relevant to homes in urban settings or locations close to a hospital. It would require a higher level of care and significant clinical leadership, most likely from a nurse practitioner.

The **Specialized Stream Model** provides a higher level of care for special needs populations including persons with late stage dementia, severe mental illness and addictions, and those at end of life. The model blends social and medical models of care with an emphasis on specialized care, pain and symptom management, quality of life and family support. This model could also support Ontarians who cannot or do not want to remain at home at end of life, to die with comfort and dignity in a home-like setting rather than in hospital. Many homes already have resident home areas consistent with this model but few have refined their staffing mix, physical environment or philosophy of care to explicitly specialize in serving these populations. This model is adaptable to small homes, wings within larger homes or collaborative initiatives between LTC and system partners.

“People have multiple, overlapping needs. We need to shift from service organization and delivery based on procedures and single diagnoses to one that is person-centred and addresses multiple needs.”

Dr Ken LeClair, Panelist

“A thoughtful review of the future role of long term care facilities and residents with acute mental health conditions is required to ensure appropriate treatment is available to these individuals and to safeguard the well-being of other residents.”

Canadian Mental Health Association, March 2010,

“For the mental health and long-term care systems to work well for residents with mental illness and/or addictions, there needs to be a strong continuum of care available in long-term care homes; strong support available to residents from mental health services such as geriatric mental health outreach teams and regular ongoing training of long-term care home staff. A review of regulations and funding mechanisms to eliminate barriers to providing adequate mental health care in long-term care homes would also be necessary to ensure better access to long-term care beds for those with mental illness and/or addictions.”

CAMH Submission to the LTC Innovation Expert Panel
The **Hub Model** sees the long term care home as a centre for the delivery of a wide range of seniors’ services; some co-located others managed by the long term care home. Services could include: primary care, chronic disease management, rehabilitation, oral care, foot care, adult day/night programs, meals on wheels, caregiver support such as home monitoring and satellite specialized geriatric services collaboratively delivered with hospital and community partners. This model takes advantage of investments in physical plant and existing LTC programs and services by centralizing care and expertise. It is particularly well suited to homes in smaller communities or rural and northern areas.

The **Integrated Care Model** would enable providers of ‘continuums’ with an enrolled population, or within a defined geographic area, to develop a variety of integrated home and community support services and receive incentives for managing chronic conditions, reducing ED visits and hospital admissions, and possibly coordinating LTC admissions within the continuum. Many municipal, private sector and non-profit LTC providers offer service-enriched housing for older adults with varying levels of functioning. In many cases, this housing is co-located with the long term care home, enabling access to specialized staff and programs. This model would be well-suited to ethno-specific or faith-based homes. It could also be refined to enable homes to support residents discharged from short-stay beds that require follow up or intensive intermittent care.

The **Designated Assisted Living Model** bridges the gap created by long term care’s shift to higher acuity residents by enabling physically and mentally frail older adults who require a protected environment but can continue to live independently with assistance with activities of daily living and limited nursing care to receive publicly-funded services in a wider range of community-based congregate settings. Among other things, this model could allow providers with excess capacity in retirement homes, to designate units or floors within those buildings as supportive living hubs eligible for publicly funded services. In some communities, these services could be delivered directly by the operator through a competitive process. This model would also enable LTC providers in northern, rural and smaller communities that are planning to redevelop to consider building a continuum of care that meets the needs of frail and cognitively impaired seniors for whom few assisted living alternatives exist. In addition to expanding consumer choice with respect to accommodation, this model would also enable aging in place by providing more options for seniors in a wider variety of naturally occurring retirement living environments.

The **Culture Change Model** revitalizes the traditional long stay long term care home. This model puts resident needs, interests and lifestyle choices at the centre of care. It maximizes the ability of all residents, including those with dementia, to participate in decisions about their care and surroundings, and to exercise autonomy over their day-to-day lives. Numerous iterations of this model exist but common to all is a philosophy that emphasizes resident

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**FACT:** Canada ranks second among OECD countries in providing an adequate standard of living for its elderly. Only 6% of Canadians over the age of 65 are considered low income. Poverty rates are highest among women, particularly widows over the age of 75, who live longer and have lower work-related pensions than men. (Source: The Conference Board of Canada, September 2011.)

“[Supportive Housing] is a rapidly emerging alternative care setting for seniors. If managed carefully, SH has the potential to help address many health system level concerns as the population ages.”

Norma M Jutan, 2010
direction, flexible routines, a home-like environment, consistent staff, respectful and caring relationships, collaborative teams and empowered staff. This model is relevant to all residential care settings but particularly those that specialize in younger residents, palliative/end of life care and those with social and medical needs that cannot be met in the community for whom long term care truly is ‘home.’

These models are not new – indeed many providers are already ahead of the curve. The purpose of articulating them in this way is to challenge all of us to think differently about long term care and its potential for transformation. Regardless of the model selected, the Expert Panel is confident that within five years there will be much greater diversity of residential accommodation options and philosophy of care models.

Most long term care homes will also be providing a more comprehensive basket of services including:

- Specialty units to meet the holistic needs of patients with behaviours and mental illness or those requiring chronic ventilation, dialysis, intravenous therapy or bariatric care
- More comprehensive end of life services
- ‘Assess and Restore’ programs
- Transitional sub-acute care

**WHAT IS CULTURE CHANGE IN LTC?**

Culture change is a movement that emphasizes home and work environments where:

- Care and resident-related activities are directed by residents
- The physical environment is designed as a home
- Close relationships exist among residents, family members, staff and the community
- Job design supports and empowers all staff to respond to residents’ needs and preferences
- Management enables collaborative and decentralized decision-making
- Systematic processes are comprehensive, measurement-based and used for continuous quality improvement.

Newer models feature self-contained environments where trained and empowered universal workers provide person-centered care to a small group of 10 or fewer residents who live together, eat together and receive services tailored to their specific needs and preferences. Most models emphasize technologically smart physical spaces with built-in safety features and medical technology, and private ensuited rooms clustered around a central area with a shared kitchen, dining and living areas. Culture change has not been rigorously evaluated but early results are promising. Some researchers note that as nursing home residents become more disabled and require higher levels of care, some medical characteristics of traditional nursing homes may be more appropriate and could be compromised by primarily social models of care.

The Artifacts of Culture Change tool developed by the US Centers for Medicare & Medicaid Services contains a comprehensive set of practices adopted by pioneering nursing home and assisted living facilities. A user-friendly online version of the tool is available at www.artifactsofculturechange.org.

• Day/night dementia care
• Health and personal support services for older adults including comprehensive health assessments, podiatry, oral care, blood pressure monitoring, diabetes management, bathing, nutritional counseling and specialized diets, exercise programs, mental health, addictions and grief counseling, immunization clinics, speech, occupational and physiotherapy, etc.
• Community outreach including home visits, special diet meal delivery, telehomecare and transportation in defined catchment areas
• Caregiver training on care of older adults with complex chronic conditions
• Advanced placements for social work and health sciences students.

The Expert Panel believes that these services can be delivered cost-effectively in long term care but substantial policy development and analysis will be required, ideally with significant input from the sector. Service and capacity planning models will need to take into account:
• Geographical variation in demand due to aging, health status, socio-economic factors, rurality, cultural diversity and availability of family caregivers to provide heavy care.
• Supply of ‘spaces’ in day/night programs and ‘places’ in a variety of settings including retirement homes and supportive housing.
• Models of service organization and delivery that ensure safety, quality and efficiency. For example volume thresholds to maintain staff competency and reduce cost per unit of service; technology to ensure access to specialist consultants; a referral-based admissions process and connections to centres of excellence to improve flow and quality of care; and more flexible operational models (i.e., hours of operation, length of stay) to better address the needs of different types of residents.
• Costs and benefits for government, consumers and providers, including the impact of various options on equity of access to publicly-funded services.

In the near term, LTC homes could improve care for existing higher acuity residents if they had better access to specialized behavioural supports, portable laboratory and diagnostic testing, and advanced Emergency Medical Services similar to the Extended Care Paramedic Project in Nova Scotia. Long term care is becoming a care setting for increasing numbers of people with severe mental illness and complex psycho-social needs. Further dialogue is required on what can reasonably be expected of the sector or alternatively, what resources and policy changes will be required to enable long term care to adequately address the needs of these residents.

WALKER REPORT RECOMMENDATIONS
• The LHINs and CCACs should ensure that seniors are provided with timely Assess and Restore/Transitional Care in LTC homes, while waiting for their first LTC home choice, in order for patients to have an opportunity to regain previous levels of function and to prevent deterioration.
• The ministry should build incentives for LTC homes to have the flexibility to address surge capacity.
To move forward, the Expert Panel recommends that the Ministry of Health and Long-Term Care work with the LHINs to:

- Develop a comprehensive service capacity plan that meets local needs and works across LHIN boundaries
- Generate cost-savings by targeting system improvements in areas such as palliative/end of life care, prescription drug utilization, stroke and diabetes management and dementia care
- Invest in community capacity to care for residents requiring episodic or less intensive care and services
- Support cost-effective care delivery in a wider range of assisted living settings
- Explore service delivery models that improve LTC utilization and optimize lengths of stay based on need and evidence
- Establish a residential care sector table and process to review delivery models and determine the pricing of new programs and services
- Develop a standardized contract format for new services to promote efficiency in administration and certainty for the provider
- Move to an outcomes based performance and accountability framework that allows providers more discretion to determine how care is provided while holding them accountable for reporting on, and meeting agreed upon results
Building a business case for both specialization and diversification will require greater regulatory flexibility, and effort and goodwill on the part of LHINs, government and providers, but the potential benefits are significant.

If implemented, these recommendations will:

- Improve coordination and access to community-based services for older adults
- Improve LTC utilization
- Strengthen the viability of rural homes and the communities that depend on them for employment and services
- Reduce unnecessary hospital visits and readmissions
- Reduce the unit cost of post-acute care
- Simplify consumer choice and improve access, quality and accountability

**EARLY LEADER EXAMPLES**

- **O’Neill Centre Peritoneal Dialysis Program** started in 1998 as a collaboration with the University Health Network. The program which has capacity for 10 residents and 5 specially trained registered staff, served as a model for other long term care homes and led to the development of the provincial LTC PD program.

- **Specialty Care Woods Park Convalescent Care Program** has been operating a 10 bed convalescent care unit since the introduction of the provincial program in 2005. The award-winning program targets medically stable individuals recovering from orthopedic surgery, amputations, fractures, and acute medical conditions requiring a period of convalescence to gain strength and return to the community. It was established in consultation with the ministry, the CCAC and local hospitals in Simcoe County, with ongoing involvement of a case manager, psychogeriatric resource consultant, pharmacist and physiotherapist.

- **Shalom Village Goldies2Home** is an integrated day program developed in collaboration with five Hamilton hospital sites and two Hamilton convalescent care sites. It is designed to get people out of hospital with an accelerated discharge into an outpatient rehabilitation environment in a LTC setting. In addition to on-site health maintenance and rehabilitation services and transportation, the program includes a case manager who focuses on ensuring safe transitions and timely discharge to independent living thus decreasing the risk of hospital readmission.

- **Leisureworld Brampton Woods** served as a quarantine facility for 58 ALC patients from Scarborough Grace and York Central hospitals during the SARS outbreak. The home also worked with the ministry and partner hospitals to establish a 20-bed critical care unit. The experience showed that long term care was able to respond to system surge capacity needs and could build advanced clinical capacity quickly.

- **St Joseph’s at Fleming** is the first long term care facility located on a college campus. In addition to intergenerational activities and resident-centred care based on the Eden Alternative and Gentle Care philosophies, it offers a rich learning environment for staff and students that promotes ongoing training and development and uptake of best practices in geriatric and long term care.

- **York Region Long Term Care & Senior Services** provides integrated programming for seniors with special emphasis on serving individuals with heavy, complex physical, cognitive and/or psychiatric care requirements. In addition to two long term care homes, it offers adult day programs, housing support services, homemaking and meals on wheels, client intervention and support services, a personal emergency response system and a psychogeriatric consulting service with an integrated outreach program.

- **Kensington Gardens** is a campus located in downtown Toronto. In addition to a 350 bed long term care facility, it offers a 10-bed residential hospice, a colonoscopy/gastroscopy screening clinic, an ambulatory academic centre of excellence for cataract surgery licensed by the province as an Independent Health Facility, and an institute dedicated to research and education in areas such as quality of life.
ASSISTED LIVING: THE TALE OF 3 PROVINCES

Ontario
Ontario's Assisted Living Services for High Risk Seniors Policy came into effect January 1, 2011. It updated the Assisted Living Services in Supportive Housing 1994 policy with the intent of enhancing alternatives to institutional care for frail and cognitively impaired seniors, reducing ER visits and ALC length of stay and promoting a continuum of care for Ontario’s frail seniors. The policy provides up to 180 hours of personal support, homemaking, and professional services per month to seniors with high to very high IADL and ADL needs, limited caregiver or social support, 2 or more chronic conditions, occasional or frequent falls, complicated medication management, high health care resource use, poor self-reported health and mild to moderate incontinence, behaviours or cognitive impairment. Services must be provided by agencies that are approved to provide these services under the Home Care and Community Services Act, 1994. Services may be provided in a variety of private sector or non-profit housing including single family homes, townhouses, condominiums, housing co-operatives or social housing located within designated geographic hubs. High risk seniors who reside in retirement homes covered under the Residential Tenancies Act, 2006 are explicitly excluded. The rate of assisted living in supportive housing is quite low and varies widely by LHIN. In 2009/10, $180 million was allocated to the program. (Source: Ontario Ministry of Health and Long Term Care, 2011.)

British Columbia
Independent Living BC was introduced in 2002 to provide an option for those who do not require 24 hour professional care but do require accommodation, hospitality services (meals, housekeeping, etc.) and assistance with medication, mobility or personal care. The province has 4,300 affordable living apartments for older adults and persons with disabilities. BC Housing and regional health authorities provide subsidies for housing and hospitality services; regional health authorities fund personal care services. For more information visit www.bchousing.org/Initiatives/Creating/ILBC.

Alberta
Alberta has over 700 licensed supportive living settings including seniors lodges, group homes, mental health and supportive living accommodations that provide a range of care and services in a home-like environment for residents with special needs. Publicly-funded designated supportive living is available through Alberta Health Services for disabled adults with assessed intermediate or high care needs. Below is a summary of the program’s target groups.

Designated Assisted Living – Level 3

<table>
<thead>
<tr>
<th>TARGETED TO</th>
<th>NOT APPROPRIATE FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled adults who are:</td>
<td>Those who require:</td>
</tr>
<tr>
<td>• Medically stable</td>
<td>• Complete meal assistance</td>
</tr>
<tr>
<td>• Living with mild dementia with no known risk of wandering</td>
<td>• Mechanical lift transfers</td>
</tr>
<tr>
<td>• Not a risk to self or others</td>
<td>• Two-person transfers</td>
</tr>
<tr>
<td>• Able to physically move independently or with a one-person transfer</td>
<td>• Help to manage incontinence</td>
</tr>
<tr>
<td>• Experiencing increased care needs that cannot be scheduled</td>
<td></td>
</tr>
<tr>
<td>• Able to use a call system to get help</td>
<td></td>
</tr>
</tbody>
</table>

Enhanced Designated Assistive Living – Level 4

<table>
<thead>
<tr>
<th>TARGETED TO</th>
<th>NOT APPROPRIATE FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled adults who:</td>
<td>• Persons with unpredictable behaviour that places them or others at risk</td>
</tr>
<tr>
<td>• Have complex physical needs that cannot be met at home or an alternate supportive living space</td>
<td>• those who need unscheduled assessment by a 24-hour onsite Registered Nurse</td>
</tr>
<tr>
<td>• Have predictable complex medical needs but can safely manage with onsite professional nursing (LPN) and direction of a home care RN</td>
<td></td>
</tr>
<tr>
<td>• May require chronic disease management</td>
<td></td>
</tr>
<tr>
<td>• May be living with varying levels of dementia</td>
<td></td>
</tr>
<tr>
<td>• May require assistance with daily activities including complete meal assistance or tube feeding, mechanical lift or two-person transfers, medication assistance or administration, total assistance with mobility, total assistance to manage a lack of bladder/bowel control</td>
<td></td>
</tr>
</tbody>
</table>

ACTION 3 Rebrand to Reflect New Service Orientation

Long term care homes are evolving into elder care centres that look and function very differently from the traditional nursing home. Some will look more like a complex continuing care unit; others like a hospice, community clinic or even a health spa. Indeed, it is time to question whether ‘home’ is applicable at all given evolving ideas about the role of long term care, the diversity of living environments and consumer preference for more streamlined design and functionality than would normally be found in a typical long term care home, apartment or bungalow. Providers will need to rethink long term care and their place within it; and some will want to rebrand to better distinguish themselves in the marketplace.

The Expert Panel believes that the sector would also benefit from rebranding to better reflect a more comprehensive strategic orientation. But rebranding is only successful if it builds on a solid foundation. The Excellent Care for All Act includes many provisions already in place in long term care. The sector has embraced Residents First, a provincial program run by the provincial health quality council to strengthen capacity for quality improvement. In the 2 years since the program’s launch, 1,400 LTC staff have received training on quality improvement tools and methodologies such as Lean, and most are participating in ongoing collaboratives to reduce pressure ulcers, falls, restraints, incontinence and responsive behaviours. The results are available on the Health Quality Ontario website along with other indicators of performance.

The Expert Panel strongly supports these efforts and further recommends that government:

- Promote cross-sectoral quality improvement collaboratives and benchmarking initiatives
- Invest in tools and education that will enable the sector to access and use performance data
- Adopt a ‘no home left behind’ policy that will ensure performance is consistently high across providers
- Retain a flow-through system of funding for nursing and personal care so the public is assured there is no profit from direct care in long term care.

If implemented, these recommendations will:

- Strengthen accountability and transparency
- Improve quality and provide a basis for broader system improvement
- Build confidence in Ontario’s system of care for older adults
Innovating long term care requires building capacity for transformation through re-allocation of resources and strategic investments in direct care, technology and facilities. This section outlines action steps in each of these areas, all designed to improve quality, productivity and sustainability.

**Action 1 Strengthen the Care Team**

The average long term care home has a director of nursing care, an on-call physician who is medical director, and a core team of nurses, part-time allied health professionals and unregulated workers who provide much of the hands on care. Staff with specialized expertise in knowledge exchange and the science and tools of quality improvement are also becoming more important to the sector.

Turning long term care homes into hubs of innovation in aging care will require new roles, a different skill mix and well integrated care teams. There is evidence that Nurse Practitioners improve family satisfaction and staff confidence. They also reduce transfers to the emergency department, hospital admissions and length of stay, and workload for long term care physicians. Physician competence and engagement are associated with lower hospitalization rates, higher functional status and resident satisfaction and reduced rates of regulatory noncompliance.

Strengthening clinical leadership and improving the knowledge base of all staff are key to innovating LTC service organization and delivery. The goal of every home should be a committed and competent medical staff that works together as a team to assure easy accessibility at all times. In order to deliver high quality, evidence-based, person-centred care in long term care physicians require a unique set of competencies - indeed the American Medical Directors Association (AMDA) is currently undertaking work in this area. An adequate commitment of physician time is also important to optimize medical care, and promote successful integration into the interdisciplinary team and acculturation to the organization. Long term care nurses require superb assessment skills and, along with the LTC physicians and nurse practitioners, must be prepared to handle complex clinical, legal, interdisciplinary and ethical issues. Nurses must also have the knowledge and leadership skills

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“All residents are required to have an assigned physician, but only physicians who agree to visit residents at regular intervals (as specified by LTC homes) are eligible to be authorized as attending physicians. Hence, for physicians with little or no LTC practice, there is little incentive to participate in LTC. It is uncertain how this concentration of care to a small number of physicians is affecting LTC residents, but if the number of physicians who practice in LTC continues to decrease in the future, it could have a negative impact to the quality of care.”

Jonathan Lam, 2009

“The definition of the health care workforce must be expanded to include everyone involved in a patient’s care: health care professionals, direct-care workers, informal caregivers and patients themselves.”

Retooling for an Aging America, 2008
necessary to work with both short stay and long stay populations. Finally, all staff will require an expanded base of knowledge to address the specialized needs and expectations of new or substantively different groups of residents and their families.

Innovation will push the boundaries of care team membership and scope of practice. Self-regulated professionals, particularly nurses, must be allowed to work to full scope. Nurses must have the capacity to respond to minor emergencies without having to transfer residents to the emergency department. PSWs are critical to resident quality of life and many have the desire and the potential to assume new or expanded roles. A restorative approach means engaging residents in self-care and educating families to become more active and confident members of the care team. Finally, the optimal size and core competencies of the LTC care team of the future need to be defined and evidence-based processes to enable interdisciplinary care planning and management clarified. (See first sidebar on page 52.)

The Expert Panel therefore recommends:

- A nurse practitioner in every long term care home
- A significant increase in the proportion of LTC nurses with advanced or specialized training, particularly in areas such as behaviours and pain and symptom management
- Creation of a long term care medical specialty similar to the AMDA Certified Medical Director in Long Term Care program
- Coverage of LTC facilities as a fixed responsibility of capitated primary care
- Development of alternate LTC physician and nurse practitioner reimbursement models which provide incentives for mentoring LTC staff and students and achieving key care outcomes targets such as reducing hospital transfers.
- All self-regulated professions work to full scope of practice, which includes delegation of acts to other health professionals and unregulated staff
- Development of clinical pathways to enable RPNs to support RNs with feeding tubes, PICC lines, tracheostomy and ileostomy care and IV therapy
- Increasing the number of LTCH staff certified in blood transfusions, peripherally inserted central catheters (PICCs) and transportation of blood products and staff with advanced training in dealing with surgical site infections, acute change of condition, end of life care, behaviour management and mental health and addictions
- Creation of new PSW roles (e.g., PSW Care Coordinator, Medication Aide, Caregiver Coach) that enable nursing staff to focus on clinical care and leadership rather than routine tasks that can be safely delegated

**FACT:** Under LTCHA, only physicians, dentists and registered nurses or registered practical nurses are able to administer a drug to a resident. In most other settings, including retirement homes and home care, personal support workers are able to assist with medication administration.

**FACT:** Long term care nurses require superb leadership and assessment skills and, along with LTC physicians, must be prepared to handle complex clinical, legal, interdisciplinary and ethical issues within a setting that incorporates both medical and social care models.

**FACT:** LTCHs receive government funding to provide an average of 2.9 hours of nursing and personal care per resident per day. Most of the care is provided by personal support workers and registered practical nurses. (Source: Ontario Ministry of Health and Long-Term Care, 2011.)
• Creation of new categories of workers (e.g., transitional care aides, universal worker) to keep care teams to a reasonable size and improve continuity and consistency of care

• Strengthening of LTC educator roles

• Creation of a multidisciplinary LTC team core competencies task force to examine the composition, skill set and level of interdisciplinary integration required to support the delivery of safe high quality care in skilled nursing centres and other models of care delivery

• A comprehensive review of, and updates to college and university curricula to better prepare front-line workers for the emerging long term care environment

• Service-based funding that considers optimal staffing mix for different groups of residents, along with outcomes of care.

If implemented, these recommendations will:

• Improve nurse and physician recruitment and retention

• Increase engagement of front-line caregivers, particularly personal support workers

• Reduce turnover and improve physician and staff satisfaction

• Improve care outcomes, family engagement and resident experience

• Improve system performance including reduced transfers to hospital

“Creating cultural change stems from listening to staff, engaging them in the decision-making process and nurturing their imagination and energy.”

Shirlee Sharkey, Panelist

“Health professionals working together and performing the right tasks at the right time will drive efficient and effective care in both hospital and community settings...HPRAC is convinced that enabling professionals to perform more tasks independently, consistent with their competence, will encourage new roles as part of collaborative health care teams.”

Health Professions Regulatory Advisory Council, January 2009

“The integration of NPs in LTC is an innovation that offers considerable promise to enable LTC organizations and health care systems to meet the current and coming challenges within the LTC sector.”

Faith Donald and Ruth Martin-Misener, 2011

“The alignment of Geriatric Mental Health Outreach Teams (GMHOTs) to long-term care facilities has been helpful in the Toronto region. By teaching long-term care staff how to tap into seniors mental health expertise outside the facility they have opened up support networks that were previously unknown or under utilized.”

Canadian Mental Health Association, 2010.
WHO IS PART OF THE LONG TERM CARE TEAM?

- Nurses (Nurse Practitioners, RNs, RPNs, LPNs)
- Physicians (Medical Directors & attending physicians)
- Consultant Pharmacists
- Personal Support Workers
- Occupational Therapists
- Physiotherapists
- Recreational Therapists
- Speech Language Pathologists
- Social Workers

- Dietitians and dietary aides
- Chefs/Cooks
- Volunteer Coordinators
- Housekeeping Staff
- Maintenance Staff
- Administrative and clinical leaders
- Families and Residents

STAFFING REQUIREMENTS UNDER THE ONTARIO LONG TERM CARE HOMES ACT, 2007

- 1 Medical Director to advise on matters related to medical care + attending physicians or NPs
- 1 RN per shift, 24 hours per day
- 1 Director of Nursing and Personal Care (hours contingent on number of beds)
- 1 Registered Dietitian onsite for minimum of 30 minutes per resident per month
- 1 Nutrition Manager with minimum number of hours per week onsite stipulated in Act
- 1 pharmacy service provider (external) responsible for medication management and distribution and clinical consultation
- Other staff with the skills and qualifications to meet resident needs and regulatory requirements (1 PSW FTE for every 3 LTC beds funded by provincial ministry of health)

Homes must have organized programs for medical, nursing and personal support services as well as a nursing and personal support services staffing plan that promotes continuity of care. Homes are also required to have designated leads for social work, recreational and social activities programs, volunteer program, spiritual care, housekeeping, laundry and maintenance with qualifications set out in the regulations.

Maintenance services must be available 7 days a week and access to therapy services provided by qualified health professionals. Homes must also facilitate access to other services required by the resident (e.g., oral care, podiatry, massage therapy, naturopathy, etc.)

LTC STAFFING MIX, ONTARIO, 2010

<table>
<thead>
<tr>
<th>Recommended by RNAO</th>
<th>MOHLTC Staffing Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 hours</td>
<td>2.9 direct care hours</td>
</tr>
<tr>
<td>• 20% RNs</td>
<td>• 10% RNs</td>
</tr>
<tr>
<td>• 25% RPNs</td>
<td>• 17% RPNs</td>
</tr>
<tr>
<td>• 55% PSWs</td>
<td>• 72% PSWs</td>
</tr>
<tr>
<td>• 1 NP per home and not less than 1 NP per 200 residents</td>
<td>• 13 NP FTEs</td>
</tr>
</tbody>
</table>

Sources: RNAO, 2011 and Ontario Ministry of Health and Long Term Care, 2011
Much debate in long term care focuses on minimum staffing hours. Very little addresses productivity or value-added per hour worked, a consideration that is crucial to health system sustainability. Redefining long term care’s role will require redefining the care team. It will also require rethinking how care is provided, including the role of technology. Both will result in safer, higher quality jobs.

The World Health Organization defines health technology as “the application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives.” Here we focus on three types of technology with significant potential to improve productivity and outcomes of care: intangible technologies, clinical information systems and assistive devices.

Intangible Technologies
In research carried out for the Institute for Competitiveness and Prosperity, University of Toronto academics Michelle Alexopoulos and Trevor Tombe argue that management techniques and production processes, which they call ‘intangible technologies,’ are important to productivity. Indeed adopting Lean techniques, managing performance, and attracting and retaining good people are hallmarks of high-performing organizations. The Residents First campaign has energized the sector and is training leaders in all these areas. And early results are encouraging. Quality improvement initiatives and improved clinical oversight are credited with reducing provincial High Intensity Needs wound care costs by over $3 million since 2008/09 according to the ministry of health. A Brampton home used Lean techniques to improve its admission process and was able to redirect 436 nursing hours annually to resident care. If other homes achieved similar results, the hours released to care would be the equivalent of adding 142 FTEs to the sector. The challenge to speeding up these initiatives is lack of a sufficient number of staff across all levels and disciplines trained in the science and tools of quality and process improvement.

Clinical Information Systems
Most Ontario long term care homes use multiple clinical information systems to manage resident health data. Some of these systems are external to the home; many are paper-based. Residents frequently require lab tests which are generally performed by community labs and the results faxed back to the home. Ontario is in the process of implementing a repository for all lab data in the province. The Ontario Laboratory Information System provides a web service to enable physicians to query results and this same interface could be used by long term care. Some lab tests could also be performed through

“There is a clear link between innovation and productivity. Productivity, in turn, generates higher standards of living and greater wealth, and there is no reason why we can’t turn the innovations we generate in health care into higher productivity and a competitive advantage for Canada.”
Ivey Centre for Health Innovation and Leadership, 2011

“Good management drives demand for innovation, leads to high quality supply of innovation and ensures effective financing of innovation.”
The Institute for Competitiveness and Prosperity, 2009

“We ... need to rethink much of today’s rhetoric about ‘evidence-based’ care in nursing homes. Many current guidelines are ‘eminence’-based...There may be too much emphasis on identifying and treating individual conditions to attain regulatory compliance and meet quality initiative objectives. It would help to also focus on evidence of what should not be done, or what is unlikely to be helpful. Just stopping many of the common non-evidence-based practices in nursing homes could free up time and resources to offer more individualized care that can improve patient outcomes”
Steven A Levenson, MD and John E Morley, MD, 2007
point of care technology, enabling more timely access to the results. There is evidence of cost-effectiveness for some of these technologies (e.g., point of care testing for anti-coagulation therapy) but calibration, accuracy and ongoing maintenance of equipment are challenges.

LTC residents have complex health conditions and many are on 12 or more medications. Ontario currently has a Drug Profile Viewer which provides access to Ontario Drug Benefit data for Ontario seniors and people on social assistance. The viewer has been deployed to hospital emergency departments and community health centres but is not yet available to long term care. Approximately 100 homes have implemented electronic medication administration record systems (e-MARS) to replace the cumbersome and resource intensive manual system used by most of the sector. The e-Mar system sends drug orders to the pharmacy system and facilitates medication management and administration on site. However, it is not well integrated with drug information systems used by pharmacies or computerized order entry systems available to a minority of LTC physicians.

The introduction of RAI MDS in long term care has led to the development of a sector-wide assessment record but there is limited ability to share this information with other providers on transfer. Long term care also does not have electronic access to complete and up-to-date assessment data collected by hospitals, community mental health providers and community care access centres. This creates challenges for appropriate matching of the needs of the prospective residents with the resources in the home and timely admissions. It also creates duplication and potential error in data entry of medications and other important information, with concomitant consequences for resident safety.

In summary there is very limited access to electronic health data in long term care and where access exists, the systems are not always seamless, user-friendly or enabled for secure access anywhere. Interdisciplinary assessments are challenging to coordinate and few team members, including physicians, are well-trained in how to access the new systems or use the data to support clinical team-based problem solving, care plan or predict and prevent adverse events.

Assistive Devices

Other types of technologies hold significant promise as well. Nearly two-thirds LTC residents are at risk of developing pressure ulcers. Using a high-density foam mattress could reduce the incidence of new pressure ulcers by 69%. Implementing this strategy sector-wide would avert 3,000 new cases resulting in estimated savings of $17.3 million per year in Ontario. Each year approximately half of LTC residents fall at least once, and 5% to 10% of these falls result in fractures. Widespread use of hip protectors could reduce the relative risk of hip fractures among LTC residents by 77% for a cost saving of $34,000 per resident in the first year following a hip fracture.

3 WAYS TO CAPITALIZE ON KNOWLEDGE WORK

- Explicitly address productivity in corporate initiatives
- Go beyond just technology to usage and behaviour
- Provide an integrated approach to support

Source: Doug Cooper Presentation to Expert Panel, 2011
Despite the potential benefits, the long term care sector is adopting most technologies at a less than optimal rate. This is because technology often has hidden costs, adoption or adherence can be problematic and regulation and funding can pose insurmountable barriers. Indeed, annual government funding for equipment and technology related to direct care is capped at $400 per bed. And current LTC design standards, which specify the use of call bell systems for example, may deter uptake of sensor technology and intelligent systems. Thus, while technology and process improvements, could lead to better care and higher productivity, the sector lacks the flexibility to implement proven technologies or test emerging ones. It also lacks access to the electronic health information infrastructure that will enable it to become a full partner in an integrated health system.

The Expert Panel recommends that:

- A plan to upgrade the sector’s clinical information infrastructure be fast-tracked and implemented in collaboration with Canada Health Infoway and e-Health Ontario within 2 years
- An innovation fund be created to accelerate the development and use of clinical decision support tools, platforms and protocols to inform day to day practice and enable uptake of new knowledge
- Up to 2% of funding for nursing and personal care in long term care homes be available for technology investments and staff training that improve LTC quality and productivity
- A “Release 5 Million Hours to Care” Campaign be launched to encourage nurses, PSWs, pharmacists, therapists, physicians, housekeeping staff, maintenance workers, and dietary staff to eliminate unnecessary or routine administrative tasks and redirect the time to improving care and strengthening relationships with residents and families.

If implemented, these recommendations will:

- Strengthen LTC capacity for quality improvement and Lean design
- Lead a safer, more efficient work environment
- Increase staff and consumer empowerment and satisfaction
- Improve sector productivity and system sustainability

**WHY PRODUCTIVITY MATTERS: 5 MILLION HOURS RELEASED TO CARE CAMPAIGN BY THE NUMBERS**

- 7,886 hours per LTC home
- 19 minutes per direct care FTE per day
- 11 minutes per resident per day
- 25% increase in nursing and personal support staff time allocated to resident-specific activities
- The equivalent of adding 2,564 PSW FTEs to the sector at a cost of $103 million annually
**DRIVING INNOVATION: A LEADERSHIP PERSPECTIVE**

<table>
<thead>
<tr>
<th>How LTC Leaders Can Help Make Cultural Shift to Innovation</th>
<th>What Success Looks Like</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify those internal workers best suited to drive innovation and put them on it – protect their time</td>
<td>• Opportunities and incentives for staff to engage in innovation thinking</td>
</tr>
<tr>
<td>• Bring in new faces with fresh ideas</td>
<td>• Culture of risk taking and willingness to ‘fail’ without it being seen as ‘failure’</td>
</tr>
<tr>
<td>• Be inclusive; make efforts to acknowledge old guard’s contributions</td>
<td>• Rewards for risk-taking, greater rewards for success</td>
</tr>
<tr>
<td>• Remove organizational silos to encourage collaboration</td>
<td>• Formal structure to support innovation, evaluation and commercialization</td>
</tr>
<tr>
<td>• Find strong external partners</td>
<td>• New external partners</td>
</tr>
<tr>
<td>• Engage the end user (the “pull” is just as important as the “push”)</td>
<td>• New products and services</td>
</tr>
<tr>
<td></td>
<td>• New revenue streams</td>
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<tr>
<td></td>
<td>• New global reach</td>
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<tr>
<td></td>
<td>• Better care, more satisfied patients, residents, families and staff</td>
</tr>
</tbody>
</table>

Sources: Baycrest Team Presentation to Expert Panel

**SELECTED PRACTICES IN OPERATIONS, PEOPLE AND PERFORMANCE MANAGEMENT**

<table>
<thead>
<tr>
<th>Best Practices</th>
<th>Worst Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All major aspects of Lean have been implemented</td>
<td>• Few aspects of Lean introduced</td>
</tr>
<tr>
<td>• Exposing problems is integral to individuals’ responsibilities rather than ad hoc solutions</td>
<td>• No process improvements are made when problems occur</td>
</tr>
<tr>
<td>• Performance is continuously tracked and communicated to all staff using a range of visual tools</td>
<td>• Tracking is ad hoc and measures are being tracked do not indicate directly if overall business objectives are being met</td>
</tr>
<tr>
<td>• Performance is continuously reviewed, based on indicators tracked, follow up ensures continuous improvement</td>
<td>• Performance is reviewed infrequently and only success or failure is noted</td>
</tr>
<tr>
<td>• Regular performance conversations focus on addressing root causes. Purpose, agenda and follow-up steps are clear to all</td>
<td>• Relevant data are often not present at meetings or discussion is based on data that is not meaningful. Agenda and purpose are not clear</td>
</tr>
<tr>
<td>• Failure to achieve agreed targets drives retraining and moving individuals around</td>
<td>• Failure to achieve targets does not carry any consequence</td>
</tr>
<tr>
<td>• Senior managers are evaluated and held accountable on the strength of the talent pool they actively build</td>
<td>• Senior management do not communicate that attracting, retaining and developing talent is a top priority</td>
</tr>
<tr>
<td>• Organization provides ambitious stretch goals with clear performance related accountability and rewards</td>
<td>• People within the organization are rewarded equally irrespective of performance goals</td>
</tr>
</tbody>
</table>

Sources: The Institute for Competitiveness and Prosperity, 2009
Building for the future requires clarity about the purpose and function of long term care, and a better understanding of consumer preferences and market realities. Demand is high for basic accommodation, with co-payment subsidies in place for some 31,000 residents last year. Current financing models are based on 60:40 ratio of private to basic accommodation. The private accommodation premium is an income stream critical to the viability of the sector. A private room will become a standard feature in the not too distant future; indeed the occupancy rate for private accommodation is 99%.

In other jurisdictions ensuite bathrooms with shower and ceiling hoists and small pods of 8-10 residents are becoming more common and could provide alternate options for premium accommodation and amenities. The culture change movement also has implications for capital redevelopment. The question is: what business models can be put in place now that will ensure a successful capital renewal program?

Ontario has 35,000 long term care beds in need of redevelopment. Most of these beds are built, owned and operated by the private sector. And many of these providers rely on the Canada Mortgage and Housing Corporation (CMHC) to insure mortgages and access financing at competitive rates. New bed license term limits ushered in by the Long Term Care Homes, Act 2007, along with new accountability and funding arrangements, have created uncertainty in the lender community. CMHC has suspended new loan insurance in Ontario’s long term care sector and consequently financing has become much more difficult and expensive to obtain. The Expert Panel understands the need for policies that promote facility maintenance and upkeep but there are other ways to achieve these objectives.

The Expert Panel recommends that:

- A template consent and acknowledgement agreement between the lender, funder, regulator and operator be put in place, and refinements made to the LTC Service Accountability Agreement to provide CMHC and the financial community with the assurance necessary for capital redevelopment
- New capital financing models be developed to enable greater choice in accommodation and amenities while preserving provider viability
- The design standards be revised in collaboration with the sector to provide greater flexibility and better accommodate the functions and market requirements of the long term care home of the future
- Building infrastructure be monitored and reported via a standardized measure such as the Facility Condition Index

“Changes in regulations and funding policies impact the financing of long-term care homes. Insurers, lenders and provincial health authorities need to work together to address issues that could limit the availability of financing for this vital housing option.”

CMHC Presentation to Expert Panel, 2011

“There are many developers and designers, too, who cling to outdated assumptions of demographic preferences. What about seniors who have a more sophisticated, modernist sensibility?”

Patricia Sheehan, Editor-in-Chief, DESIGN Magazine

FACT: Lack of physical facilities necessary for care was the reason most often given by homes for declining to admit an LTC wait list client. (Source: OACCAC, 2011.)

WALKER REPORT RECOMMENDATIONS

The ministry should:

- Review the current distribution of basic and preferred beds and ensure availability of affordable options
- Ensure that the geographic location of LTC homes corresponds with identified need.
- Ensure that the appropriate physical design requirements are in place to support this shift in care delivery.

“Changes in regulations and funding policies impact the financing of long-term care homes. Insurers, lenders and provincial health authorities need to work together to address issues that could limit the availability of financing for this vital housing option.”

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“There are many developers and designers, too, who cling to outdated assumptions of demographic preferences. What about seniors who have a more sophisticated, modernist sensibility?”

Patricia Sheehan, Editor-in-Chief, DESIGN Magazine

FACT: Lack of physical facilities necessary for care was the reason most often given by homes for declining to admit an LTC wait list client. (Source: OACCAC, 2011.)
• Post-occupancy evaluations of new LTCHs be carried out at 6-12 months and 4-5 years to identify best practices in building design and construction
• A research centre on design for an aging population be established to share knowledge and promote good practice.

If implemented, these recommendations will:
• Increase lender confidence and private sector investment
• Ensure a successful capital redevelopment program
• Support ongoing improvements to capital infrastructure at no additional cost to government
• Increase access to new facilities and consumer satisfaction

EVOLUTION OF ONTARIO’S LTC DESIGN STANDARDS

1998 New Capital Program
• 20,000 new LTC beds
• Redevelopment of approximately 16,000 ‘D’ beds
• New capital funding program
• New design standards: Long-Term Care Facility Design Manual, May 1999
• Established the “Resident Home Area” (RHA) concept

2002 ‘D’ Bed Program
• New retrofit design standards: Long-Term Care Retrofit Design Manual, January 2002
• Recognized that there may be circumstances where an operator could not fully comply with the standards within the existing structure

• Intended to give greater flexibility
• Goal: an environment that is “comfortable, aesthetically pleasing and as “home-like” as possible”

Source: Michelle Wolfenden, Presentation to the Expert Panel, 2011

HOW OTHER PROVINCES APPROACH LTC CAPITAL FINANCING

British Columbia
BC Health Authorities and the Ministry of Health have approved a form of consent and acknowledgement agreement which can be used for all loans. This agreement addresses assignment of agreements and license; notice of default and cooperation regarding transfer of agreements and license.

Alberta
A tripartite agreement between the operator, lender and health authority is available. The agreement contains all of the assurances CMHC is looking for regarding notice of defaults, continuation of funding and transfer of service agreements. Alberta Health Services can also take over the project and assume the mortgage payments.

Quebec
The province is facilitating the construction of new LTC projects through public-private-partnerships where the operator receives a funding envelope for care, capital, and operations. Operators that comply with provincial norms and standards will own the building free and clear after 25 years. In case of borrower default, the province has option to take over the project or find another operator.

Source: CMHC Presentation to Expert Panel, 2011
10 SENIOR LIVING DESIGN INNOVATIONS

1. Intentional Elder-Friendly Communities
2. The Green House Project
3. Codifying Person Centred Care and the Household Model
4. Eliminating the Nursing Station
5. Eliminating the Medication Cart
6. Smaller is Better
7. Better Bathrooms
8. Lighted Grab Bars
9. Better Ceiling Lifts
10. Universally Designed Implements

Source: Margaret P. Calkins, 2011

2009 ONTARIO LTC DESIGN STANDARDS - RECOMMENDATIONS TO SUPPORT ‘HOUSEHOLD’ AND ‘CULTURE CHANGE’ MODELS OF CARE

<table>
<thead>
<tr>
<th>Section</th>
<th>Current Requirement</th>
<th>Possible Alternative</th>
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<tr>
<td>2.3 Resident Bath Rooms and Shower Rooms p. 12</td>
<td>One separate bathroom and one separate shower room per resident home area (RHA)</td>
<td>Each resident room has en-suite (or European) showers where the whole room acts as the wet room</td>
</tr>
<tr>
<td>3.1 Nursing and Program/Therapy Work Space p. 14</td>
<td>The work space for staff must also be designed so that it can readily be identified by residents, staff, visitors and others as an information centre or an area for contacting staff</td>
<td>Eliminate the nursing station. It creates a barrier between staff and residents and current resident data can be found on any computer. Decentralize work spaces throughout the household or incorporate into kitchen areas</td>
</tr>
<tr>
<td>5.2 Dietary Service Space p. 19</td>
<td>Kitchens must comply with Ontario Regulation 562 (Food Premises) under the Health Protection and Promotion Act. Municipal governments administer the regulation</td>
<td>Meet with regulatory authorities early in the design process. Know the intended program.</td>
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<tr>
<td>6.1.6 Outdoor Space p. 23</td>
<td>Outdoor space in resident-accessible areas must incorporate hard, flat surfaces and not include inclines and steps</td>
<td>Include steps! They require someone to help</td>
</tr>
<tr>
<td>6.2.1 Beauty Salon/Barber Shop p. 24</td>
<td>The LTC home must have a beauty salon/barber shop that is available to all residents</td>
<td>Eliminate the beauty salon as a requirement. In a few years no one will use them. Consider wellness centres with juice bars, healthy eateries, spas, pools</td>
</tr>
<tr>
<td>10.2 Non-Resident Space p. 35</td>
<td>There must be separate male and female staff change areas with lockers for storage of personal items</td>
<td>In a small ‘household’ style home, this is not necessary</td>
</tr>
<tr>
<td>10.5 Way-Finding p. 37</td>
<td>The following areas must have signage and/or symbols: each bedroom entrance must includes the bedroom number and name of the resident residing in the room; resident common areas; the lobby; work station(s)</td>
<td>This is very institutional. In a small ‘household’ style home, this is not necessary</td>
</tr>
<tr>
<td>10.7 Public Washrooms p. 38</td>
<td>A securely fastened grab bar must be located within easy reach of the resident</td>
<td>A variance that permits the use of fold-down grab bars adjacent to the toilet. This puts grab bars within easy reach on both sides of the toilet, a better option for someone with a 1-side neglect or weakness. It also allows placing the toilet further from the wall to create more room for staff to provide assistance without injury.</td>
</tr>
</tbody>
</table>

Sources: Baycrest Team Presentation to Expert Panel Source: Michelle Wolfenden, Snyder & Associates Architects Presentation to the Expert Panel, July 2011
STRATEGY 3

ENABLE USER-DRIVEN INNOVATION

Strategy 2 laid the groundwork for the creation of a robust innovation system within long term care. Strategy 3 focuses on building an enabling infrastructure for innovation across aging care that will produce value for the health care system and the Ontario economy. A new generation of healthier, wealthier and better educated seniors is driving social change and economic opportunities across much of the Western world and soon, in developing countries as well. Ontario can leverage its investments in aging care provision, education and research not only to improve the productivity of its workforce and quality of life of its citizens but also to develop niche markets for export of specialized products, services and expertise. The sections below discuss three levers for getting there: education, applied research, and funding and regulatory policy.

ACTION 1 Retool Education and Training

Aging care workers are knowledge workers and their skills and expertise will become more valuable as the proportion of those in the labour force shrinks and the worldwide phenomenon of population aging reaches a peak. Innovation in aging care requires a fresh approach to education and training. The relatively low status of gerontology makes it difficult to attract and retain nurses and physicians, particularly new graduates. Yet we know that long term care provides rewarding careers for these and other health professionals and the opportunities will only grow in the future. The sector can also serve a resource for the preparation of workers destined for other settings within aging care and beyond.

The creation of three new LTC centres of learning, research and innovation provide an opportunity to more fully engage providers in the creation and diffusion of evidence on care for the aging. More importantly they provide models for turning all 630 long term care homes across the province into learning labs and learning hubs. This can be achieved through the creation of new college and university faculty appointments or research and teaching assistant liaison positions in homes. It can also be achieved through a dramatic expansion of placements for students from traditional disciplines in the health and social sciences as well those in areas such as statistics, finance, computer science, engineering and hospitality. These placements will bring thousands of new students into the sector every year creating unprecedented
opportunities for creative exchange of knowledge and ideas. They will enable ongoing professional development of staff in the home and ensure that curricula remain relevant and up-to-date. They will also provide an opportunity to integrate emerging modalities of person-centred, team-based learning, including collaboratives and social media, into the training of health care professionals.

Expanding co-operative education will only attract more workers to the sector if the learning experience is positive. Currently nursing placements take place too early to allow students to practice advanced skills. They end up taking on tasks commonly done by personal support workers, reinforcing the perception that long term care is the “backwater of nursing.”

Cooperative education also needs to be retooled to address the needs of those already in the workforce. Most aging care providers have relatively flat organizational structures and very tight budgets. The only way to provide opportunities for growth and development, and substantively increase compensation, is by creating “grow your own” career pathways that enable dedicated front-line workers already in the sector to progressively upskill and move into clinical or administrative leadership positions. The challenge is that most of these workers are women with family responsibilities who do not have the time or money to go back to school. Those who are able to make the commitment often find a large gap between the classroom and the real world. All learners, particularly adult learners benefit from experiential learning. The sector is attracting increasing numbers of immigrants and foreign trained professionals who often have difficulty accessing careers in the health field. These groups would also benefit from an expanded cooperative program in aging care.

The Expert Panel believes that in order for such a program to be successful, a strategic discussion on the aging care labour force needs to take place. We know very little about who works in the sector and their skill levels. We know very little about the needs of employers and the extent to which new graduates are addressing them. Repositioning long term care for the future will require new roles, new skills and therefore new education programs. There is also an urgent need for advanced management and leadership training targeted to the aging care and services market.

Finally, there is a need to extend the e-learning capacity of homes and educational institutions. The Ontario Telemedicine Network (OTN), one of the world’s largest, provides access to clinical care, distance education and collaborative meetings via 2-way videoconferencing technology. Some 3,000 professionals in 1200 sites across Ontario use the service annually but few are in long term care homes or colleges and school boards that train most of the workers in aging care. Extending the service or developing a new one to meet the needs of the sector would deepen expertise and extend capacity in the
education system, potentially opening up markets for collaborative delivery of caregiver training beyond Ontario.

The Expert Panel therefore recommends that:

- A labour force survey be conducted to identify skill needs and gaps in education and training in the sector
- Advanced degree programs in the business of aging, and leadership of aging care organizations be expanded
- A comprehensive provincial cooperative education initiative in aging care be created, along with expanded bridging programs and prior learning assessment to maximize participation
- A standardized survey to evaluate satisfaction with LTC placements be implemented by colleges and universities and the results shared with the sector
- OTN be expanded to meet sector needs or alternate e-learning platforms supported to facilitate cost-effective delivery of training and education
- The network of LTC Centres for Learning, Research and Innovation be expanded and hubs focusing on palliative/end of life care and rural and northern elder care created
- Knowledge exchange collaboratives be refined to better address the needs of front-line caregivers, and learners and faculty in co-op programs.
- A comprehensive evaluation of these and other efforts to increase knowledge and skills in the aging care sector be undertaken to inform future policy direction.

If implemented these recommendations will:

- Build on existing government initiatives such as “Grow Your Own Nurse Practitioner,” New Graduate Guarantee and the Late Career Nursing Initiative
- Increase available supply of high quality workers
- Increase direct care hours in long term care
- Improve recruitment and retention in the sector
- Facilitate move to technology-enabled, just-in-time education
- Create a more relevant and competitive education sector
Applied research is the scientific study of practical solutions to everyday problems. In long term care it can:

- Identify unmet needs
- Challenge expectations about what type of care is appropriate for frail older persons and acceptable risks associated with greater freedom and choice
- Evaluate the impact of programs or policies
- Uncover more efficient or effective ways to deliver care
- Create new tools and technologies
- Inform practice through effective knowledge transfer.

User-driven applied research is critical to enabling seniors to live independently longer and improving elder care for those who need it.

Most clinical research has been conducted on younger populations. Therapies and technologies effective for these groups may not be cost-effective or safe for older adults, particularly those at the end of life. Where consensus on better practices exists, adoption varies with sometimes very negative consequences for patients, families and public confidence. One area ripe for improvement is drug safety. There is wide variation in prescription practice and little agreement on how to address the specific needs of older adults. Long term care has taken leadership on potentially inappropriate prescribing with assistance from the Institute for Safe Medication Practices and the new MedsCheck Program. But further opportunities exist to review prescription drug utilization in the elderly and develop evidence-based guidelines that prevent over- and under-treatment, or inappropriate treatment.

Another area that would benefit from greater clarity is rehabilitation of older adults in post-acute settings. Long term care has long emphasized a restorative approach. However, there is little guidance on appropriate targeting of higher intensity therapies such as special rehab and nursing rehab, and consequently great variation and inequity in service delivery exist. There is also lack of consensus across settings of care on interventions that are cost-effective and most likely to increase quality of life of older adults or produce improvements in functional status of the frail elderly. Guidance on these questions would be helpful.

Finally there is an opportunity to improve uptake of evidence in front-line care delivery. Although much is known about the personal, organizational and environment factors that facilitate knowledge exchange, much more
practical application and evaluation are required. For example, in a review of evidence on addressing aggressive behavior in long term care, the Canadian Agency for Drugs and Technologies in Health found that while the evidence and array of alternatives was considerable, there was little discussion of the economic implications of competing interventions. They concluded that the gap between the research on non-pharmacologic, no restraint interventions and day-to-day practice may be due in part to reimbursement practices. More research on cost-benefit and the role of incentives or barriers to good practice is required.

Beyond clinical practice, there are technologies for aging care. Rapid and aggressive development of products and services for consumer and business markets is underway but limited information exists on their usefulness or cost-effectiveness. In addition to lack of information, aging care providers often lack financial resources to develop and purchase these technologies, and expertise in implementing and managing technological change. Lack of standards for technologies in residential care and lack of regulatory clarity or flexibility create additional barriers. There are also issues related to interoperability, relevance and value-added of these products. Yet technology innovation holds the key to achieving continuous improvements in care and productivity. It also holds promise for economic growth.

The Economist estimates that the global aging market will grow to $55 billion and innovators worldwide are paying attention. MIT researchers, Joseph Coughlin and Jasmin Lau, have developed a typology to assist business leaders to identify market opportunities and policymakers to strategically position themselves in the global marketplace. Their key message: awareness of current care delivery and development capacity relative to other countries can help develop trade and sustainability policies related to technology and aging.

Ontario has recognized the opportunity and put in place HTX to commercialize enhanced medical and assistive technologies and ONE, an Ontario-wide network to support commercialization of technology-based products. However, many innovators, particularly small and medium-sized enterprises and even research centres such as Baycrest and Toronto Rehab lack ready access to real-life settings where large numbers of products can be tested and improved, ideas from the front-line can germinate and business models can be developed. Ontario aging care providers have the breadth and volume of services to serve as ready laboratories for product testing and research and development. The challenge is creating the infrastructure for applied research to be carried out ethically, efficiently and in a manner that is beneficial to users, providers and innovators.
The Expert Panel believes there is room for growth in the evidence-base for elder care and opportunities for technology innovation. Therefore it recommends that:

- Health Quality Ontario work with the Council of Academic Hospitals of Ontario, Regional Geriatric Programs and LTC leaders including researchers, nurses, physicians, pharmacists and rehabilitation specialists, to evaluate and further expand and diffuse leading practices and clinical pathways related to the care of older adults and the frail elderly.
- MaRS establish a central clearinghouse for technology in aging care to assist providers and consumers to share information and post-market research and address challenges related to inter-operability, adoption and adoption.
- LTC leaders and funding and research bodies collaborate on a funding program to address gaps in areas such as LTC regulation and funding policy and incentives, program evaluation, leadership, culture change, technology in aging care, data analysis and clinical pathways for care of frail elders.
- All foster the creation of an aging care and services innovation cluster to develop an aging care R&D infrastructure, including identifying emerging needs and accelerating development, validation and adoption of needed technologies.

If implemented these recommendations will:

- Strengthen the evidence base for care of frail elders and older adults
- Increase market-oriented collaborative initiatives
- Facilitate adaption and adoption of proven or promising technologies
- Increase research and technology funding available to aging care providers
- Improve productivity and quality of aging care providers
- Improve competitiveness of aging care innovators in Ontario
- Strengthen Ontario’s knowledge-based economy and international competitiveness in a growing market.

“Successful innovations can move quickly from small national niche markets into a growing global market. Countries hoping to transform aging challenges into growth opportunities are looking at a market worth more than $55 billion in 2004, with expectations of exponential growth when developing countries reach their peak demographic shift in two decades.”

Joseph Coughlin and Jasmin Lau, 2006

“[U]ser-driven “innovation calls for the integration of new players and institutions into clusters such as “living labs” or design centres that can provide feedback from users and test innovative ideas with them. This challenge has to be addressed through cluster policies and initiatives that must acknowledge that innovation is not only driven by research and technologies but also by other forms of knowledge. [T]he user-driven approach also represents an operational challenge in terms of finding better ways to involve users in innovation processes. Cluster organisations—as the entities in charge of managing cluster interactions and providing or channelling specialised and customised business support services—seem to be particularly well placed to play this role.”

European Commission Enterprise & Industry Directorate General, 2009
Long term care is among the most heavily regulated and scrutinized industries in Ontario. Many of the recommendations proposed here cannot be implemented without policy or regulatory change and some of these changes will be controversial. The Expert Panel believes opportunities for innovation exist and the time has come to act decisively. A system that focuses on process rather than outcomes risks doing what counts rather than what matters.

Building a better health care system requires putting the interests of the consumer at the heart of decision-making. Currently all homes provide a similar basket of services and the vast majority of these services target ‘long stayers’, most of them frail elders at the end of life. These residents chose a home that appealed to them based on proximity to family, reputation, perceived quality of care and other factors. As policymakers decide where to reallocate resources and long term care begins to specialize and diversify its services, access will increase, system sustainability will increase, but individual choice may not. In essence maximizing choice of where to receive treatment makes sense if long term care is indeed ‘long term’ or ‘home’ and there is wide variation in quality. It makes less sense if long term care becomes an intermittent care setting and it operates as a ‘high performing system’ that promotes consistent, high quality care across all providers.

Moving from a system that maximizes choice to one that respects choice and informed consent but demands access, quality and transparency is fundamental to system transformation. Getting there requires a fulsome review of the long term care legislation and related inspection program. Since both came into effect relatively recently, changes will be difficult. However opportunities for improvement exist with respect to care and service requirements, admission of residents, and licensing and operation of homes. A lighter regulatory touch focused on fewer but key requirements, would reduce non-value-added activities and improve accountability and care. Continued efforts to promote transparency and engage consumers will stimulate innovation.

Funding policy will also require attention. Currently, Ontario long term care homes are funded through three envelopes:

- Nursing and personal support which covers salaries and benefits of direct care staff, medical director fees and nursing and medical equipment and supplies. This envelope is case mix adjusted to account for resident acuity and is reconciled at year end. Any unspent revenues are returned to government.

- Program and support services covers salaries and benefits of program staff, pastoral care and therapy and recreation equipment and supplies.
This envelope is also reconciled at year end and unspent revenues returned to government.

- Other Accommodation covers salaries and wages and equipment and supplies for dietary, laundry and housekeeping, furnishings, building maintenance and operating costs and administration. The costs of raw food including approved nutritional supplements, flow through this envelope and are reconciled at the year of the year, along with legislated dietary staff hours.

Funding is set by the Ministry of Health but flowed through service accountability agreements with 14 Local Health Integration Networks. Homes also collect co-payments room and board, including premium accommodation and extra services, directly from residents. Additional funding for capital redevelopment and reimbursement for unusually high care needs and other extraordinary costs is provided directly by the province.

The Expert Panel believes Ontario’s public/private funding and delivery mix in long term care is sustainable and should be retained. The existing service-based funding model is based on a common assessment instrument and already includes elements such as acuity adjustments that recognize that some residents require more care resources than others. This model will need to be refined to better account for the resource requirements associated with caring for different types of patients/residents (e.g., the medically complex, special care populations and those with difficult to manage behaviours). Importantly, it will need to be refined based on clearer eligibility and care guidelines related to rehabilitation therapies. Work will be required to ensure the price set for new services is informed by the actual cost of delivering them and provides a fair return on investment for providers and government. Consideration will also need to be given to the cost of teaching activity and funding and support for small or stand alone homes. Many face large swings in acuity-adjusted funding despite high fixed costs and do not have centralized support or the economies of scale to make necessary investments in technology and other infrastructure.

Finally, the question of pay for performance will need to be addressed. Many jurisdictions are linking funding to improvements in quality or efficiency, either as bonus payments for achieving certain performance targets, or reduced funding for adverse events such as avoidable hospitalizations or emergency department transfers. Rigorous evaluations of these programs in long term care are few and the results mixed. There is no consensus in the literature on this issue. Many individual, organizational and environmental factors influence performance. Adverse outcomes are often related to poor system design. Organizations that do well in one domain of performance (e.g., regulatory compliance, clinical quality), do not always do well in another (e.g., resident satisfaction, cost). Indicator selection and target setting can be challenging. Taking away funding from poor performing homes could exacerbate existing inequities and have a negative impact on residents.

“Pay for performance systems should foster provider initiated quality improvement strategies, help providers to equip themselves with the tools for improving their performance, and promote sustainable efforts to produce better care.”

Cooke et al., 2009

“Prescriptive staffing and regulatory micro-management discourage initiative and critical thinking.”

Carolyn Clubine, Panelist

ENABLING REGULATORY INNOVATION

The University of Minnesota has developed a website (www.hpm.umn.edu/NHRegsPlus) to track state regulations and waivers or variances affecting the ability of nursing homes to promote culture change and resident autonomy. Some of the approaches adopted by these jurisdictions may be useful to consider in Ontario.
It would make it more difficult for these homes to make needed investments in technology, staff education and other organizational change initiatives that will improve. Rewarding providers for doing the right thing can be costly and not produce any additional value to the system. Unique to the sector is the fact that long term care’s performance tends to be judged uniformly—deficiencies in one home are automatically attributed to all homes.

Thus it may be useful to consider acuity-adjusted service-based funding conditional on achieving performance standards and indicators embedded in accountability agreements as a rudimentary form of pay for performance. Opportunities exist to pool funding regionally or across providers to stimulate improvements at the system level or alternatively within the sector. For example, a portion of the cost savings associated with reductions in falls, pressure sores or inappropriate prescriptions could be made available to all homes within a LHIN that collectively achieve an agreed upon target. Alternatively, cost-savings could be pooled into an innovation fund available to offset needed investments in training or technology. Additionally new service delivery models will provide opportunities to develop new bundled service or blended funding models that enable some providers to experiment with providing care across the continuum or directly purchasing physician, pharmacy, rehabilitation therapy, dental, vision and other services currently billed directly to individuals or programs such as OHIP and the Ontario Drug Benefit. Finally, providers also value excellence, engagement, reputation and earned autonomy. Therefore, it will be important to consider non-financial incentives.

In summary, policy and regulation are enablers to sector and system transformation. Careful consideration of the impacts of proposed funding and regulatory changes will be required. The long term care sector appears ready to engage in further analysis, consultation and discussion.

The Expert Panel recommends that:

• A common Resource Utilization Group (RUG-III) and funding model be adopted for all continuing care providers including CCC, LTC and Home Care
• Refinements be made to grouper categories and related funding, given the proposed new roles for long term care and the policy interest in driving care delivery to the most appropriate and cost-effective setting
• Indicators of data quality be developed and made available to providers for improvement purposes
• A costing study be undertaken, and performance targets and incentives for new short stay programs developed in collaboration with the sector
• Pooled pay-for-performance incentives be introduced to stimulate system level improvements and complement service-based funding

ELEMENTS OF HIGH-PERFORMING HEALTH SYSTEM
• Culture
• Leadership
• Strategy & Policy
• Structure
• Resources
• Information
• Communication Channels
• Skills Training
• Clinician Involvement

Source: MacIntosh-Murray et al., 2006
• Bundled service or blended funding models be piloted to enable further differentiation in service delivery

• A broader range of non-financial incentives available to LTC providers be considered, including earned autonomy for those that consistently exceed performance benchmarks

• A comprehensive review of existing legislation and inspection process be carried out to identify potential barriers to implementing the recommendations proposed in this strategy

• Enabling provisions for sector transformation be set out in regulation via an omnibus bill or alternatively, by bringing long term care under the auspices of Excellent Care for All, thereby replacing all but the licensing provisions of the Long Term Care Homes Act.

If implemented, these recommendations will:

• Transform the long term care sector
• Transform aging care in Ontario
• Increase the sustainability of the health care system

WHAT ARE RESOURCE UTILIZATION GROUPS (RUGS)?

Complex continuing care and long term use a common assessment instrument, the Resident Assessment Instrument (RAI) 2.0, to assess care needs. LTC residents are assigned to one of seven resource utilization categories, each with additional subgroups that take into account the level of assistance or nursing and specialized services required. These categories, ranging from low to high resource intensity, are:

1. Reduced Physical Function - residents requiring assistance with activities of daily living (ADL) such as bathing, eating, toileting, etc

2. Behaviour Problems - residents with behaviour disturbances coupled with mild to moderate ADL impairment

3. Impaired Cognition - residents with cognitive impairment and mild to moderate ADL impairment

4. Clinically Complex - residents with mild ADL impairment coupled with special needs or conditions (e.g., burns, internal bleeding) and treatments (e.g., oxygen therapy, dialysis)

5. Special Care - residents with moderate to high ADL impairment and various medical diagnoses (e.g., selected neurological conditions), care requirements (e.g., tube feeding), or problems with skin condition, and medical symptoms (e.g., dehydration, weight loss)

6. Extensive Services – residents requiring medical treatments like parenteral feeding, IV medication, suctioning, tracheostomy care, and ventilator/ respirator care

7. Special Rehabilitation - residents requiring physical therapy, occupational therapy, and speech therapy, including the number of days, minutes and types of therapies received

Funders use Resource Utilization Groups (RUGs) to adjust funding for nursing and personal care based on resident acuity. Providers can also use these groups to guide staffing decisions. Ontario currently has two versions of RUGs III, a 44 grouper in Complex Continuing Care and a 34 grouper in long term care. The 34 grouper has fewer rehabilitation subgroups and places more emphasis on nursing care. Both would benefit from additional research on resource requirements associated with managing different types of behaviours and specialized care for older adults with various types of mental health problems. Funding per case differs by setting even when residents have the same care requirements.

Source: CIHI and MOHLTC

“Casemix provides a fair way to divide the pie. Payment system defines the size of the pie.”

Dr John Hirdes, 2011
TOWARDS A CULTURE SHIFT:
THE LTC INNOVATION STRATEGY AT A GLANCE

VISION
The Expert Panel on Innovation in Long Term Care believes that Ontarians should be supported to live in the community for as long as possible. This requires creating age-friendly communities, providing a range of supportive housing and retirement living options, increasing investments in home and community care and developing new models of care. It also requires ensuring that high quality facility-based long term care is accessible to those who need it when they need it.

The long term care sector will become an integral partner in a sustainable health care system as a provider of high quality, integrated person-centred care, services and accommodation for older adults and a source of innovation on care and services for an aging population. The Expert Panel proposes a 3-pronged innovation strategy for transforming long term care that will improve quality, reduce cost and produce value for providers, consumers and the health care system.

STRATEGY 1: REENGINEER LONG TERM CARE TO MEET CONSUMER EXPECTATIONS AND SYSTEM NEEDS

ACTION 1.1 Improve Placement and Flow

1. Provide patients and families with access to a consumer-friendly assessment tool to help them determine the likelihood of long term care placement, assess options and plan ahead
2. Strengthen assessment and patient navigation capacity and expand it to key community settings including family health teams
3. Streamline and standardize placement processes and information across the province and eliminate paper-based referrals
4. Provide comprehensive up-to-date assessment data to the homes on referral, and enable timely access and electronic transfer of these data on admission, transfer and discharge
5. Implement a referral-based admissions process for access from hospital to specialized programs and convalescent and other short stay beds
6. Review current approaches to managing LTC wait lists and consider a wait time guarantee for a ‘place’ in LTC that could include a long- or short-stay bed or a space in a day, night or outreach program
7. Introduce a real-time standardized navigation and placement satisfaction survey to stimulate all stakeholders to build a better system
**ACTION 1.2 Develop New Service, Funding and Business Models**

8. Develop a comprehensive health service capacity plan that meets local needs and works across LHIN boundaries

9. Generate cost-savings by targeting system improvement efforts in areas such as palliative/end of life care, prescription drug utilization, chronic disease management and dementia care

10. Invest in LTC and community capacity to care for residents requiring episodic or less intensive care and services

11. Support cost-effective care delivery in a wider range of assisted living settings

12. Explore service delivery models that improve LTC utilization and optimize lengths of stay based on need and evidence

13. Establish a sector table and process to review delivery models and determine the pricing of new programs and services

14. Develop a standardized contract format for new services to promote efficiency in administration and certainty for the provider

15. Move to an outcomes based performance and accountability framework that allows providers more discretion to determine how care is provided while holding them accountable for reporting on and meeting agreed upon results

**ACTION 1.3 Rebrand to Reflect New Sector Orientation**

16. Reconsider use of 'long term' care to describe sector

17. Promote cross-sectoral quality improvement collaboratives and benchmarking initiatives

18. Invest in tools and education that will enable the sector to access and use performance data

19. Adopt a 'no home left behind' policy that will ensure performance is consistently high across providers

20. Retain a flow-through system of funding for nursing and personal care so the public is assured there is no profit from direct care in long term care

*Why Not Now? A Bold, Five-Year Strategy For Innovating Ontario’s System of Care for Older Adults  71*
STRATEGY 2: BUILD CAPACITY FOR TRANSFORMATION

ACTION 2.1 Strengthen the Care Team

21. Put a nurse practitioner in every long term care home
22. Significantly increase the proportion of LTC nurses with advanced or specialized training
23. Create a long term care medical specialty similar to AMDA Certified Medical Director in Long Term Care program
24. Strengthen LTC educator roles
25. Ensure all self-regulated professions work to full scope of practice, which includes delegation of acts to other health professionals and unregulated staff
26. Create new PSW roles (e.g., PSW Care Coordinator, Medication Aide, Caregiver Coach) that enable nursing staff to focus on clinical care and leadership rather than routine tasks that can be safely delegated
27. Create new categories of workers (e.g., transitional care aide, universal worker) to keep care teams to a reasonable size and improve continuity and consistency of care
28. Develop clinical pathways to enable RPNs to support RNs with such tasks as tube, PICC line, tracheostomy and ileostomy care and resident and family caregiver education.
29. Certify more LTCH staff in blood transfusions, PICCs, transportation of blood products and provide more staff have advanced training in end of life care, management of surgical infections and acute change of condition
30. Ensure all capitated primary care agreements include coverage of LTC facilities as a fixed responsibility
31. Develop alternate LTC physician and nurse practitioner reimbursement models which provide incentives for mentoring LTC staff and students and achieving key care outcomes targets such as reducing hospital transfers
32. Create multidisciplinary LTC team core competencies task force to examine the composition, skill set, knowledge base and level of interdisciplinary integration required to support the delivery of safe high quality care in skilled nursing centres and other models of care delivery
33. Update college and university curricula to better prepare front-line workers for the emerging long term care environment
34. Ensure service-based funding considers optimal staffing mix for different groups of residents, along with outcomes of care
**ACTION 2.2 Harness Technology**

35. Fast-track plan to upgrade the sector’s clinical information infrastructure in collaboration with Canada Health Infoway and e-Health Ontario

36. Create an innovation fund to accelerate development and use of clinical decision support tools, platforms and protocols to facilitate uptake of new knowledge and inform day-to-day practice

37. Enable up to 2% nursing and personal care funding to be spent on technology investments and training that improve LTC quality and productivity

38. Launch a “Release 5 Million Hours to Care” Campaign to encourage Lean thinking and redirect time saved to building relationships with residents and families

**ACTION 2.3 Rebuild for the Future**

39. Refine the Long Term Care Service Accountability Agreements and implement a multi-stakeholder template consent and acknowledgement agreement to provide CMHC and the financial community with the assurance necessary for capital redevelopment

40. Develop new capital financing models to enable greater choice in accommodation and amenities while preserving provider viability

41. Revise design standards in collaboration with the sector to provide greater flexibility and better accommodate the functions and market requirements of the long term care home of the future.

42. Conduct post-occupancy evaluations of new LTCHs at 6-12 months and 4-5 years to identify good practices in building design and construction

43. Monitor the quality of building infrastructure via a standardized measure such as the Facility Condition Index

44. Establish a research centre on design for an aging population to share knowledge and promote good practice
STRATEGY 3: ENABLE USER-DRIVEN INNOVATION

ACTION 3.1 Retool Education and Training

45. Conduct workforce survey to identify skill needs and gaps in education and training in the sector
46. Expand advanced degree programs in the business of aging, and leadership of aging care organizations
47. Create a comprehensive province-wide cooperative education initiative in aging care along with expanded bridging programs and prior learning assessment to attract and retain staff and enable those already in the sector to upgrade their skills
48. Implement a standardized survey to evaluate satisfaction with LTC student placements and share results with the sector
49. Expand the Ontario Technology Network (OTN) to meet sector needs or support alternate e-learning platforms to facilitate cost-effective delivery of training and education
50. Expand the network of LTC Centres for Learning, Research and Innovation and create hubs focusing on palliative/end of life care and rural and northern elder care
51. Refine knowledge exchange collaboratives to better address the needs of front-line caregivers and learners and faculty in co-op programs
52. Undertake a comprehensive evaluation of these and other efforts to increase knowledge and skills in the aging care sector to inform future policy direction

ACTION 3.2 Invest in Applied Research

53. Evaluate and further expand and diffuse leading practices and clinical pathways related to the care of older adults and the frail elderly through collaborative initiative led by Health Quality Ontario
54. Create an aging care and services innovation cluster to identify emerging needs and accelerate development, validation and adoption of needed technologies
55. Establish a central clearinghouse for technology in aging care at MaRS for providers and consumers to share information and post-market research
56. Collaborate with LTC leaders and research bodies such as CIHR and NRC on a funding program to address gaps in areas such as LTC regulation and funding policy, program evaluation, leadership, culture change, technology in aging care, data analysis and clinical pathways for care of frail elders

ACTION 3.3 Remove Policy and Regulatory Barriers

57. Adopt a common Resource Utilization Group (RUG-III) and funding model for LTC and CCC
58. Refine grouper categories and related funding to take into account proposed new sector roles and policy interest in driving care delivery to the most appropriate and cost-effective setting
59. Develop indicators of data quality and make them available to providers for improvement purposes
60. Undertake a costing study and develop performance targets and incentives for new short stay programs in collaboration with the sector
61. Introduce pooled pay-for-performance incentives to stimulate system level improvements and complement service-based funding
62. Pilot blended or bundled funding models to enable further differentiation in service delivery
63. Expand the range of non-financial incentives available to LTC providers, including earned autonomy for those that consistently exceed performance benchmarks
64. Conduct a comprehensive review of existing legislation and inspection process to identify potential barriers and solutions to implementing the recommendations proposed in this strategy
65. Facilitate innovation and sector transformation through appropriate regulatory change (e.g., enabling provisions in an omnibus bill, amendments to LTCHA and Excellent Care for All Act)

**MEASURING PROGRESS**

The Expert Panel believes implementation of this innovation strategy will increase access, quality and sustainability of the sector and the health system. To facilitate the culture shift, the Panel recommends that:

66. A Task Force composed of sector leaders and representatives from government (health, social services, housing), LHINs and system partners be struck to advise on the implementation of this Strategy
67. Health Quality Ontario add innovation to its framework for reporting to Ontarians on the quality of their health care system and provide an independent assessment of progress made

**MEASURING VALUE**

- **Access**: Community capacity, LTC length of stay, wait time to placement (convalescent, respite and long stay beds), ALC days
- **Quality**: resident and family satisfaction, caregiver stress, quality of work life, clinical quality, time released to care
- **Cost**: ED transfers, hospital admissions, demand for new LTC beds, productivity
- **Innovation**: Regulatory burden, technology use, absorptive capacity, economic contribution of aging care & services cluster

**MILESTONES**

![Milestone Timeline](image-url)
Transformation requires balancing the needs of all stakeholders including residents and families, providers, employees, funders, regulators, innovators and educators, and system partners. A transformed long term care system will create value for all, starting with residents and families.
Too often, long term care policy and regulation have been driven by perceived system failures. Very few times have policymakers, consumers and providers stepped back and considered: what are the root causes of the problem? Will the proposed changes fix it?

The time has come for all stakeholders to question how things are done in long term care – and more broadly in the health care system - and to come up with creative solutions for doing them better and at less cost.

The Long Term Care Innovation Expert Panel has developed a multi-phase strategy it believes will create fundamental changes in the system of care for older Ontarians. This strategy would benefit from further discussion and debate. Nevertheless it offers a vision for long term care within a more sustainable, more integrated health care system and a roadmap for transformation.

_Innovation lies in the implementation._

“The creation of value for patients should determine the rewards for all others”

Michael Porter
APPENDICES
APPENDIX A: LTC INNOVATION EXPERT PANEL BIOGRAPHIES

C.W. (Bill) Dillane (Co-Chair)

In his capacity as President of The Responsive Group, Bill Dillane oversees the operations of 12 Long Term Care Homes and 7 retirement homes in Ontario. He also provides financial, operational, strategic consulting and advisory services. Previously, Mr. Dillane held the position of Executive Vice President, Strategic Initiatives and Chief Operating Officer, for Retirement Residences REIT, now known as Revera which is the largest owner/operator of long term care and retirement home facilities in Canada.

Mr. Dillane’s career has focused entirely on Health Care Management for over 35 years. His experience includes the Administration of private hospital, long term care homes, retirement and assisted living complexes, and the operation of facilities through contract management. Mr. Dillane participates in a number of proprietary and not for profit boards and organizations including ADDUS, and is a founding member of the Canadian Alliance for Long Term Care (CALTC). He is also the past president, Board of Directors of the Ontario Long Term Care Association (OLTCA) and is currently a member of the Board.

William E. Reichman, MD (Co-Chair)

Dr. William E. Reichman is President and Chief Executive Officer of Baycrest, one of the world’s premier academic health sciences centres focused on aging and brain function. Dr. Reichman, an internationally-known expert in geriatric mental health and dementia is also Professor of Psychiatry on the Faculty of Medicine at the University of Toronto. He is a noted authority on the delivery of mental health and dementia services in nursing home settings.

Dr. Reichman received a B.S. from Trinity College in 1979 and an M.D. degree from the State University of New York at Buffalo, School of Medicine in 1984. He pursued residency training in general adult psychiatry at the University of California at Los Angeles (UCLA) Neuropsychiatric Institute and completed fellowship training in neurobehavior at the UCLA Reed Neurological Research Institute.

Dr. Reichman is a former President of the American Association for Geriatric Psychiatry and the Geriatric Mental Health Foundation and served as a consultant to the Civil Rights Division of the United States Department of Justice on dementia and mental health-care delivery within nursing homes. He previously served as the Senior Health columnist for the Star Ledger, New Jersey’s highest circulation newspaper and has been interviewed and quoted by most of the major media outlets in the United States and Canada. Among honors received, Dr. Reichman is named among the Best Doctors in America and Canada and previously has been recognized by the New Jersey Society on Aging as Gerontologist of the Year. He is a recipient of a Bronze Telly award for an educational documentary film entitled, Reflections of Memory Lost: Understanding Alzheimer’s disease.

Adalsteinn (Steini) D. Brown, D. Phil

Adalsteinn Brown became the Dalla Lana Chair of Public Health Policy at the University of Toronto and a Scientist in the Keenan Research Centre of the Li Ka Shing Knowledge Institute of St. Michael’s Hospital on the first of January, 2011. Past roles span the public, private, and government sectors and include Assistant Deputy Minister for strategy at the Ontario Ministry of Health and Long-term Care and for science and research at the Ontario Ministry of Research and Innovation, Assistant Professor in the Department of Health Policy, Management, and Evaluation at the University of Toronto, and a founding role in consulting, software, and internet companies.

Dr. Brown received his bachelor’s degree in government from Harvard University and his doctorate from the University of Oxford, where he was a Rhodes Scholar. In 2003, he was named one of Canada’s “Top 40 Under 40” in recognition for his work on performance measurement in health care.
Daniel Burns, BA (Hon), MSc

Daniel Burns retired from the position of Deputy Minister at the Ontario Ministry of Health and Long Term Care in January 2002. A longtime senior public servant, Mr. Burns also held the post Deputy Minister at the Ministry of Economic Development and Trade and the Ministry of Economic Development, Trade, and Tourism.

Currently, Mr. Burns is a director/trustee of several corporations, teaches and consults in public policy and public administration. He is Chair of the Board of the Centre for Addiction and Mental Health, Advisory Board member for Specialty Care and the central Ontario division of the Salvation Army, a member of the Board of the Maytree Foundation, a member of the Advisory Committee to the Quebec Ministry of Health on the reconstruction of the teaching hospitals in Montreal, and Chair of Queen’s Campus Planning and Development Committee, a post he has held for 15 years. He previously served on the Board of Directors of the Canadian Institute for Health Information and Canada Health Infoway. Mr. Burns has taught at Queen’s University, the University of Toronto, and at the University of Waterloo, where he was the ‘Planner in Residence.” As a consultant he has provided advice and support to all three levels of government, industry associations, and private companies.

Mr. Burns was born in Ottawa and received his B.A. (Hon.) in geography and economics from Queen’s University and his M.Sc. in urban and regional planning from the London School of Economics and Political Science. He is a member of the Canadian Institute of Planners.

Dino Chiesa

Mr. Chiesa currently serves as chair of Canada Mortgage and Housing Corporation and Leisureworld Senior Care. He is principal of Chiesa Group, a commercial real estate developer. Mr. Chiesa served as President and Chief Executive Officer of Residential Equities Real Investment Trust. Prior to that, Mr. Chiesa held several positions within the Government of Ontario, including Assistant Deputy Minister, Municipal Affairs and Housing and Chief Executive Officer of each of Ontario Housing Corporation and Ontario Mortgage Corporation.

Mr. Chiesa is a former Director of Dynacare Laboratories, Inc., was a member of the Board of Trustees of Sunrise Senior Living Real Estate Investment Trust and has served on the board of two public hospitals. He sits on the advisory board for the Schulich School of Business at York University and is President of the Expert Advisory Committee on Real Estate Development at Ryerson University. Additionally, Mr. Chiesa has been active in the charitable sector, including his role as chair at Villa Charities. Mr. Chiesa holds a Bachelor of Arts in Economics from McMaster University.

Carolyn Clubine, CHE

As Director of Regional Municipality of Peel Long Term Care Division, Ms. Clubine oversees the management and operations of the Region of Peel’s five long-term care homes and Community Support Services. A certified Health Executive with Canadian College of Health Leaders, Ms. Clubine holds an Honours Degree in Physical and Health Education from the University of Western Ontario, and Canadian Healthcare Association designation in Long Term Care Management.

Ms. Clubine is a member of the Board of the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) representing Charitable, Municipal LTC Homes and Community Support Services and Seniors Housing. She works with the Ontario Association of Residents Councils (OARC) and Concerned Friends and is a member of the Steering Committee for the development of Diversity in Action toolkit by Ontario Seniors Secretariat, is a member of the Association of Municipalities of Ontario Long Term Care Advisory Committee, and a member of the leadership team for Public Health, Paramedic Services, Health Policy and Long Term Care and an International partnership (Costa Rica) for wellness outreach to poor community including elderly services. Ms. Clubine works with seniors’ service planning initiatives in Central West Local Health Integration Networks and across Peel Region. She led the effort to secure Accreditation with Commission on Accreditation of Rehabilitation Facilities (CARF). Ms. Clubine was an advisor for the first Multi-Sector Service Accountability Agreement (MSAA) and Long Term Care Service Accountability Agreement (LSAA) between Ontario’s Local Health Integration Networks and service providers in both LTC and in community services.
Don Fenn

Don Fenn is a 40-year veteran of advertising, media and marketing, but his approach is as fresh and innovative as ever. The Chairman of the Fenn Group of Companies, President of Caregiver Omnimedia and Publisher of the Family Caregiver News Magazine, Mr. Fenn is committed to the home care industry, cultivating strong personal relationships, leveraging social media and the new media technologies and above all, being different.

Mr. Fenn co-founded Caregiver Omnimedia as a result of years of caregiving for his mother with Alzheimer’s and his father with cancer. Under his leadership, several initiatives have been launched: The Family Caregiver News Magazine with over 150,000 circulation and growing; The Family Caregiving and Home Care Expos across Canada; the first ever, Home Modification Guide released in 2009; and, the first commercial portal for family caregivers in Canada. Mr. Fenn is passionate about Family Caregiving, he spends all his free time trying to understand home care, and he believes that the most effective way to cope with change is to help create it.

Paul R. Katz, MD, CMD

Dr. Paul Katz is Professor of Medicine at the University of Toronto and Vice President Medical Services Baycrest Geriatric Health Centre. Dr. Katz was Chief of the Division of Geriatrics at the University of Rochester and Director of the Fingerlakes Geriatric Education Center just prior to his recent move to Canada. He has published extensively on issues related to geriatric education, quality and physician practice in long-term care. Dr. Katz has co-edited 11 texts and received funding from private foundations, the NIH, Veterans Administration and the Bureau of Health Professions. Dr. Katz is immediate past president of the American Medical Directors Association and has recently advocated for a nursing home specialty. Dr. Katz continues as an active nursing home physician.

J. Kenneth Le Clair, MD, FRCPC

Dr. J. Kenneth Le Clair is a Professor and Chair, Division of Geriatric Psychiatry and Community and Primary Care Psychiatry, Department of Psychiatry, Faculty of Health Sciences and the Co-Director, Centre for Studies on Aging and Health, and the Co-Director, Interfaculty Program in Collaborative Mental Health at Queen’s University. He is the Regional Development Coordinator of Geriatric Psychiatry Services, Partnerships and Community Services at Providence Care Mental Health Sciences in Kingston, Ontario.

Dr. LeClair is affiliated with the University of Western Ontario as a Clinical Professor, Department of Psychiatry and is an Adjunct Professor at Sheridan College. He is the Co-Chair of the Canadian Coalition for Seniors’ Mental Health, Chair, Southeastern Ontario Regional Dementia Network; a member of the Seniors’ Advisory Committee, Mental Health Commission of Canada; and, a member of the Research Policy Committee, Alzheimer Society of Canada. Dr. Le Clair is also a member of the Mental Health and Addictions Minister’s Advisory Group 10-Year Plan for Ontario; the Past President of the Canadian Academy of Psychiatry (CAGP) and the Senior Project Consultant for P.I.E.C.E.S Educational Strategy in Long-Term Care and Senior Health.

Anne-Marie Malek

Anne-Marie Malek is President and Chief Executive Officer of West Park Healthcare Centre in Toronto. She joined West Park in 1995 as Vice President, Programs and Chief Nursing Executive and was appointed to her current position in 2005. Ms. Malek’s experience spans the acute care, complex continuing care, rehabilitation, and long term care sectors. She has championed the quality and performance agendas at West Park and has provided executive leadership to the practice setting.

A graduate of Dalhousie University’s Bachelor of Nursing Programme, Ms. Malek also holds a Master of Health Services Administration from the University of Alberta and has completed executive leadership programs at the University of Toronto’s Rotman School of Management and York University’s Schulich School of Business. Ms. Malek is a certified health executive with the Canadian College of Health Executives.
Tom McCormack, MA (Economics)

Tom McCormack is a recognized authority on Canada’s economic and demographic prospects. He is the President of Strategic Projections Inc. (SPI), a company he founded in 1989, and a Partner of the Centre for Spatial Economics (CASE), a partnership established in 2000 between SPI and Stokes Economic Consulting Inc. to improve the quality of geographic economic research in a Canadian setting and to make the results of this research available to the public.

Mr. McCormack’s companies regularly produce and update detailed long-term projections up to year 2061 of output, employment, households, and personal income for both the United States and Canada. His clients include municipalities, provincial government departments, retailers, property developers, utilities, transportation service providers and planning consultants, across the continent. Mr. McCormack specializes in developing assessments of the economic and demographic potential of metropolitan areas and specific municipalities.

Katherine McGilton, RN, PhD

Dr. McGilton is a Senior Scientist at Toronto Rehabilitation Institute. She is an Associate Professor at the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto and an Adjunct Scientist, KLASU, Baycrest Geriatric Health Care System. Dr. McGilton’s research focus is in care of persons with cognitive impairment, particularly in identifying interventions and models of care delivery that led to effective patient outcomes. She also has experience in outcome measure development and has published on various aspects of intervention and outcomes in dementia care, rehabilitation care and long term care.

Dr. McGilton holds an Ontario Ministry of Health and Long-Term Care Nursing Mid Career Scientist Award. She has research funding as the principal investigator from the Canadian Institutes of Health Research (CIHR), Alzheimer Society of Canada, Nursing Research Fund, MOHLTC, and the Canadian Health Services Research Foundation.

Parminder Raina, PhD

Dr. Parminder Raina is a Professor in the Department of Clinical Epidemiology and Biostatistics at McMaster University. He specializes in the epidemiology of aging with emphasis on developing the interdisciplinary field of geroscience to understand the processes of aging from cell to society. He has expertise in epidemiologic modeling, systematic review methodology, injury and knowledge transfer. He was recently awarded a Tier 1 Canada Research Chair in Geroscience. Dr. Raina holds the inaugural Raymond and Margaret Labarge Chair in Research and Knowledge Application for Optimal Aging and was a CIHR Investigator. He received the Ontario Premier’s Research Excellence award on research in aging in to train and mentor new researchers. He received The Sun Life Research Fellow, from Sun Life Assurance Company of Canada and a Teaching Excellence Award for Professors, Clinical Epidemiology and Biostatistics, McMaster University.

Dr. Raina is the lead principal investigator of the Canadian Longitudinal Study on Aging. He is the Director of the internationally recognized McMaster Evidence-based Practice Center which is funded by the U.S based Agency for Healthcare Research and Quality (AHRQ) and the CIHR funded McMaster Evidence Synthesis and Review Centre (MERSC). Dr. Raina is a Co-Director of R. Samuel McLaughlin Centre for Research and Education in Aging and Health. Dr. Raina is the founding member of the Ontario Research Coalition of Aging Research Institutes/Centers funded by the Ontario Ministry of Health and Long-term Care. He holds several national and international grants and has published many peer-review reports and articles for national and international agencies, and has over 90 original publications in peer-reviewed journals and has served on several national and international committees.
Graham W. S. Scott, CM, QC

Graham Scott is President of Graham Scott Strategies Inc. and Partner Emeritus of McMillan LLP. Mr. Scott brings a wealth of experience in public policy, governance and accountability in the voluntary and private sectors with a particular emphasis on health care policy and issues. His diverse experience in the health sector includes serving as a Deputy Minister of Health in Ontario, Interim CEO of Cancer Care Ontario, and serving as a supervisor of three Ontario hospitals in recent years. Mr. Scott’s health and public policy initiatives reveal commitment to a diversity of challenging health issues ranging from organ and tissue donation to Alzheimer disease. He is the Chair of Canada Health Infoway and AllerGen NCE. Among his other current responsibilities he serves as Vice Chair of Enterprise Canada and the Institute for Research in Public Policy and as a director of the Ontario Institute for Cancer Research, the Association of Faculties of Medicine of Canada and the Advisory board of Sanofi Pasteur. He is a recent past Chair of the Board of the Canadian Institute of Health Information and until recently was a member of the board of Revera Inc. For his volunteer services he was appointed as a member of the Order of Canada in 2005.

Shirlee M. Sharkey, CHE, MHSc, BScN, BA

Shirlee Sharkey is president and CEO of Saint Elizabeth Health Care (SEHC), an internationally-renowned leader in home and community care known for its social capital, strong financial performance and track record of innovation. As a diversified not-for-profit charitable health services organization, SEHC employs almost 6,000 staff and delivers 5 million visits annually.

Ms. Sharkey also serves as CEO of Community Rehab, an interdisciplinary Canadian home health care organization that has been a leader in rehabilitation since 1985. She is involved with many not-for-profit boards, ranging from health to education. Ms. Sharkey is a past chair of George Brown College in Toronto and a former president of the Canadian Home Care Association. Internationally, she is chair of the World Homecare and Hospice Organization and is also a past president of the Registered Nurses Association of Ontario (RNAO). In 2007, she was appointed by the Minister of Health and Long-Term Care to act as an expert advisor on staffing and care standards for long-term care homes in Ontario. Ms. Sharkey is cross-appointed to the Lawrence S. Bloomberg Faculty of Nursing and the Faculty of Medicine (Department of Health Policy, Management and Evaluation) as an adjunct professor at the University of Toronto. She has presented and published widely on issues related to nursing, home and community-based health care and the need for system change.

Gregory R. Shaw

Greg Shaw has a science and health administration background and until taking up the position of Director, International and Corporate Relations at the International Federation on Aging (IFA), held senior management positions within the Australian Commonwealth Department Health and Ageing in Australia. Prior to joining the IFA he was the Manager for residential aged and community aged care programs in Western Australia. His long career with the Australian Government included management of the Compliance, Complaint and Accountability Section of the Department, having responsibility for the regulatory regime associated with quality of care and certification programs in both residential and community care services.

An advocate of the aged care needs of marginalized community groups in the 1990s, Mr. Shaw worked with many ethnic communities in Western Australia that resulted in the establishment of a number of aged care homes and community aged care services specifically designed and targeted for those communities. Mr. Shaw worked closely with the South African Human Rights Commission to establish an older persons forum in that country is acutely aware of the importance to consider the needs and priorities of older people in planning built and social environments.
Leslie Shinobu, MD, PhD

A Torontonian by birth, Dr. Leslie Shinobu completed her undergraduate education in Biochemistry and Nutrition at the University of Toronto. Since then, she has accumulated over 30 years of experience within academe and industry. She holds a PhD in Inorganic Chemistry & Environmental Toxicology (Vanderbilt University) and is an MD (Vanderbilt University Medical School).

Dr. Shinobu has a longstanding career as a neuroscientist and expert in movement disorders (Massachusetts General Hospital, Harvard Medical School) and is rounded out with a “power tour” through the world of drug development (including being employee number 7 in a Harvard-based start up, senior medical director in the biotechnology sector, and vice-president in a division of a global pharmaceutical corporation). She specializes in working with innovative teams, partnering to help crystallize vision and strategy. Over the years, she has studied, worked, or volunteered in many different countries including the United Kingdom, Denmark, Bangladesh, Venezuela, Japan and China. Currently, Dr. Shinobu is an advisor in the Life Sciences and Health Care Practice at MaRS, a public-private partnership working to nurture innovation by better connecting the worlds of science, government and business.

Anne Snowdon, PhD

Dr. Anne Snowdon is Chair of the Ivey Centre for Health Innovation and Leadership. She is also a Full Professor at the Odette School of Business at the University of Windsor. Dr. Snowdon holds an Adjunct Appointment as Professor at the School of Nursing, Faculty of Medicine at McGill University.

Formerly, Dr. Snowdon was the Vice President of Womens’ and Children’s Programs at Windsor Regional Hospital and Chief Nursing Officer. Dr. Snowdon holds a Bachelor of Science in Nursing from the University of Western Ontario, a Masters of Science from McGill University and a Ph.D. in Nursing from the University of Michigan.

In addition to her expertise in health system leadership and innovation, Dr. Snowdon’s research also looks at the role of engaged consumers as agents of change and reform to health systems.

Robyn I. Stone, DrPh

Robyn I. Stone, a noted researcher and internationally recognized authority on long-term care and aging policy, is the executive director of the Institute for the Future of Aging Services (IFAS) at LeadingAge (formerly AAHSA) in Washington, DC. Since she started IFAS 10 years ago, Dr. Stone has developed and directed a number of national programs including the Center for Medicare Education, the Better Jobs Better Care National Program and the National Initiative to Link Affordable Senior Housing with Health and Supportive Services.

Dr. Stone has served in the U.S. Department of Health and Human Services as Deputy Assistant Secretary for Disability, Aging and Long-term Care Policy from 1993 through 1996 and as Assistant Secretary for Aging in 1997. She has been a senior researcher at the National Center for Health Services Research (currently the Agency for Healthcare Research and Quality), Project Hope’s Center for Health Affairs, and Georgetown University.

Dr. Stone is a distinguished speaker and has been published widely in the areas of long-term care policy and quality, chronic care for the disabled, aging services workforce development and family caregiving. She serves on numerous provider and non-profit boards that focus on aging issues. Her doctorate in public health is from the University of California, Berkeley.
Lois Cormack, MHSc, CHE (Ex-Officio)

Lois Cormack was named President of Specialty Care in 2008. In this role, she provides organizational leadership in the delivery of high quality care and services in 20 long term care and retirement communities throughout Ontario. Under Ms. Cormack’s direction, Specialty Care focuses on continuously improving the resident experience and enhancing employee quality of work life. These efforts have resulted in consistent resident and employee satisfaction ratings of above 80% and quality outcomes exceeding provincial and national standards and averages.

Presently, Ms. Cormack serves as President of the Board of Directors of the Ontario Long Term Care Association, and is a strong advocate for an innovative and sustainable long term care sector. Ms. Cormack holds a Masters in Health Administration from the University of Toronto and is a graduate of the Ivey Executive Program at the Ivey School of Business. She is also a Certified Health Executive with the Canadian College of Health Service Executives.

Debbie Humphreys (Ex-Officio)

Debbie Humphreys was Acting Chief Executive Officer of the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), a provincial association of not-for-profit long term care homes, seniors’ housing and community service agencies.

Debbie has over 20 years’ experience in advocacy, public relations, communications and marketing in the not-for-profit long term care sector. Her expertise spans the full continuum of seniors’ care and services. She has contributed to the work of numerous sector and government advisory groups and committees related to programs, policies, services and other initiatives to improve the quality of life of Ontario’s seniors. Debbie holds an Honours Degree in Human Kinetics and Leisure Studies with a Minor in Gerontology from the University of Waterloo.

Gail Paech (Ex-Officio)

Gail is a highly focused, seasoned professional with over 25 years of senior executive experience in the public, private and not-for-profit sectors. She is a former Associate Deputy Minister Economic Development and Trade and Assistant Deputy Minister, Health and Long-Term Care. During her tenure as a senior civil servant, Gail gained the reputation for her ability to lead large-scale, high profile provincial initiatives that resulted in system transformation and lasting change in the delivery of core public services. Prior to her government experience she was President and CEO of a large community teaching hospital in Toronto and was National Director of the health care practice of a global consulting company. Gail has academic cross appointments as Assistant Professor at The University of Toronto, Faculty of Nursing and Faculty of Medicine. Gail is currently the interim Chief Executive Officer for the Ontario Long Term Care Association.
APPENDIX B: LTC INNOVATION EXPERT PANEL TERMS OF REFERENCE

PREAMBLE
The Ontario Long Term Care Association provides trusted leadership and value-added advocacy, education and member services to 430 charitable, not-for-profit, municipal and private long term care homes; business development opportunities to 250 suppliers; and networking and partnership opportunities to a growing number of research and education affiliate members. Our member homes offer rewarding career and volunteer opportunities to some 50,000 caring individuals, and high-quality nursing, personal care and accommodation services to 50,000 of Ontario’s frailest residents. Many also provide other services along the continuum of aged care, including retirement, assisted living and home care.

In June 2010, OLTCA commissioned the Conference Board of Canada (CBoC) to investigate the innovation potential of the Ontario residential long term care sector. CBoC's report, Towards an Innovation Strategy for Long-Term Care (January 2011) highlights significant challenges related to funding, health human resources, technology and policy and regulation. The report also discusses the important role of long term care within an integrated health care system. Among other things, it recommends that the sector develop a comprehensive strategy to promote innovation at three levels:

- **Internal Innovation**—innovation focused on improving performance inside the firm or institution. Examples include: changes in HR recruitment, retention, and scheduling practices; accelerating the adoption of information and assistive technologies; research partnerships with academics to identify new and better ways of delivering high quality care and/or executing administrative functions; outsourcing certain financial and administrative functions rather than maintaining expensive specialized staff or relying on overworked staff to complete these tasks (especially attractive for smaller homes); further intensifying the recruitment, training, and best placement of staff dedicated to residents of specific ethnicities and with specific linguistic needs.

- **Sector-Wide Innovation**—innovation to exploit inter-firm strengths and to enhance collaboration and cooperation across the LTC sector. Examples include: supply chain and procurement innovation (such as shared purchasing arrangements); research collaboration and knowledge exchange (such as a teaching nursing home program); shared HR recruitment and training; and improved coordination of advocacy.

- **Innovation for Integration and Health System Transformation**—innovation to better integrate LTC into the overall health system and identify new services and products for a changing environment. Examples include: expanding adult day/night dementia care and other adult care programs; expansion of respite care services, expansion of convalescent care services; education and support services for home-based caregivers; and support for research on improving system interfaces and performance.

PURPOSE
Building on the 2011 report of the Conference Board of Canada, the purpose of the LTC Innovation Expert Panel is to advise the OLTCA board on the content of an Innovation Strategy for the Ontario long term care sector within the out-of-hospital continuum of care.

OBJECTIVES
- To consult with key stakeholders on possible content and priorities for an innovation strategy that promotes internal innovation, sector collaboration and system integration and transformation.
- To promote a focused and informed strategic discussion on the future of long-term care and aging care policy in Ontario.
- To provide comprehensive input into a vision for LTC within an integrated health care system.

MEMBERSHIP
Membership will consist of leaders from within and outside of Ontario, with expertise in a variety of areas including:
- Health policy, regulation and funding
- Technology and innovation
- Planning, architecture and design
- Management and leadership
- Health human resources
- Models of service delivery within an integrated health system
• The future of aging and aging care
• Consumer needs and perspectives
• Long term care financing and operations

The panel will be co-chaired by two leaders broadly representative of the diversity of OLTCA membership, with additional representation and links as required. OLTCA staff will provide research and analytical support.

**FREQUENCY OF MEETINGS**

The Expert Panel will meet approximately 6-8 times between March and November 2011. Meetings will be held in person and by teleconference.

**REPORTING**

The Expert Panel is an ad hoc time-limited work group appointed by, and reporting to the OLTCA Board. Panel recommendations reflecting the best advice of panelists will be stratified by degree of consensus.
APPENDIX C: PRESENTATIONS & SUBMISSIONS TO THE EXPERT PANEL

INNOVATION

- Aging: From People to Prototype, Doug Cooper, Intel
- Examining the Drivers to Innovation and Health System Transformation, Shirlee Sharkey, Panelist
- Overview of the Conference Board Report on Innovation, Christina Bisanz, Ontario Long Term Care Association
- The Innovation Imperative (Baycrest Model), Dr. William Reichman, Panelist, & Baycrest Senior Management Team

SERVICE ORGANIZATION & DELIVERY

- Ontario Context, Lois Cormack, Panelist
- Chronic Conditions and Aging of the Population: Preliminary data from CLSA-CCHS Healthy Aging Survey, Dr. Parminder Raina, Panelist
- What the Future Holds for Long Term Care in Ontario: Insights from Demographic - Ethnographic Trends, Tom McCormack, Panelist
- Family Caregivers/Women as catalysts for Change in LTC in Ontario, Don Fenn, Panelist
- A Roadmap for Change in Long Term Care, David Harvey, Alzheimer Society of Ontario
- Contributions to an Innovation Strategy for Long Term Care in Ontario, Christie Brenchley, Ontario Society of Occupational Therapists
- Emergency Mobile Services, Dr. David Ryan, Regional Geriatric Program of Toronto
- Helping Older People Stay at Home: The Australian Aged Care System, Greg Shaw, Panelist
- Quality Palliative Care in LTC Alliance, Dr. Mary Lou Kelley, Lakehead University
- Re-Imagining Long Term Residential Care: An International Study of Promising Practices, Dr. Pat Armstrong, York University
- LTC Innovation Expert Panel Submission, Marsha Nicholson, City of Toronto, Long-Term Care Homes and Services and Sharon Trotman, Regional Community & LTC Coordinator, West GTA Stroke Network
- Mental Health and Addictions Issues for Older Adults: Opening the Doors to a Strategic Framework, Randi Fine, Canadian Mental Health Association
- Recommendations for Service Organization & Delivery related to Addictions and Mental Health in LTC, Janine Luce and Gaby Golea, Centre for Addiction and Mental Health
- Ontario Neurotrauma Foundation, Dr. Rick Riopelle and Kent Bassett-Spiers, Ontario Neurotrauma Foundation
- Stakeholder Dialogue about Organizing a Care System for Older Adults in Ontario, Michael G. Wilson, McMaster University
- Organization of Service Delivery in Long-Term Care in the U.S., Dr. Robyn Stone, Panelist
- Reviewing Innovative US Delivery Models of Chronic Disease Management: Implications for Long-Term Care in Ontario, Hsien Seow, McMaster University
- Innovating for the Future: A Hospital Perspective, Anne Marie Malek, Panelist
- Innovating for the Future: Community Care Perspective, Tricia Khan, Erie St. Clair Community Care Access Centre

FUNDING, FINANCING & REGULATION

- Approaches to LTC Regulation, Steini Brown, Panelist
- Considerations of the Municipal Role in Long Term Care, Petra Wolfbeiss, Association of Municipalities of Ontario
- Case Mix and Payment Systems for Long Term Care: Evidence from the CAN-STRIVE Study, Dr. John P. Hirdes, University of Waterloo
- Financing for Long-Term Care Facilities, Dino Chiesa, Panelist
- LTC Insurance, Lori Down, Canadian Life and Health Insurance Association
HUMAN RESOURCES

• Health Human Resources Planning Presentation, Residents’ Perspective, Donna Fairley, Ontario Association of Residents’ Councils (OARC)
• Highlights from Doctoral Research on Personal Support Workers (PSWs) in LTC Homes, Dr. Catherine Brookman, Saint Elizabeth
• Human Resources Issues – An Employer’s Perspective, Carolyn Clubine, Panelist
• Interprofessional Collaboration and Centres of Learning, Dr. Ken Leclair, Panelist
• LTC Staffing from a Family Perspective, Phyllis Hymmen, Concerned Friends of Ontario Residents in Care Facilities
• Medical Care in the Nursing Home: Workforce Issues and Policy Implications, Dr. Paul Katz, Panelist
• The LTC Physician: Presentation to Innovation Panel, Dr. James Edney, Ontario Long Term Care Physicians
• The Long Term Care Workforce of the Future, Dr. Kathy McGilton, Toronto Rehabilitation Institute
• Using Best-Evidence to Optimize Skill Mix in Ontario LTC Homes: A Knowledge Translation Research Proposal LTC Innovation Expert Panel, Sara Clemens, Registered Nurses Association of Ontario

BUILDINGS & TECHNOLOGY

• Building for the Future: Models from Other Jurisdictions, Greg Shaw, Panelist
• Building for the Future: Policy & Planning Considerations Clifford Harvey, Capital Project Management Office, Ministry of Health and Long Term Care
• Canada’s eHealth Strategy - Opportunities for Long Term Care, Graham Scott, Panelist
• Innovative Architecture & Design, Michelle Wolfenden, Snyder & Associates Architects Inc.
• Intelligent Homes and Systems: Supporting Older Adults and Aging-in-Place, Dr. Alex Mihalidis, Toronto Rehabilitation Institute
• Technologies of the Future: Lessons from the US, Dr. Robyn Stone, Panelist

WRITTEN SUBMISSIONS

• Centre for Addiction and Mental Health
• College of Dental Hygienists of Ontario
• Quality Palliative Care in LTC Alliance
• Nurses Association of Ontario
• Ontario Dental Hygienists Association
• Ontario Long Term Care Physicians
• Ontario Neurotrauma Foundation
• Ontario Podiatric Medical Association
• Ontario Society of Occupational Therapists
• Dr. Hsien Seow, Cancer Care Ontario Research Chair in Health Services Research, Assistant Professor, Department of Oncology, McMaster University
APPENDIX D: QUALITY & ACCOUNTABILITY IN LONG TERM CARE

- Long term care homes are governed by the Long Term Care Homes Act, 2007 (LTCHA) which came into effect on July 1, 2010. The Act sets out resident rights and detailed requirements related to home operations, care and service delivery, admission and discharge, licensing, data collection and reporting and more.

- All homes are inspected against approximately 600 regulatory requirements through the Long Term Quality Inspection Program which includes a structured, evidence-based program developed by Dr Andrew Kramer, Head of the Division of Health Care Policy and Research at the University of Colorado. Inspection reports and associated orders are posted on the Ministry of Health and Long Term Care website.

- All homes have service accountability agreements with the Local Health Integration Networks (LHINs) and the Ministry of Health and Long Term Care. These funding agreements, which describe provider obligations, performance targets and consequences for non-performance, are publicly available on LTC home and LHIN websites.

- All homes use a common instrument (RAI MDS 2.0) to assess resident needs and guide care delivery. Assessment data are also used for system planning and to adjust the care portion of the home's funding based on resident acuity.

- All homes submit quarterly financial (MIS) data and undergo an annual reconciliation process to ensure public funding is spent in accordance with policy posted on the Ministry website. Unspent dollars for nursing and personal care, personal support services, and raw food are returned to government. Data quality reviews are also in place to address coding or reporting anomalies and financial penalties for inaccurate, late or incomplete reporting may apply.

- All homes must have an independent residents’ council that among other things has the right to review the operations of the home, Ministry inspection reports, details on funding from government or payments made by the residents and financial statements filed annually with government. Many homes also have a family council and its powers are also outlined in the Act. In both cases, home management is required to respond to concerns and prohibited from interfering with their operation or attending meetings, unless invited.

- All homes have a duty to protect residents from harm, including abuse and neglect, and are required to investigate, report and take action on any alleged incident. The Act includes timelines for completion of investigations by the Ministry of Health and Long Term Care and whistleblowing protections for residents, staff and others who may make a complaint. During the first 12 months following the introduction of LTCHA, there were 3.047 reported incidents of abuse per 100 LTC beds; two thirds involving aggressive behaviour by residents toward other residents or toward staff (Ontario Ministry of Health and Long Term Care, 2012).

- Health Quality Ontario (HQO) reports on long term care quality via its annual report and public website. The site includes provincial data on some 33 indicators and home-level data on pressure ulcers, falls, continence and restraints. HQO also hosts Residents First, one of the largest quality improvement projects in Canada involving over three quarters of long term care homes to date. Within the first two years of its 5 year mandate, the program has trained 1,400 LTCH staff in quality improvement methods and tools.

- Many homes participate in quality collaboratives and research projects led by the Registered Nurses Association of Ontario (RNAO), Safer Healthcare Now!, Alzheimer Knowledge Exchange, Seniors Health Research Transfer Network (SHRTN), Quality Palliative Care in LTC Alliance, Partnerships in Dementia Care and others.

- Most homes also undergo a voluntary accreditation process through Accreditation Canada or CARF Canada. The process is comprehensive and covers areas such as clinical leadership, staff training and engagement, process improvement, clinical information systems, and quality person-centered care.
APPENDIX E: FACTS AND STATISTICS

Table 1: Profile of Ontario Home Care, Long Term Care and Complex Continuing Care Patients, 2010/2011

<table>
<thead>
<tr>
<th>Cognitive Performance</th>
<th>Homecare*</th>
<th>LTC</th>
<th>CCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatively Intact</td>
<td>0-20</td>
<td>0-20</td>
<td>0-20</td>
</tr>
<tr>
<td>Moderate</td>
<td>20-40</td>
<td>20-40</td>
<td>20-40</td>
</tr>
<tr>
<td>Severe</td>
<td>40-60</td>
<td>40-60</td>
<td>40-60</td>
</tr>
</tbody>
</table>

Sources: CCRS Quick Stats Tables 2010/2011 and HCRS Quick Stats Tables 2010/2011, CIHI

<table>
<thead>
<tr>
<th>Activities of Daily Living</th>
<th>Homecare*</th>
<th>LTC</th>
<th>CCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Dependence</td>
<td>0-20</td>
<td>0-20</td>
<td>0-20</td>
</tr>
<tr>
<td>Dependent</td>
<td>20-40</td>
<td>20-40</td>
<td>20-40</td>
</tr>
<tr>
<td>Extensive 1</td>
<td>40-60</td>
<td>40-60</td>
<td>40-60</td>
</tr>
<tr>
<td>Extensive 2</td>
<td>60-80</td>
<td>60-80</td>
<td>60-80</td>
</tr>
<tr>
<td>Limited</td>
<td>80-100</td>
<td>80-100</td>
<td>80-100</td>
</tr>
<tr>
<td>Supervision</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Independent</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Sources: CCRS Quick Stats Tables 2010/2011 and HCRS Quick Stats Tables 2010/2011, CIHI

Table 2: Mental Health Status of Residents in Long Term Care & Complex Continuing Care, Ontario

<table>
<thead>
<tr>
<th></th>
<th>CCC Ontario</th>
<th>LTC Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Dementia</td>
<td>4879</td>
<td>25.3</td>
</tr>
<tr>
<td>Psychiatric/Mood Disorder</td>
<td>5503</td>
<td>28.5</td>
</tr>
<tr>
<td>Huntington’s</td>
<td>46</td>
<td>0.2</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>340</td>
<td>1.8</td>
</tr>
<tr>
<td>No Aggressive Behaviour</td>
<td>14275</td>
<td>74.6</td>
</tr>
<tr>
<td>(0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some Aggressive Behaviour</td>
<td>2784</td>
<td>14.5</td>
</tr>
<tr>
<td>(1–2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe Aggressive Behaviour</td>
<td>1417</td>
<td>7.4</td>
</tr>
<tr>
<td>(3–5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Severe Aggressive Behaviour</td>
<td>662</td>
<td>3.5</td>
</tr>
<tr>
<td>(6 or More)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19138</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: CCRS Quick Stats Tables 2011/12, CIHI.
Table 3: Resident-Specific Time* in LTC and CCC, Ontario CAN-STRIVE Phase 1 Results by Setting

<table>
<thead>
<tr>
<th></th>
<th>LTC</th>
<th>CCC</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean daily nursing minutes</td>
<td>74.6</td>
<td>135.3</td>
<td>95.3</td>
</tr>
<tr>
<td>Mean weighted nursing minutes</td>
<td>83.1</td>
<td>198</td>
<td>122.2</td>
</tr>
<tr>
<td>RNs as proportion of all nursing minutes</td>
<td>7.6%</td>
<td>35.6%</td>
<td>21.1%</td>
</tr>
<tr>
<td>RPNs as proportion of all nursing minutes</td>
<td>18.4%</td>
<td>56.3%</td>
<td>36.7%</td>
</tr>
<tr>
<td>PSWs/aides as proportion of all nursing minutes</td>
<td>74.1%</td>
<td>8.1%</td>
<td>42.2%</td>
</tr>
<tr>
<td>Mean rehab minutes</td>
<td>3.5</td>
<td>14.6</td>
<td>7.3</td>
</tr>
<tr>
<td>PT/OT/SLP as proportion of all rehab minutes</td>
<td>7.7%</td>
<td>63.3%</td>
<td>45.8%</td>
</tr>
</tbody>
</table>

* Resident-specific time or staff measurement time is time spent with the resident or on behalf of the resident. Table excludes non-resident specific time spent on support activities such as administration, cleaning, training, corporate activities, etc. Data was collected using real-time data collected in a sample of CCC and LTC facilities.

Source: Hirdes et al, January 2011.

Table 4: Ontario LTC Staff Complement, 2010

<table>
<thead>
<tr>
<th>ROLE</th>
<th>FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role</td>
<td>FTEs</td>
</tr>
<tr>
<td>PSWs</td>
<td>27,912</td>
</tr>
<tr>
<td>RPNs</td>
<td>6,693</td>
</tr>
<tr>
<td>RNs</td>
<td>3,822</td>
</tr>
<tr>
<td>Program &amp; Support Services Staff</td>
<td>3,515</td>
</tr>
<tr>
<td>Administrators &amp; Clinical Leaders</td>
<td>1,812</td>
</tr>
<tr>
<td>RAI Coordinators</td>
<td>555</td>
</tr>
<tr>
<td>Dietitians</td>
<td>197</td>
</tr>
<tr>
<td>Volunteer Coordinators</td>
<td>97</td>
</tr>
<tr>
<td>NPs</td>
<td>13</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 5: Sources of Funding, Ontario Residential Aged Care Facilities*, 2008/2009

- MOHLTC: 60.7%
- Co-Insurance or Self-Pay: 27.5%
- Preferred Accommodation: 3.4%
- Sundry Earnings: 1.2%
- Ministry of Social Services: 2%
- Other Provincial Ministries: 0.3%
- Municipal/Regional Governments: 3.8%
- Other Agencies: 1.1%

* Includes long term care homes and other publicly funded aged care facilities with 4 or more beds staffed and in operation during reporting period.

**Table 6:** LTC Resident Per Diem Co-Payment Rates ($) by Type of Accommodation, Canada, 2011

<table>
<thead>
<tr>
<th>Province</th>
<th>Basic Accommodation</th>
<th>Semi-Private</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>29.40 to 96.13</td>
<td>29.40 to 96.13</td>
<td>29.40 to 96.13</td>
</tr>
<tr>
<td>Alberta</td>
<td>45.85</td>
<td>48.40</td>
<td>55.90</td>
</tr>
<tr>
<td>Manitoba</td>
<td>31.30 to 73.40</td>
<td>73.40 to 75.90</td>
<td>73.40 to 78.40</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>31.26 to 59.40</td>
<td>31.26 to 59.4</td>
<td>31.26 to 59.4</td>
</tr>
<tr>
<td>Ontario</td>
<td>Long Stay: 0-53.23</td>
<td>Short Stay: 34.63</td>
<td>53.23 to 61.23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>53.23 to 71.23</td>
</tr>
<tr>
<td>Quebec</td>
<td>33.91</td>
<td>45.62</td>
<td>54.58</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>95.00</td>
<td>95.00</td>
<td>95.00</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>99.00</td>
<td>99.00</td>
<td>99.00</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>92.05</td>
<td>92.05</td>
<td>92.05</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>69.30</td>
<td>69.30</td>
<td>69.30</td>
</tr>
</tbody>
</table>

* Preferred accommodation surcharge does not apply to residents in respite or convalescent care.


**Table 7:** Major Components of Health Care Spending in Ontario, 2010/2011

![Annual Expenditure Pie Chart](chart.png)

Source: Drummond Report, 2012

**Table 8:** Emergency Department Visits & Hospital Admissions by Setting & Jurisdiction

<table>
<thead>
<tr>
<th></th>
<th>Residential Care</th>
<th>Residential Care</th>
<th>Residential Care</th>
<th>Residential Care</th>
<th>Residential Care</th>
<th>Residential Care</th>
<th>Residential Care</th>
<th>Residential Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Newfoundland</td>
<td>Manitoba</td>
<td>Saskatchewan</td>
<td>British Columbia</td>
<td>Ontario LTC</td>
<td>Ontario CCC</td>
<td>Ontario Home Care</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1 &gt; ED Visit in</td>
<td>16</td>
<td>7.9</td>
<td>135</td>
<td>5.5</td>
<td>134</td>
<td>4.6</td>
<td>445</td>
<td>8</td>
</tr>
<tr>
<td>last 90 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 &gt; Hospital</td>
<td>15</td>
<td>7.4</td>
<td>161</td>
<td>6.6</td>
<td>176</td>
<td>6</td>
<td>382</td>
<td>6.8</td>
</tr>
<tr>
<td>Admission in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>last 90 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9: Convalescent Care Program Client Satisfaction with Staff

![Convalescent Care Program Client Satisfaction with Staff](source: MOHLTC, 2009, p. 35)

Table 10: ALC Patients Waiting for Other Types of Care, December 2011

![ALC Patients Waiting for Other Types of Care, December 2011](source: OHA, 2012)
### Table 11: ALC Patients in Acute & Other Inpatient Care Waiting for LTC Bed by LHIN Region, Dec. 2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia¹</td>
<td>44.8</td>
<td>42.3</td>
<td>278</td>
<td>24.4</td>
<td>51.4</td>
<td>48.2</td>
<td>30.5</td>
<td>27.4</td>
</tr>
<tr>
<td>Austria</td>
<td>48.4</td>
<td>17.2</td>
<td>15.5</td>
<td>14.9</td>
<td>27.4</td>
<td>11.5</td>
<td>13.5</td>
<td>12.8</td>
</tr>
<tr>
<td>Canada¹</td>
<td>48.6</td>
<td>33.2</td>
<td>36.5</td>
<td>41.2</td>
<td>47.8</td>
<td>33.5</td>
<td>34.6</td>
<td>42.3</td>
</tr>
<tr>
<td>Denmark</td>
<td></td>
<td>14.2</td>
<td>10.3</td>
<td></td>
<td>11.3</td>
<td></td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>12.9</td>
<td>14</td>
<td>13.1</td>
<td></td>
<td>11</td>
<td>12.7</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td></td>
<td>17.7</td>
<td>16.1</td>
<td></td>
<td>18.7</td>
<td></td>
<td>17.5</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>44.3</td>
<td>48</td>
<td>27</td>
<td>21.7</td>
<td>31.6</td>
<td>22</td>
<td>17</td>
<td>22.8</td>
</tr>
<tr>
<td>Norway</td>
<td></td>
<td>8.6</td>
<td>7</td>
<td></td>
<td>7.6</td>
<td></td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>Sweden¹</td>
<td>19.8</td>
<td>16.4</td>
<td>14.6</td>
<td></td>
<td>27.7</td>
<td>23.7</td>
<td>21.8</td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td></td>
<td>54.3</td>
<td>42.6</td>
<td></td>
<td>99.8</td>
<td>72.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td>74.3</td>
<td>62.2</td>
<td></td>
<td>77.5</td>
<td>66.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States²</td>
<td></td>
<td>13.4</td>
<td>11.3</td>
<td>10.5</td>
<td>8.2</td>
<td>8.4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>OECD Average³</td>
<td>29.1</td>
<td>26.8</td>
<td>19.2</td>
<td>16.7</td>
<td>51.4</td>
<td>28.2</td>
<td>19.5</td>
<td>17.7</td>
</tr>
<tr>
<td>OECD Average⁴</td>
<td>29.1</td>
<td>31</td>
<td>24.3</td>
<td>23.2</td>
<td>34.4</td>
<td>25.5</td>
<td>25.4</td>
<td>24.2</td>
</tr>
</tbody>
</table>

Data for Canada: a break in series in 2006 leads to longer reported average length of stay.
1: Data for 2008 refer to 2007.
2: Data for 2008 refer to 2006.
3: Unweighted average on countries reporting data, per respective year.
4: Unweighted average for all countries that report data as of 1994 (six for dementia; five for Alzheimer’s disease).

Source: OHA, 2012

*Note: According to the CIHI Patient Cost Estimator, average length of stay in Ontario for those diagnosed with dementia (CMG 670) in 2008/09 was 24 days (10 days in acute care and 14.2 days in an ALC bed).*

### Table 12: Distribution of MAPLe Priority Levels in 10 Jurisdictions

<table>
<thead>
<tr>
<th>MAPLe</th>
<th>Low</th>
<th>Mild</th>
<th>Moderate</th>
<th>High</th>
<th>Very High</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iceland</td>
<td>39.4</td>
<td>12.8</td>
<td>20.9</td>
<td>22.9</td>
<td>4</td>
<td>297</td>
</tr>
<tr>
<td>Manitoba</td>
<td>32.9</td>
<td>17.5</td>
<td>24.6</td>
<td>20.9</td>
<td>4.1</td>
<td>7,915</td>
</tr>
<tr>
<td>Sweden</td>
<td>32</td>
<td>12.4</td>
<td>35.4</td>
<td>14.6</td>
<td>5.6</td>
<td>178</td>
</tr>
<tr>
<td>Ontario</td>
<td>24.4</td>
<td>22.6</td>
<td>28.1</td>
<td>17.6</td>
<td>7.3</td>
<td>4,836</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>23.3</td>
<td>10</td>
<td>31.7</td>
<td>24.4</td>
<td>10.6</td>
<td>180</td>
</tr>
<tr>
<td>British Columbia</td>
<td>12.9</td>
<td>13.1</td>
<td>20.8</td>
<td>37.5</td>
<td>15.7</td>
<td>1,081</td>
</tr>
<tr>
<td>Michigan</td>
<td>5.7</td>
<td>7.2</td>
<td>42</td>
<td>31.9</td>
<td>13.2</td>
<td>19,491</td>
</tr>
<tr>
<td>Georgia</td>
<td>0.5</td>
<td>1.5</td>
<td>52.4</td>
<td>34.4</td>
<td>11.1</td>
<td>12,761</td>
</tr>
<tr>
<td>Japan</td>
<td>5.3</td>
<td>3.6</td>
<td>37.1</td>
<td>33.3</td>
<td>20.8</td>
<td>3,106</td>
</tr>
<tr>
<td>Italy</td>
<td>3.5</td>
<td>1.8</td>
<td>33.7</td>
<td>39.6</td>
<td>21.5</td>
<td>6,151</td>
</tr>
</tbody>
</table>

Source: Hirdes et al., 2008
### Table 13: Cross-Jurisdictional Comparison of Rates of Caregiver Distress by MAPLe Priority Level

<table>
<thead>
<tr>
<th></th>
<th>MAPLe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Italy</td>
<td>14.5</td>
</tr>
<tr>
<td>Michigan</td>
<td>11.9</td>
</tr>
<tr>
<td>Iceland</td>
<td>6</td>
</tr>
<tr>
<td>Sweden</td>
<td>1.8</td>
</tr>
<tr>
<td>British</td>
<td>8.6</td>
</tr>
<tr>
<td>Columbia</td>
<td></td>
</tr>
<tr>
<td>WRHA, Manitoba</td>
<td>5.7</td>
</tr>
<tr>
<td>Ontario</td>
<td>4.2</td>
</tr>
<tr>
<td>(8 CCACs)</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>0</td>
</tr>
<tr>
<td>Japan</td>
<td>15.2</td>
</tr>
<tr>
<td>Georgia</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Hirdes et al. 2008

### Table 14: A Snapshot of Home Care Service Utilization: Central CCAC

<table>
<thead>
<tr>
<th>Avg Length of Stay (days)</th>
<th>Annual Cost/Client ($)</th>
<th>% Caseload</th>
<th>% Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>778</td>
<td>1679</td>
<td>23.72</td>
<td>6.19</td>
</tr>
<tr>
<td>936</td>
<td>3216</td>
<td>30.72</td>
<td>15.35</td>
</tr>
<tr>
<td>1082</td>
<td>4780</td>
<td>13.74</td>
<td>10.2</td>
</tr>
<tr>
<td>1210</td>
<td>6389</td>
<td>5.66</td>
<td>5.62</td>
</tr>
<tr>
<td>1138</td>
<td>7870</td>
<td>6.03</td>
<td>7.37</td>
</tr>
<tr>
<td>1150</td>
<td>9483</td>
<td>2.82</td>
<td>4.15</td>
</tr>
<tr>
<td>1303</td>
<td>13990</td>
<td>10.56</td>
<td>22.95</td>
</tr>
<tr>
<td>1426</td>
<td>22790</td>
<td>5.77</td>
<td>20.45</td>
</tr>
<tr>
<td>1004</td>
<td>34733</td>
<td>0.54</td>
<td>2.91</td>
</tr>
<tr>
<td>547</td>
<td>69010</td>
<td>0.45</td>
<td>4.81</td>
</tr>
</tbody>
</table>

Source: P Doody, 2010
Table 15: Accommodation Options, Ontario LTCHs, July 2011

**LONG STAY BEDS**

<table>
<thead>
<tr>
<th>Type</th>
<th>Spaces</th>
<th>Vacancy</th>
<th>Type</th>
<th>Spaces</th>
<th>Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>35,552</td>
<td>46.1%</td>
<td>Semi-Private</td>
<td>14,280</td>
<td>18.8%</td>
</tr>
<tr>
<td>Private</td>
<td>26,241</td>
<td>34.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-Private</td>
<td>14,280</td>
<td>18.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: MOHLTC, 2012

Table 16: Ontario LTC Homes by Structural Classification

**LTC Beds by Structural Class**

<table>
<thead>
<tr>
<th>Class</th>
<th>Spaces</th>
<th>Vacancy</th>
<th>Spaces</th>
<th>Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/A</td>
<td>35.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>8.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>34.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>12.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New: Built after 1998 to current design standards
A class: Built prior to 1998, almost meet current design standards
B class: Substantially exceed 1972 standards
C class: Meet 1972 standards
D class: Do not meet 1972 Nursing Home Act standards

Source: OLTCA, 2011

Table 17: Seniors Housing Supply, Ontario, 2011

<table>
<thead>
<tr>
<th>Region</th>
<th>Semi-Private &amp; Ward</th>
<th>Private/Studio</th>
<th>One Bedroom</th>
<th>Two Bedroom</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spaces</td>
<td>Vacancy</td>
<td>Spaces</td>
<td>Vacancy</td>
<td>Spaces</td>
</tr>
<tr>
<td>GTA</td>
<td>430</td>
<td>18.5%</td>
<td>7762</td>
<td>15.4%</td>
<td>5652</td>
</tr>
<tr>
<td>Central Ontario</td>
<td>1001</td>
<td>18.5%</td>
<td>8943</td>
<td>11.7%</td>
<td>3156</td>
</tr>
<tr>
<td>Ottawa</td>
<td>258</td>
<td>13.6%</td>
<td>4167</td>
<td>16.2%</td>
<td>1931</td>
</tr>
<tr>
<td>Eastern Ontario</td>
<td>328</td>
<td>20.6%</td>
<td>3625</td>
<td>11.7%</td>
<td>1097</td>
</tr>
<tr>
<td>SW Ontario</td>
<td>340</td>
<td>21.4%</td>
<td>4754</td>
<td>14.9%</td>
<td>2101</td>
</tr>
<tr>
<td>Northern Ontario</td>
<td>1485</td>
<td>5.6%</td>
<td>605</td>
<td>13.9%</td>
<td>85</td>
</tr>
<tr>
<td>Ontario</td>
<td>2423</td>
<td>19.4%</td>
<td>30736</td>
<td>13.9%</td>
<td>14541</td>
</tr>
</tbody>
</table>

Sources: CMHC 2011.
Table 18: Current Supply of Aged Care Spaces

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated Population Aged 75+</td>
<td>Residential Aged Care Beds Staffed and In Operation</td>
<td>Residential Aged Care Beds per 1000 Pop 75+</td>
<td>Seniors Living Spaces</td>
<td>Seniors Living Spaces Per 1000 Pop 75+</td>
<td>TOTAL Aged Care Spaces</td>
<td>Aged Care per 1000 Pop Aged 75+</td>
</tr>
<tr>
<td>Canada</td>
<td>2,274,208</td>
<td>214,368</td>
<td>94.3</td>
<td>198,739</td>
<td>87.4</td>
<td>413,107</td>
<td>181.6</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>33500</td>
<td>5,809</td>
<td>173.4</td>
<td>2623</td>
<td>78.3</td>
<td>8,432</td>
<td>251.7</td>
</tr>
<tr>
<td>PEI</td>
<td>9700</td>
<td>1,877</td>
<td>193.5</td>
<td>980</td>
<td>101</td>
<td>2,857</td>
<td>294.5</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>68100</td>
<td>6,804</td>
<td>99.9</td>
<td>1447</td>
<td>21.2</td>
<td>8,251</td>
<td>121.2</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>54000</td>
<td>7,411</td>
<td>137.2</td>
<td>2074</td>
<td>38.4</td>
<td>9,485</td>
<td>175.6</td>
</tr>
<tr>
<td>Quebec</td>
<td>562,824</td>
<td>39,287</td>
<td>69.8</td>
<td>97012</td>
<td>172.4</td>
<td>136,299</td>
<td>242.2</td>
</tr>
<tr>
<td>Ontario</td>
<td>886510</td>
<td>89,295</td>
<td>100.7</td>
<td>49596</td>
<td>55.9</td>
<td>138,891</td>
<td>156.7</td>
</tr>
<tr>
<td>Manitoba</td>
<td>83400</td>
<td>9,742</td>
<td>116.8</td>
<td>3648</td>
<td>43.7</td>
<td>13,390</td>
<td>160.6</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>77000</td>
<td>8,514</td>
<td>110.6</td>
<td>5260</td>
<td>68.3</td>
<td>13,774</td>
<td>178.9</td>
</tr>
<tr>
<td>Alberta</td>
<td>186,200</td>
<td>18,583</td>
<td>99.8</td>
<td>9429</td>
<td>50.6</td>
<td>28,012</td>
<td>150.4</td>
</tr>
<tr>
<td>BC</td>
<td>312974</td>
<td>26,769</td>
<td>85.5</td>
<td>26670</td>
<td>85.2</td>
<td>53,439</td>
<td>170.7</td>
</tr>
</tbody>
</table>

*Residential aged care facilities refers to facilities with four beds or more that are funded, licensed or approved by provincial/territorial departments of health and/or social services. Facilities provide counselling, custodial, supervisory, personal, basic nursing and/or full nursing care to at least one resident. Excluded are those facilities providing active medical treatment (general and allied special hospitals). “Beds staffed and in operation” refers to the number of beds that are either occupied or available for new resident admissions on the last day of the reference period.

APPENDIX F: DENMARK’S LONG TERM CARE SYSTEM

Denmark’s 5.5 million citizens, one in six of whom are over the age of 65, enjoy one of the most comprehensive long term care systems in the world. Various types of supportive living environments exist for older adults with varying levels of functioning. Often this housing is near or linked to nursing homes, sheltered accommodations, day homes or day centres and community centres in order to take advantage of personnel and facilities and facilitate access to home care and community services. Case managers coordinate integrated care at the local level, with much of it provided under the auspices of housing and social services rather than health. While traditional nursing homes still exist, modern nursing houses and other protected dwellings function as supportive housing for the elderly and the disabled.

People living at home or in seniors housing are eligible for home nursing, health services including health promotion and rehabilitation, and permanent home help for personal care, homemaking, etc. following a comprehensive assessment. Almost two thirds of those living in their own home receive fewer than 2 hours of help per week versus 20 hours or more for over half of those in nursing homes. Caregiver support is also available in the form of substitute and respite services, a stipend for caregivers who step out of workforce for up to 6 months to care for a close relative and a constant care allowance to support end of life care at home. Recent efforts to improve quality and choice have focused on consistent assignment of home health workers, funding for uptake of productivity-enhancing technology, citizen-directed personal budgets to purchase services directly, and a 2 month wait time guarantee for placement in a care home or social housing.

| 2007 | |
| Population aged 65+ (% of total population) | 844,000 (15%) |
| Aged 80+ (% of total population) | 225,000 (4%) |

**Care and Services**

| Persons aged 75+ that received preventive home visits & care planning/case management | 45% |
|Persons aged 65+ receiving temporary home care (e.g., following hospitalization) | ~17,500 |

Population aged 65+ (80+) receiving publicly funded permanent help

| *at home | 145,545 (87,383) |
|*other residential settings | 38,353 (28,554) |

Type of care received

| *Personal Care | 2% (4%) |
|*Homemaking, etc | 7% (15%) |
|*Both | 12% (32%) |

Weekly hours of permanent home care per person aged 65+ living at home (living in nursing home)

| <2 hours | 62% (5%) |
|2-3 hours | 13% (5%) |
|4-7 hours | 12% (8%) |
|8-11 hours | 6% (10%) |
|12-19 hours | 5% (22%) |
|>19 hours | 3% (51%) |

**Residential Care Places**

| Population aged 65+ receiving institutional care (nursing home) | 9.5% |
|Places in Nursing homes | 12,591 |
|Places in Sheltered homes / protected dwellings | 2,202 |
|Places in Assisted living / nursing dwellings | 32,249 |
|Places in Social housing / general dwellings for elderly persons | 29,636 |
|Places in Other dwellings for elderly persons | 10,012 |

Total residential care places for older persons

| Places for persons with dementia | 5,672 |
|Spaces in day care centres / day care homes | 29,500 |

*Assisted living includes permanent employees and service areas, while social housing has no permanent staff.

Sources: Danish Ministry of Social Services & Integration, 2012; E Schultz, 2010 & OECD, 2011.
APPENDIX G: AUSTRALIA’S AGED CARE SYSTEM

Australia’s aged care continuum consists of a mix of residential and community care. Residential services include:

- **High level care**: For people who need 24-hour nursing care because they are physically unable to move around and care for themselves, or because they have severe dementia or other behavioural problems. Residents in high care must receive additional care and services as required.
- **Low level care**: For people who need some help but can walk or move about on their own. Low level care focuses on personal care services (help with dressing, eating, bathing etc.), accommodation, support services (cleaning, laundry and meals), some allied health services such as physiotherapy and nursing care when required. Most low level aged care homes have nurses on staff, or at least have easy access to them.
- **Ageing in place**: Homes that offer both high and low level care, or situations where it is possible to stay in the same home if care needs increase.
- **Extra services**: A higher standard of accommodation, food and services for an additional daily fee or accommodation bond.
- **Palliative care**: For people who have a life threatening illness, with little or no prospect of a cure, and for whom the primary treatment goal is quality of life. Palliative care in aged care homes focuses on resident quality of life, reducing the need to move to another location such as a hospital or hospice.
- **Short term care**: Respite or short term care on a planned or emergency basis to provide caregivers a short break.
- **Transitional care**: For people who require low-intensity therapy and support to optimize function and independence following a hospital stay. Provides up to 12 weeks of rehabilitative care community or in residential setting prior to undergoing assessment. The service gives individuals and families more time to determine if they can return home with additional support from community care services, or need to consider the level of care provided by an aged care home.
- **Cultural and identified needs**: Specialized services for veterans, people who live in rural and regional areas, people with a disability, people who are culturally and linguistically diverse, Aboriginal people, and people who are socially or financially disadvantaged.
- **Particular health conditions**: Specialized facilities for people with dementia, mental health problems or requiring fall or continence management.
- **Multipurpose services (MPS)**: MSPs offer a range of health and aged care services under one management structure in rural and regional areas.
- **Independent Living units**: Residential communities that offer a range of services for independent older people, and are regulated by state and territory governments.

Community Care Packages provide flexible, individually planned and coordinated care to enable frail older Australians with special needs to remain at home as long as possible. Community Aged Care Packages (CACP) provide an average of 7 hours of care per week as an alternative to low level residential care. Extended Aged Care at Home (EACH) provides an average of 23 hours per week for people eligible for high level residential care that could be cared for at home. EACH Dementia provides additional specialized services to enable those with complex cognitive, emotional or behavioural needs to remain at home for as long as possible. Consumer Directed Care (CDC) Packages provide frail elders eligible for residential care with the option of receiving subsidized respite, personal support, transportation, nursing and other care at home from their preferred provider. The program, which has three subsidy levels depending on care needs, allows older adults and caregivers greater control over the design and delivery of formal and informal care and services received.

Wait Times for Admission to Residential High Care

![Wait Times for Admission to Residential High Care](chart.png)
The Australian government has set a planning target of 113 aged care (residential and community care) places per 1000 population aged 70+. As of May 2011 there were 43 residential high, 44 residential low, 4 community care high and 21 community care low care places per 1000 population aged 70+. Rising demand for community care led to the conversion of 4,000 undersubscribed residential care places to community service packages in 2009/10. Allocation of residential aged care, community care and extended care places occurs through an annual competitive process called the Aged Care Approvals Round managed by the Australian Department of Health and Aging. Capital grants and zero interest loans are also available to providers.

Australia has adopted the Aged Care Funding Instrument which assesses residents based on low, medium or high care needs in 3 domains (activities of daily living, behaviours and complex care). This instrument is used for funding purposes only; not care planning. Regional Aged Care Assessment Teams determine eligibility for community and residential care. Two thirds of low care and three quarters of high care residents are admitted within three months of assessment. Services are subsidized and residents contribute to accommodation and capital costs through a refundable accommodation bond or capped per diem fee. Bonds and charges are means-tested. The Australian government requires that a proportion of residential places be set aside for assisted or supported residents. This ranges between 16 and 40% depending on the region. Approximately one third of residents admitted to residential care in 2008/09 were partially or fully subsidized.

In 2011, the Productivity Commission, an independent research and advisory body to the Australian government, released a comprehensive review and integrated package of reforms that if implemented will transform the country’s aged care system. Among other things, Caring for Older Adults recommends that a gateway be created to enable consumers to easily find information about the system, assess their care needs and coordinate access to an entitlement of approved services as well as other community resources. It also recommends giving consumers more choice regarding whether to receive care at home and their approved provider as well as ability to purchase additional services and higher quality accommodation. The Report calls for a phasing out of limits on the number of residential places and community care packages and changes to user fees and subsidies and aged care funding and financing. It also recommends that an Australian Aged Care Commission be responsible for quality and accreditation and providing independent and transparent recommendations to government on prices for services. The full report is available on the Productivity Commission’s website, www.pc.gov.au.

**FACTS:**

- 2 million Australians aged 70+ (9% of the population)
- 2,773 government subsidized aged care homes (average occupancy rate: 92%)
- $11 billion spent on aged care; $7.3 billion directed to residential care in 2009/10
- $39,516 average annual subsidy per residential care place
- 78,075 high care places
- 4,377 low care places
- 92,297 mixed care places
- 8% of all residential care places were approved for extra service; 85% were in high care
- 4,000 transition care places
- 160,000 frail Australians receiving day therapy services (physiotherapy, occupational, speech therapy, podiatry) annually
- 1.3 million respite days (60,000 admissions annually)
- 214,000 people received permanent residential care (10.5% of Australians aged 70+)
- 29 days was the median wait time for residential care

**AUSTRALIA’S DESIGN STANDARDS**

- No more than 1.5 residents per room on average
- No one room with more than 2 residents
- No more than 3 residents per toilet (minimum)
- No more than 4 residents per shower (minimum)
- New facilities generally have ensuites
- Aggregate capital costs are approximately $226,000 per bed. Accommodation bonds paid by low care or extra care residents on admission function as interest-free loans to facilitate capital investment or offset capital costs. As of 2008, there were 60,000 bonds worth $8 billion.


### APPENDIX H: OPTIMIZING LTC UTILIZATION IN ONTARIO

#### Impact of Length of Stay & Bed Redesignation on Access to Care in Residential Care

<table>
<thead>
<tr>
<th>Total Beds</th>
<th>Long Stay</th>
<th>Respite</th>
<th>Convalescent</th>
<th>Interim / Other Short Stay</th>
<th>Total</th>
<th>Increased Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Bed Supply</td>
<td>76073</td>
<td>404</td>
<td>438</td>
<td>948</td>
<td>77863</td>
<td></td>
</tr>
<tr>
<td>Current Bed Ratio</td>
<td>97.70%</td>
<td>0.50%</td>
<td>0.60%</td>
<td>1.20%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Maximum Length of Stay (Continuous/Total Days)</td>
<td>NA</td>
<td>60/90</td>
<td>90/90</td>
<td>120/+60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay (Days)</td>
<td>1144</td>
<td>25</td>
<td>54</td>
<td>96</td>
<td>1022</td>
<td></td>
</tr>
<tr>
<td>Actual Occupancy Rate</td>
<td>99.00%</td>
<td>70.00%</td>
<td>93.20%</td>
<td>96.30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Turnover Rate</td>
<td>31.91%</td>
<td>1460%</td>
<td>676%</td>
<td>380%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals Served Per Year*</td>
<td>99341</td>
<td>4129</td>
<td>2759</td>
<td>3471</td>
<td>111777</td>
<td></td>
</tr>
<tr>
<td><strong>Scenario 1 - Optimizing Length of Stay</strong></td>
<td>97.70%</td>
<td>0.50%</td>
<td>0.60%</td>
<td>1.20%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Bed Supply</td>
<td>76073</td>
<td>404</td>
<td>438</td>
<td>948</td>
<td>77863</td>
<td></td>
</tr>
<tr>
<td>Occupancy Rate</td>
<td>99%</td>
<td>85%</td>
<td>95%</td>
<td>96.30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay (Days)</td>
<td>913</td>
<td>23</td>
<td>45</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Bed Turnover Rate</td>
<td>40.00%</td>
<td>1587%</td>
<td>811%</td>
<td>562%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Individuals Served (est.)</td>
<td>105437</td>
<td>5450</td>
<td>3375</td>
<td>5126</td>
<td>119388</td>
<td>7611</td>
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102 Why Not Now? A Bold, Five-Year Strategy For Innovating Ontario’s System of Care for Older Adults
<table>
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<th>Scenario</th>
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*Total capacity is based on number of LTC residents who were in the facility and admitted, assessed or discharged in 2010/2011 as reported in CIHI’s CCRS Quick Facts 2010/2011. Numbers served by bed type is estimated based on the Long Term Care System Report, July 2011 and additional occupancy and turnover rates provided by the Ontario Ministry of Health and Long Term Care. Estimated number of individuals served by bed type does not equal Total Individuals Served due to the inability to reconcile these two data sources. It is possible that the two data sources use different inclusion/exclusion criteria.

**SOURCES & RESOURCES**


Assessing Needs of Care in European Nations (ACIEN), http://www.acien-longtermcare.eu/


Canadian Life and Health Insurance Association Inc. (2011, September). *Toward Sustainable Long-Term Care*. Toronto: CLHIA.


Canadian Research Network for Care in the Community. (2009). *Aging at Home: Connecting the dots in Ontario and Beyond*, [Powerpoint Presentation], June 22, Toronto.


Jansen, I., & Murphy, J. (2009). *Residential Long-Term Care in Canada, Our Vision for Better Seniors’ Care*. Ottawa: CUPE.


The Gold Standards Framework in Care Homes, http://www.goldstandardsframework.org.uk/GSFCareHomes


3. Data from CCRS Quick Stats Tables 2011/12 (CIHI, 2012). Includes residents who were in the facility and were admitted, assessed with the RAI MDS 2.0 instrument or discharged in 2010–2011. Residents should be assessed within 14 days of admission, then every quarter during their stay or when they have a significant change in health status. Residents may not have assessment records if their stay in the facility was less than 14 days; their initial assessment was not due until the first 14 days of 2011–2012; they were admitted close to the end of the fiscal year or discharged close to the beginning of the fiscal year; or the facility did not successfully submit the record to CIHI.
4. The Ontario Ministry of Health and Long Term Care Staffing Report defines direct care is defined as care provided by Personal Support Workers, Registered Practical Nurses, Registered Nurse, Infection Control Practitioner, Clinical Nurse Specialist or Nurse Clinician, and Nurse Practitioner.
5. In Ontario, Alternate Level of Care applies when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (acute, complex, continuing care, mental health or rehabilitation). The patient must be designated alternate level of care at that time by the physician or delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to an alternate destination.
6. STRIVE defined resident-specific activities as both direct care activities such as changing a dressing, taking vital signs, administering medication, giving bath, assisting a resident and documenting care and resident-specific care coordination activities such as talking to family or physician, care planning, arranging activities and completing the MDS assessment. Non-resident specific tasks include: reporting, charting, ordering medications, ordering and stocking supplies, cleaning or servicing equipment, training and meetings, down time and meals, breaks and other unpaid time. For more information see STRIVE Project PDA Functions, https://www.qtso.com/download/strive/PDA_section_032807.pdf.
8. The Panel’s vision was informed by several documents including Caring for Older Australians, Australian Productivity Commission, June 2011.
9. Assumes 25% of new beds will be not for profit (current ratio) and 160 beds per home.
11. To download the RAND MDS 3.0 Final Study Report visit www.cms.gov.
12. From What We Heard: Long Term Care Quality Consultation, Ontario Ministry of Health and Long Term Care, 2008.
13. K Brazil, Improving Care for Older Persons living and Dying in Long Term Care Homes, 2010.
15. Ministry of Health and Long-Term Care, 2011.
17. The Ontario Drug Benefit Program covers the cost of prescription drugs in the Ontario Drug Benefit Formulary for persons aged 65+, residents of long term care homes and homes for special care, persons receiving home care professional services and Trillium Drug Program registrants. Some restrictions apply. See Ontario Ministry of Health and Long Term Care website for details.
18. This model would require extensive consultation to determine if it is a feasible direction for government, providers and consumers. It would require policy change and resources for program expansion. Among other things, retirement living providers would need to de-link the cost of services from accommodation within designated areas or in designated types of accommodation within their facility. Rental subsidies or consumer-organized shared accommodation could offset or reduce accommodation costs.
19. In its submission, the Centre for Addiction and Mental Health noted that the 90 day length of stay for behavioural assessment and support units is problematic and may require an alternate service model to better address the needs of those not stable enough for a regular long term care bed, but not ill enough to occupy either an acute hospital bed or an inpatient psychiatric bed.
20. The intent is to determine optimal care pathways for different groups of patients/residents based on these develop guidelines for length of stay that optimize care and assist with discharge planning and successful transition back to the community.
21. The Ontario Hospital Association has proposed that a provincial payment commission be established to develop and continuously update provincial rates for hospital services. This body could also be responsible for setting future rates for long term care services, similar to MedPAC in the United States.

22. The template agreement would need to be sensitive to the diversity of operational structures in long term care, including the role of municipalities.


24. For a description of clients living in supportive housing see Juttan (2010)


27. A practical approach to implementation may be to ensure that every home has direct access to a nurse practitioner, with home funding levels based on a ratio of 1 NP FTE per x number of residents.

28. The intent is not to replace medication administration and oversight by regulated staff but to extend their role in areas where it is safe to do so. The creation of a Medication Aide role would extend the ability for PSWs in long term care to fully assist residents with activities of daily living, including helping residents with oral medication under the supervision of regulated staff. PSWs in long term care can already administer topicals but cannot administer natural health products; in other settings including home care, PSWs prompt clients to take both over-the-counter and prescription medications. Consultation would be required on the class of medication appropriate for this new role to handle, training needed and safeguards for regulated staff and residents/clients.

29. Workers who attend to needs of the resident including dietary, housekeeping, personal support and in some long term care culture change service delivery models, nursing tasks.

30. According to 2010 MOHLTC LTC Staffing Report there were 27,912 PSW FTEs reported by 604 homes for calendar year 2010.

31. Assuming these were Personal Support Workers earning an average of $40,000 annually in salary and benefits, this would be equivalent of a $5.7 million investment in LTC.


34. Based on CAN-STRIVE study, direct care staff in LTC spend an average of 75 minutes per resident per day (of 174 minutes for nursing, personal care and personal support services funded by the provincial government) on resident-specific tasks.

35. 2011 data, Rate Reduction Working Group, Ontario Ministry of Health and Long Term Care.


38. For example, create additional subgroups to better account for care needs and resource requirements related to the management of aggressive behaviours.

39. In the LTC grouper, the order of the Special Rehab and Extensive Services categories are reversed.

40. The intent is not to replace medication administration and oversight by regulated staff but to extend their role in areas where it is safe to do so. The creation of a Medication Aide role would extend the ability for PSWs in long term care to fully assist residents with activities of daily living, including helping residents with oral medication under the supervision of regulated staff. PSWs in long term care can already administer topicals but cannot administer natural health products; in other settings including home care, PSWs prompt clients to take both over-the-counter and prescription medications. Consultation would be required on the class of medication appropriate for this new role to handle, training needed and safeguards for regulated staff and residents/clients.

41. Cross-trained workers who attend to all needs of the resident including dietary, housekeeping, laundry, social activities and activities of daily living, often in nursing homes that have adopted ‘culture change’ approaches to resident-centered care.

42. All persons 75+ are eligible for up to 2 visits per year although recipients may decline the service.