Future Care for Seniors

Canadian Alliance for Sustainable Health Care
Core Research for 2013-2014
May 10, 2013
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Outline

- **Local Health Integration Networks** – Ontario’s Devolution
- **The Burning Platform** – What Fueling the Fire
  - Different, Long, Tough Economic Environment
  - Different Patient Demand – Requiring a New Response
- **The SE LHIN Response**
  - Horizontal and Vertical Integration
  - Clinical Services Roadmap
  - ALC – Home First
  - Behavioural Supports
  - Assisted Living
  - Health Links
Overview of LHINs

• Created in 2005
  • – Last province to devolve health care to regional decision making
• Local Health Services Integration Act passed April 2006
• 14 LHINs – averaging 900,000 people per
• SE LHIN 500,000 – most rural of southern LHINs
• 124 Health Service Providers (including 7 hospitals) accountable to the SE LHIN, representing $1.1 B in annual funding
• Governed by nine member Board – OIC appointed
South East Local Health Integration Network

Mandates

- Local Health System Planning
- Integration
- Funding ($1B for 124 Health Services Providers)
- Accountability Agreements
- Performance Targets, Monitoring and Reporting
- Community Engagement
SE LHIN – Corporate Strategic Plan (2011 – 2014)

**SE LHIN Mission**
Planning, accountability, and funding that drive improved health care performance in the South East

**SE LHIN Vision**
Achieving better health through proactive, integrated and responsive health care in partnership with an informed community

**SE LHIN Strategic Goals**

- **GOAL #1**
  To build a true system of integrated health care that optimizes the use of resources.

- **GOAL #2**
  To build understanding of the role of the SE LHIN in developing and managing a regional system of integrated patient-centred care.

- **GOAL #3**
  To build a functional integrated e-health system that supports better health care services and healthier citizens.

- **GOAL #4**
  To demonstrate leadership as a knowledge-based organization that is credible, professional, proactive and responsive.
Integrated Health Services Plan 3
Transforming Health Care in the SE

- Integrated System of Health Care
  - Primary Care Hubs
  - Strong Hospitals
  - Improved Coordination within CCS and CMHA sectors
  - Information Management

- Improve Patient Experience
  - Seniors Strategy
  - MH&A
  - Chronic Disease Management
  - Palliative Care

- Unique Populations
  - Francophone
  - Aboriginal
Transforming Health Care

What is driving the need for Transformation?

- A changing demand and the need for a different response.
- A very different economic environment.
Economic Context

- China’s economy is sputtering
- Europe is in trouble again (Germany can borrow at 1.5% - Spain is borrowing at 7.5%)
- US is recovering slowly but with slow job growth

- Still, over the last ten years, US productivity has increased by 2% per year

- Meanwhile, Canada’s productivity has not improved during the same timeframe, even with our dollar at par.
Canada’s Economy

- Recovery in Canada will be slow
- Low job numbers
- No great gains for 3 to 5 years, maybe longer

- Canada currently has limited trade with the emerging economies

- Ontario’s reliance on manufacturing means we are impacted by these economic shocks
Ontario’s Economy

- $100sB debt, $10B annual to service the debt
- Recession caused drop in revenues
- 5 years of double digit Billion dollar deficits could result in a doubling of debt and potential of debt servicing costs rising much beyond $10B
- Canada and Ontario must aggressively attack deficits or they too will have credit ratings reduced, leading to increase servicing costs, and unattractiveness for new businesses
Composition of Total Expense, 2013–14

Health Sector
38.3% $48.9B

Other Programs
14.0% $17.8B

Interest on Debt
8.3% $10.6B

Justice Sector
3.2% $4.1B

Children’s and Social Services Sector
11.2% $14.3B

Postsecondary and Training Sector
6.1% $7.7B

Education Sector
18.9% $24.1B

1 Excludes Teachers’ Pension Plan. Teachers’ Pension Plan expense is included in Other Programs.

Note: Numbers may not add due to rounding.
Health Care Context

- Canada spends more on health care than almost all other countries without achieving top outcomes.

- Christensen (2009) states the US, the highest health spending country in the world, could improve quality and outcomes while reducing costs by more than 50%.

- Ontario spends $48B (38%) of the Province’s budget on health care for 13,000,000 people.
Health Economics in Ontario

• Few health care systems have grown at less than 6%/yr
• Health in Ontario will grow at 1.9, 2.1 and 2.3%
• Education will grow at 1% - all other programs <1%

• 2.1% may be the new norm – for 5 or even 10 years

• 2.1% rolls out as 0% for hospitals and 4% for community care
• A new funding formula for hospitals which will fund for performance and population need – some will grow, some will shrink
Changing Demand - Current Realities

- The existing system is fragmented
- It is designed to serve the patient with a single acute care episode – the patient from history
- Today’s patient is typically elderly, frail and presenting with multiple, life long, chronic conditions

- These patients spend too much time in acute care beds and are admitted to LTC too soon

- These patients require transitions among multiple components of our health care “system”
Aging Population in the South East

Population Pyramid

The ‘Baby-Boom’ cohort is just reaching 65 years of age. The pressure and impact of this cohort on the long-term care home sector has yet to be fully felt.

The South East LHIN currently has, and will continue to have, the highest percentage of population aged 75+

Percent Aged 75 and Older by LHIN (2013, 2021, 2031)

IF the SE LHIN was to maintain the current ratio\(^1\) of long-stay LTC beds per population aged 75+, we would need to drastically increase the bed complement as a function of population growth and aging.

Solutions are required outside of LTC. The need for services (both LTC and Assisted Living) will increase dramatically over the next 20+ years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population 75+</th>
<th>Long Stay LTC Beds Required</th>
<th>Deficit</th>
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<td>4,609</td>
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<td>51,770</td>
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<td>78,530</td>
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<td>2031</td>
<td>81,270</td>
<td>7,743</td>
<td>3,715</td>
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</table>

\(^1\) 195.3/1,000 aged 75+ as per June 2012 LTC System report
Population Pyramid by SubLHIN, 2011, 2016 & 2021, MOF/Migration Adjusted
These are the patients we now know are the:
- 1% which use 35% of the resources
- 5% which use 66% of the resources
- 10% which use 79% of the resources

But it isn’t these patients that are causing those costs
And it is not our providers that are causing those costs

It is in fact the “system” that is failing these patients and generating these costs.
Quality

**Improving access to high quality care** is our commitment.

- We want all patients to be safe and to receive the right care at the right time from the right provider

- But we also know that when we ask the public about quality, most will say:
  - They had high quality from the professional
  - They had high quality from their provider organization
  - But
  - Most will also say they had poor quality with the system
Current Realities, cont.

These patients require:

• An integrated system of care

• Care coordinators

• A strong, integrated primary care system with same day access

• Clinical and non-clinical services provided in the home or other non-institutional settings — (they don’t want to be in a hospital bed if they don’t need to be there, plus it isn’t safe if they don’t need to be there).
Transforming Health Care

• We can’t save the burning platform by watering edges

• Fussing around the margins will lead to mediocrity

• To achieve improved access to high quality care, we need transformational change – disruptive solutions
Changing the Health System in the SE

- Regional systems of integrated care – horizontal and vertical

- Hospitals working together as regional systems of integrated acute care across the SE (horizontal)
  - i.e. regional systems of integrated cardio-vascular care

- Hospitals, LTC, Mental Health, Primary Care, working together within sub-regional areas to collaboratively serve the new patient with multiple chronic conditions (vertical)
  - i.e. Health Links
Why Integration?

The main benefits of integration are:

• A better patient journey (an aspect of quality care)

• Improved access to high quality care

• More effective use of valued health care resources, shifting funds to direct care, quality care.
Transformation – Things will not be the same

- The Community will often resist change – interpret change as a loss of health care
- Example from the past – laproscopic surgery
- Also, the public generally has trouble believing the shift in emphasis from hospitals to the community can be achieved without loss of care
- Health Leaders, Business Leaders, Health Researchers, need to stand together to help communities and the general public understand change can lead to:
  “improved access to high quality care”
How We See the System Transforming

• We see a health care system that provides access to high quality care through regional systems of integrated care.

• We see organizations with leaders who promote coordination and cooperation across settings and levels of care

• We see a health care system that provides effective care built on evidence and knowledge.

• We see healthcare providers protecting patients from infection; providing them with factual and accurate information so they can direct their care and choose where to receive it.

• We see our residents living longer and healthier lives.
How We See the System Transforming

• We see people getting the right care at the right time at the right place; smoothly moving from hospital to community in a manner that instills confidence and assures good results.

• We see choice, dignity and independence as the drivers of clinical decision-making; with everyone working to keep people safe, healthy and living in their community until it is no longer possible.

• We see a health care system that lives within its financial means, works constantly to improve its capacity, and makes “better care” its driving priority.
Horizontal and Vertical Integration

• We need a matrix of integrated care

• Regional systems of integrated care which offer a common standard of access and delivery across the region within a single sector of care (clinical services roadmap)

• Sub-regional system of integrated care which offer a coordination of care along a continuum of services across various sectors of care (health links)
Clinical Services Roadmap (horizontal integration)

- Seven hospitals and the CCAC committed to ensuring regional systems of care for seven clinical services:
  - Cardiology
  - Mental Health
  - Restorative Care
  - Health Acquired Infections
  - New born and high risk maternal care
  - Emergency Care
  - Surgery
All seven hospitals have worked with the CCAC to adopt the practice of **Home First**

- ALC patients are placed in the community with appropriate care and supports for further assessments and decision re: LTC admissions
- Significant drop in ALC patients
- Rates don’t indicate the true story, due to impact on numerator and denominator
- But more care is being delivered in the home
- And hospital beds are being closed
SMILE

- Seniors Managing Independent Living Easily (SMILE)
- As part of Ontario’s Aging @ Home strategy, the SE LHIN engaged seniors to tell us what would give them and their family the confidence and comfort, for them staying home
- It was less about clinical services and more about not-clinical
- SMILE was developed and grew rapidly
- Provides funding for the patient/family to pay for non-traditional services – ethnic meals, bringing wood into the house, etc.
Behavioural Supports

• LTC patients who in the past experienced behavioural problems often were sent to the ER, with an increase in ER wait times and slowing of patient flow
• As an early adopter, the SE LHIN implemented the Behavioural Supports Organization Program
• All 34 LTC homes signed an agreement
• All were trained and nurse outreach teams were established
• Result: LTC homes are better able to handle behavioural problems => less ER visits
Assisted Living

- When LHINs were first established in 2005, 13 inherited assisted living and/or supportive housing programs for seniors
- The SE did not
- With the growth in the 75+ population at 3% per year, and the high occupancy of its LTC homes, an Assistant Living strategy is being developed which will offer programs to seniors living in common buildings/neighborhoods
- This will add to the continuum of care for the frail elderly and delay admissions to LTC homes and reduce ER visits
Continuum of Care

Frequency of Services

24 hr support and nursing on-site

Frequent Personal Support with visits within a 24 hr period and unscheduled care needs

Scheduled Care

Persons on Wait List Receiving services that exceed service maximums

CCAC Unlimited Support

Assisted Living Services for High Risk

Long-term Care Home

Nursing Care
- 24/7 Supervision
- Hands-on Support with IADLs
- Medication Management

Urgency and Intensity of Service

Scheduled Care:
- Home visits
- Prompt with IADLs
- Professional Services
- Community Services
- Medication Support
- Episodic acute care

Scheduled and Unscheduled Care
- ‘Just-in-time’ support for urgent personal care
- Essential homemaking
- Community Support
- IADL provision
- Medication prompting
- Professional services for chronic conditions

Persons on Wait List Receiving services that exceed service maximums
In the Ontario health system, alignment is achieved by:

- MOH providing provincial priorities to LHINs and LHINs being accountable to MOH
- LHINs providing provincial and locally determined priorities to HSPs and HSPs being accountable to LHINs

- Clear accountabilities, Clear alignment

**Except for Primary Care**
PHC – the weakness in the Model

- No horizontal integration among primary care providers
- There are 4000 of primary care entities in the province
- An average of over 200 per LHIN
- Many different models
- Little linkage between models
- Some entities can offer 24 on-call coverage, some can not
- Some entities can offer diabetes education, some can not,
  Etc.
- So…some patients have better access to PC than others
- Many of these are the frail elderly, with multiple chronic conditions which they will have for life
Further weakness

- Our system does not assist patients with multi-chronic conditions to transition well across levels of care

- We need primary care to be better linked with:
  - Home care
  - Acute care
  - Long-term care
  - Mental Health care
  - Etc.
Key Strategy

- Minister’s Action Plan notes planning and accountability for Primary Care will come to the LHINs.
- We expect individually FHTs, FHOs, NPLC will be eventually be accountable to LHINs.
- **Health Links** – Organizes primary care, provides horizontal integration of primary care entities, allows vertical integration with primary care, acute care, CCACs, MH&A, LTC, public health.
- Health Links are accountable to LHINs.
Health Links Identification

- SE LHIN: started by reviewing the ICES data which indicates there are 70-74 natural groupings of primary care providers throughout the Province
  - ICES data indicates 4 such groupings in the SE
- Then analyzed the ICES data and drilled deeper
  - In the SE drilling deeper into the ICEs data indicates 7 or 8 natural groupings
- Then engaged the primary care community to confirm the number of “hubs”
- Then used a “readiness survey” tool to select primary care providers and other sector providers to determine where to start.
Metrics for Measuring the Success of Health Links

1. Increase number of high risk patients with regular and timely access to primary care provider
2. Reduction of time for referrals from PC to specialist
3. ALC rate to 9% or less.
4. Improved system experience for high risk patients
5. Reduction of 30 day readmission rates.
6. Reduction of average cost of care for high risk patients
7. Reduction of avoidable ED Visits
8. Reduction of time from referral to home visits
9. Reduction of unnecessary admissions to hospital
10. PC follow up 7 days post discharge
11. All high risk patients have coordinated care plans
Summary

• Change has happened:
  • Tougher economy – lowest growth in funding
  • Different patients – needing a coordinated response to their care

• Change will happen:
  • Each health provider will work as an equal member of regional systems of integrated care to ensure we are utilizing our valued resources in the best way to meet the needs of our patients

• We need to study the impact
Possible Research Questions

- How do we measure improvements in the transition points?
- How do we measure the impact of improvements in the transition points?