Living Longer, Living Well

Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario.

Dr. Samir K. Sinha, MD, DPhil, FRCP
Provincial Lead, Ontario’s Seniors Strategy

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Ontario’s Coming of Age

While aging is inevitable, the proportion of Ontario’s population living longer and living well into their later years has never been greater. Our province is also aging faster than ever before. In 2011, there were 1,878,325 Ontarians aged 65 years and older, representing 14.6 per cent of the province’s overall population. However, as the boomers started turning 65 last year, this demographic imperative will continue well into the future. In fact, the number of older Ontarians, defined in this report as those 65 years and older, is expected to double over the next two decades.

Older Ontarians have helped to build our country and our province and remain a vital part of our society. They represent our grandparents, our parents, our uncles and aunts, our brothers and sisters, our neighbours, and our friends. They continuously help shape our society by sharing their experience, knowledge, expertise, and wisdom. They have been contributing to our economy longer than any other age group. Indeed, the contributions of older Ontarians continue to be wide-ranging and significant. They are volunteers, mentors, leaders, caregivers, and skilled workers who offer an abundance of experience to their families, workplaces, and communities. As such, the resilience and sustainability of our society will also depend on their continued contributions.

While older Ontarians are living longer and with less chronic illness or disability than generations before them, the vast majority of older adults have at least one chronic disease or condition. Indeed, as we age, our chances of living with chronic illness or disability will increase. While 77 per cent of older Ontarians recently reported being in good health, we know that there exists a minority who particularly struggle with multiple complex and often inter-related health and social care issues.

To put this in perspective, we know that the top 10 per cent of older Ontarians, characterized as having the most complex issues, accounts for 60 per cent of our annual spending on health care for this population. At the same time, the healthiest 50 per cent of our older population accounts for only six per cent of our overall annual spending on health care for older adults. It is clear, therefore, that the heterogeneity of our older population significantly affects their patterns of use of health, social, and community care services.

We know that older adults in general – and those with complex issues in particular – drive health care costs as they tend to use more expensive and intensive types of services, particularly in acute care settings. Indeed, while accounting for only 14.6 per cent of our current population, nearly half of our health care spending occurs on their behalf. While some warn against “apocalyptic demography,” few jurisdictions have grasped the complexity of illnesses and social challenges that too many older adults face, or the difficulties that this aging demographic will pose for our health, social, and community care delivery systems as they currently exist.

If left unaddressed, our demographic challenge could bankrupt the province. This means our demographic challenge should be seen as a demographic imperative, which amounts to an enormous opportunity for Ontario to better understand and meet the needs of its aging population. If we get this demographic imperative right, we will maintain the sustainability of our health, social, community, and other programs that have come to define us as Ontarians and Canadians, as well as the progressive society that we live in.

“We believe that the time for the development of a totally integrated program for older Ontarians is long overdue.” – Submission from CARE (Caring, Advocacy and Research for the Elderly)

Over the past decade, the Government of Ontario and its ministries have introduced a number of progressive strategies and programs linked with significant investments through initiatives like its Aging at Home Strategy. These have allowed us to better support the needs of our oldest citizens.

Most recently, in 2012, Ontario set out a bold new vision to make the province the healthiest place in North America to grow up and grow old. In striving to better meet the needs of our aging population, we understand that this will be particularly challenging, given our current unprecedented fiscal and demographic challenges. Therefore, to establish the direction we want to take moving forward, we will undoubtedly be required to take stock and thoughtfully examine what we are currently doing, along with understanding where the current and future challenges and opportunities for the province now rest. This will be integral to make the best choices based on our needs, preferences, and values as Ontarians.

Never before have we had such compelling reasons to closely examine the ways in which we serve older Ontarians, their families, and their caregivers. Therefore, in January 2012, the province launched Ontario’s Action Plan for Health Care. It established a new direction for the province’s health care system, with a focus on equity, quality, access, value, and choice to ensure Ontarians receive the right care, in the right place, at the right time. The Action Plan highlighted the development of a Seniors Strategy as a way to establish sustainable best practices and policies at a provincial level that could in turn support the local delivery of health, social, and community care services with a focus on helping older Ontarians to stay healthy and stay at home longer.

The Minister of Health and Long-Term Care announced the appointment of Dr. Samir Sinha as the Provincial Seniors Strategy Expert Lead on May 24, 2012. His mandate was to lead the development and implementation of the Seniors Strategy with the help of a team of dedicated public servants. Our team’s first act was to establish and oversee a comprehensive provincial consultation process that would support the development of findings and recommendations. These would be submitted before the end of the year in the form of a comprehensive report to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors.

In embarking on a journey, with the enormous responsibility to deliver a Seniors Strategy for the province, our team decided the best thing we could do was listen. This came out of a recognition
that what Ontario was doing was unique, as no other jurisdiction in Canada had ever embarked on developing a strategy that dealt as broadly and in such depth with all of the issues related to aging.

“My biggest concern is to be able to stay in my home as long as possible.”
– Seniors Strategy Survey Respondent

As we travelled across the province this summer, we communicated with thousands of older Ontarians, their families and caregivers, municipal leaders and staff, and legions of dedicated health, social and community care providers, and volunteers who work hard to serve the growing needs of older Ontarians every day. These engagements not only helped our team learn so much, but they also positively influenced our thinking on a number of occasions as we came to appreciate the full extent of both the challenges and opportunities that exist for this province and its people, especially given our current fiscal and demographic imperatives.

Through our early work, we quickly came to realize that the development of a Seniors Strategy would need to address issues beyond the health, social, and community care needs of older Ontarians. Indeed, we found those whom we engaged with were as interested in talking about housing, transportation, and social inclusion as they were in health care – most likely because all of these seemingly different areas are inextricably linked to one and other. We also came to appreciate that, despite our vast and diverse geography and peoples, Ontarians share a great deal of commonality in their thinking, values, and preferences related to the province we all aspire to grow up and grow old within. Furthermore, we learned that most older Ontarians today preferred to be addressed as “older adults” or “elders” rather than “seniors.” So what started as an initiative of the Ministry of Health and Long-Term Care quickly evolved into an interministerial effort that was overwhelmingly met with great enthusiasm and support.

We need to continually recognize the aging of Ontario as a success story, but at the same time we need to work towards identifying and addressing the ways we can do better as the needs of older Ontarians continue to evolve over the coming years. Through our engagements just like the Senate Committee on Aging, we heard a clear call to recognize and support the place of older Ontarians as active, healthy, and engaged citizens in our society; a call to afford more older Ontarians the opportunity to age in the place of their choice; and a call to place as much importance on adding life to years, as we do on adding years to life. Above all, we heard a call to recognize our aging population not as a challenge, but rather as an opportunity for Ontario.¹

“Age is not an illness.” – Seniors Strategy Survey Respondent

In the pages that follow, this Seniors Strategy seeks to lay out the findings and recommendations that we believe will help to define and shape, in the most sustainable ways possible, Ontario’s opportunity to achieve its vision to be the healthiest place in North America to grow up and grow old.

Approach Towards Developing Ontario’s Seniors Strategy

Information Gathering

A team to lead the development of the Seniors Strategy was established in the Implementation Branch of the Ministry of Health and Long-Term Care and received additional support from the Ontario Seniors’ Secretariat. The team started its work by conducting a jurisdictional review of the evidence on strategies, approaches, and practices towards meeting the needs of an aging population.

Sources included published and unpublished reports, briefs, data, and analyses from Ontario and beyond, particularly from jurisdictions demonstrating leadership in these areas of focus. In particular, the work of developing the Seniors Strategy was seen as an opportunity to build upon previous ministry and other expert reports that included, in particular:

- Public Services for Ontarians: A Path to Sustainability and Excellence
- Caring for Our Aging Population and Addressing Alternate Level of Care
- Enhancing the Continuum of Care
- Healthy Aging in Canada: A New Vision, A Vital Investment
- Canada’s Aging Population: Seizing the Opportunity

During the subsequent consultation process, a number of additional published and unpublished reports, briefs, data, and analyses were shared with and reviewed by our team.

Stakeholder Consultations

Our team consulted broadly with a wide range of stakeholders over a six-month period to inform the overall findings and recommendations that would support a Seniors Strategy.

Interministerial Consultations

Within the Ministry of Health and Long-Term Care, over 20 branches were consulted for specific input. Ministries across the Government of Ontario were also consulted for feedback on interministerial issues of relevance to older Ontarians, including:

- Ministry of Aboriginal Affairs
- Ministry of Training, Colleges and Universities
- Ministry of Community and Social Services

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• Ontario Seniors’ Secretariat
• Ministry of Finance
• Ministry of Labour
• Ministry of Municipal Affairs and Housing
• Ministry of Transportation

**Provincial Tour and Stakeholder Engagements**

As part of our mandate to consult broadly, we embarked on a provincial tour supported by all 14 Local Health Integration Networks (LHINs) that took us to 19 communities over the months of July, August, September, and October 2012. The goal of the tour was to obtain a better understanding of how local contexts have influenced our common challenges and opportunities to meet the needs of older Ontarians. The tour was equally invaluable in allowing for common and unique issues, priorities, and themes to be identified. It also provided an opportunity to further identify, observe, and understand best practices that currently exist.

Each LHIN visit took place over one or two days, often with multiple site visits in each region. The visits included targeted discussions with LHIN leadership, as well as lead and front-line administrators and health, social, and community care providers who may be working with:

• Community Support Services (CSS)
• Community Care Access Centres (CCACs)
• Long-Term Care (LTC) Homes
• Hospitals
• Community Health Centres
• Aboriginal Health Access Centres (AHACs)
• Family Health Teams (FHTs)
• Nurse Practitioner-Led Clinics (NPLCs) and other primary care models
• Public Health Units
• Emergency Medical Services (EMS).

Municipal officials and members of the public – including patients, caregivers, and advocates – also took part in these engagements or other public forums that provided more of a town-hall format. A listing of the stakeholder organizations that participated in the LHIN Visits is provided in Appendix D.

The range of viewpoints represented in these engagements allowed a broad set of issues to be examined and explored around how best to address the issues most pertinent to older Ontarians. These discussions also allowed our team to account for and consider important rural, urban, geographical, and cultural nuances related to the themes they explored.

Our team further worked with over 95 provincial, national and international stakeholder groups representing older Ontarians, caregivers, provider organizations and agencies, professional bodies, and private for-profit and not-for-profit corporations (See Appendix D) through face-to-face meetings or through written submissions or both. Our team also cultivated relationships with existing expert
panels and committees supporting the work of the government in ways that are related to the needs of older Ontarians. These included:

- Ontario Seniors’ Secretariat Liaison Committee
- Ontario Emergency Department (ED) LHIN Leads Committee
- Ontario Primary Care Physician LHIN Leads Committee
- Ontario Emergency Room/Alternate Level Care (ER/ALC) Expert Panel.

Our team was also able to consult with experts from around the world who gave generously of their time to explain their innovative approaches to care.

To further ensure that every voice possible in Ontario was heard as part of a thoughtful consultation process, a public questionnaire was distributed over the summer. Close to 5,000 people responded. Lastly, to ensure the views of caregivers were understood, the ministry conducted in-depth, structured interviews with 800 caregivers across the province.

In total, it is conservatively estimated that over 5,000 older Ontarians, over 2,500 health, social, and community care providers and municipal officials, and over 1,000 caregivers participated in providing views that were invaluable to shaping the findings and recommendations contained in this report.
Five Principles for a Seniors Strategy

As the Seniors Strategy moves forward to help build a province that values, encourages and promotes the wellness and independence of older Ontarians, it will be vital to ensure that any proposed policies, programs, and services adhere to the five principles that Ontarians told us mattered most to them.

Access

We are spending more on health, social, and community services than ever before, yet older Ontarians, their families, and their caregivers still find it challenging at times to access the right care, in the right place, at the right time. Therefore, when planning, reviewing, and delivering services we need to ask ourselves whether we are ensuring that older Ontarians, their families, and their caregivers can easily access the services and supports they need in a timely and efficient way.

Equity

We recognize that one of our greatest assets is our diversity as a province. Given that diversity is both visible and invisible, we need to ensure that not only are the needs of older Ontarians from different ethnocultural groups acknowledged, but also those from our lesbian, gay, bisexual, transsexual and queer (LGBTQ) communities, those whose abilities are limited, those with special needs, such as the homebound. Therefore, when planning, reviewing, and delivering services, we need to ask ourselves whether we are ensuring, where possible, that older Ontarians from diverse backgrounds are having their needs met in a way that acknowledges their unique needs.

Choice

We offer an incredible variety of supports and services for older Ontarians, yet their ability to understand their options and express their choices is not always as fully realized as it should be. Older Ontarians have the right to know what their options are and, when capable, make informed decisions with which they are comfortable. We never question a younger adult’s right to make good or poor decisions, so we also need to appreciate and acknowledge that older Ontarians should still be supported even if they make informed decisions that allow them to live at risk. Therefore, when planning, reviewing, and delivering services to them, we need to ask ourselves whether we are ensuring that older Ontarians, their families, and their caregivers have as many choices as is reasonable and possible, and whether they are also supported and empowered with the best information to make informed choices.
Value

With our current and future fiscal and demographic imperatives, we need to ensure we are spending our tax dollars in the most effective and efficient ways to help ensure the future sustainability of our systems, programs, and services. Therefore, when planning, reviewing, and delivering services, we need to ask ourselves whether we are ensuring that every dollar we spend is providing the best value possible.

Quality

Within our mandate to control current and future costs, we need to ensure that we never do this at the cost of quality. We are increasingly understanding that better quality care in many cases doesn’t actually cost more; it will not only meet our expectations, but also deliver desired outcomes that governments, service providers, and the public all value. Therefore, when planning, reviewing, and delivering services, we need to ask ourselves whether we are ensuring that a focus on quality is central to the work at hand.

“We need to ensure all current services for older Ontarians are welcoming to people of different races, language groups, sexualities, gender identities, religions and abilities.” – Seniors Strategy Survey Respondent
Summary of Our Overall Findings and Key Recommendations

Supporting the Development of Elder Friendly Communities

Through our consultations, we learned that our communities need to be the foundation of a Seniors Strategy. Therefore, to fulfill the government’s mission to make Ontario the best place to grow up and grow old, we will need to foster the development of elder friendly communities that recognize the great diversity amongst older persons, promotes their inclusion and contributions in all areas of community life, respects their decisions and lifestyle choices, and anticipates and responds flexibly to aging-related needs and preferences.

We also learned that building the strong communities that we desire will require partnerships between municipal governments and the province, especially around the provision of accessible and affordable housing, transportation and health care options that will support more Ontarians to age in the place of their choice.

Key Recommendations:

- The Government of Ontario should support its communities and citizens to ensure they have access to a variety of programs and supports that will enable them to adapt their residences to accommodate their evolving functional needs so that they can continue to age in place whenever possible and for as long as they desire.

- The Ministry of Health and Long-Term Care, in partnership with the Ministry of Transportation and through partnerships with Local Health Integration Networks (LHINs), Municipalities and Community Support Sector agencies, needs to further enhance the development and availability of non-profit, safe, dignified, and consumer-oriented transportation systems for older Ontarians across urban and, wherever possible, rural communities as well.
Promoting Health and Wellness

Through our consultations, we learned that while older Ontarians are living longer and with less chronic illness or disability than the generations before them, they and their families and caregivers want improved access to information and services that can allow them to stay healthy and stay at home longer. While the Government of Ontario and its LHINs and municipalities provide an incredible range of health, social, and community services, too many Ontarians remain unaware of their existence and/or how to access them in ways that are most convenient to them, such as in their language of choice.

We also learned through our consultations how poverty can limit the ability of our poorest older Ontarians to stay healthy and stay independent. While Ontario has done much to reduce poverty levels in older adults to well below national levels, we need to continue to recognize that people have different access to income and wealth and that this can often influence decisions that allow them to stay healthy and stay at home longer. Living longer and living well will also mean that we need to do all that we can to ensure that Ontarians should not be allowed to age in poverty.

We must also put an increased focus on providing more services that promote staying healthy, active, and well-connected with others in ways that are respectful of changing societal needs and preferences and our overall diversity.

**Key Recommendations:**

- The Government of Ontario, through the Ontario Seniors’ Secretariat, should actively portray and promote healthy aging and the benefits of staying active in one’s older age through physical activity, volunteer work, continuous learning, and meaningful employment.

- The Government of Ontario should encourage and support the development of communication systems to ensure that older Ontarians, their families, and their caregivers are aware of the diverse range of programs and services available within their communities and can access information in accessible ways.

- The Ministry of Health and Long-Term Care should support its Local Health Integration Networks (LHINs) to develop more positive and collaborative relationships with their respective municipal councils to increase the number of and strengthen the role of Elderly Person Centres (EPCs) in Ontario.

- The Ministry of Health and Long-Term Care should increase the availability of accessible exercise, falls prevention, and health promotion classes across the province.

- The Government of Ontario should support efforts to ensure all eligible older Ontarians receive the retirement and age-related benefits to which they are entitled by maintaining its current and future commitments to financially support low- and moderate-income older Ontarians.
Strengthening Primary Care for Older Ontarians

Through our consultations, we learned that strengthening the provision of primary care will be essential to securing the health of older Ontarians. As they are likely to have more complex and often inter-related health and social care issues, they will often benefit from a team-based approach to primary care that prioritizes continuous quality improvement. We also learned through our consultations that communication among primary care providers, hospitals, and community care coordinators in particular, is not currently required. This often can create care gaps that everyone agrees should not exist.

We also learned that there still are older Ontarians who cannot easily find a primary care provider. This is especially the case for those who are homebound and would benefit from house calls. We need to do more to improve primary care for older Ontarians by building models of care that deliver high quality care and best serve their needs, while ensuring that every older Ontarian who wants a primary care provider can get one.

Key Recommendations:

- The Ministry of Health and Long-Term Care should promote and develop mechanisms in accordance with legislative/regulatory frameworks to advance the goal that all older Ontarians who want a primary care provider will have one.

- The Ministry of Health and Long-Term Care should ensure that its development of Quality Improvement Plans in Primary Care and Health Links support a core focus around the care of older Ontarians – with an emphasis on supporting primary care access for older adults and focusing attention on areas of care that influence the health and well-being of older adults.

- The Ministry of Health and Long-Term Care should mandate that care coordinators from Community Care Access Centres (CCACs), Community Support Services (CSS), and Community Mental Health agencies providing care or service coordination support must identify and notify a patient’s primary care provider of their name, their role, their contact details, and the services being coordinated for the patient/client.

- The Ministry of Health and Long-Term Care should maintain and improve funding levels to support the provision of house calls by primary care providers.
Enhancing the Provision of Home and Community Care Services

Through our consultations, we learned that providing the right care, in the right place, at the right time means that we will have to strengthen and invest more in our home care and community support services sectors. Providing a wider range of home care, community support services, and affordable housing options will enable us to offer the care and support that will allow more people to remain independent and age in the place of their choice, rather than requiring more costly and sometimes less desirable care or living options.

Ontario’s Aging at Home Strategy was the current government’s first major attempt to invest in a wider range of programs and services that could support the development of a more integrated continuum of care. Continuing and strengthening this commitment to invest more in home care and community services will do much to support Ontarians staying healthy and staying at home longer.

Finally, the development of more progressive, fairer, and sustainable financing systems should be welcomed to support our future care needs, while not only preserving but enhancing overall access, equity, quality, value, and choice around the provision of services. In following the learnings of other provinces, we may identify clear ways that will likely not only allow us to enhance the overall sustainability of our home and community care sector, but also enable us to serve more people as well.

Key Recommendations:

- The Ministry of Health and Long-Term Care should at least maintain its commitment to increase home and community sector funding for this current fiscal year and the next two years by four per cent and is encouraged to invest future additional budget increases and savings achieved through future efficiency gains into its home and community care sector.

- The Ministry of Health and Long-Term Care should support the LHINs, their CCACs and CSS agencies to formalize a Standardized Collaborative Care Model that can allow acuity-based wait-list and care coordination assignments between CCACs and select CSS agencies. This will allow both sectors to provide publicly funded personal support services in each LHIN. This will allow both sector organizations to play to their strengths and better address client needs.

- The Ministry of Health and Long-Term Care should explore the implications of developing an income-based system towards the provision of home care and community support services based on the experiences and learnings of other jurisdictions. Framing this exploration with the goal of a system that can prioritize the principles of access, equity, choice, quality, and value will be integral to this process.

- The Ministry of Health and Long-Term Care should enhance access to clinic-based physiotherapy services in every LHIN, especially for those on limited incomes who often forgo this therapy when prescribed due to their financial means.

- The Ministry of Health and Long-Term Care, in partnership with the Ministry of Municipal Affairs and Housing, should encourage the development of more Assisted Living and Supportive Housing Units as alternatives to Long-Term Care Home placement for those who would benefit most from these environments.
Improving Acute Care for Elders

Through our consultations, we learned that we could do more to ensure that our hospitals are providing the care older Ontarians need, and only when they need it. While older Ontarians account for over half of our hospital care costs, and therefore represent the sector’s greatest users, our hospitals need to do more to prioritize their care. Every hospital in Ontario needs to be a Senior Friendly Hospital and we need to do more to promote the fact that the adoption of elder friendly care processes and models can deliver better patient, provider, and system outcomes, including lower Alternate Level of Care (ALC) rates. Hospitals also told us that they want and need to be better supported on this journey with access to the expertise that will allow them to achieve their goals. Furthermore, advancing innovative process and models that allow us to help older adults stay out of the hospital or return home as soon as possible, when appropriate, with seamless transitions of care, will ensure hospitals can remain effective and efficient parts of our overall health care system.

Key Recommendations:

• The Ministry of Health and Long-Term Care, in collaboration with Local Health Integration Networks (LHINs) and local municipal Emergency Medical Services (EMS) programs should explore the development and expansion of Community Paramedicine programs across Ontario, especially in northern and rural communities. These programs could better support high-users of EMS to avoid emergency department (ED) visits and hospitalizations and potentially delay entry into a long-term care home as well.

• The Ministry of Health and Long-Term Care, with LHINs’ collaboration, should support the development and launch of the Hospital at Home model in Ontario. A successful proof of concept of this model in Ontario will provide the information required to further implement this model across the province if deemed successful.

• The Ministry of Health and Long-Term Care, in partnership with the LHINs, should continue to promote the adoption of Senior Friendly Hospital principles through its accountability agreements with hospitals to aid them in the development of more enhanced care environments for hospitalized older adults that deliver better patient provider and system outcomes.

• The Ministry of Health and Long-Term Care and its LHINs should support hospitals across the province to adopt, implement, and strengthen models and processes of care that deliver better patient and system outcomes for older adults through the implementation of a collaborative coaching program model in partnership with leading hospitals, based on peer support and knowledge transfer and exchange.

• The Ministry of Health and Long-Term Care should continue to work with Health Quality Ontario (HQO) to expedite the implementation of the care transitions standards and processes and their associated outcome and process indicators, as recommended in the Avoidable Hospitalization Advisory Panel’s report Enhancing the Continuum of Care.
Enhancing Ontario’s Long-Term Care Home Environments

Through our consultations, we learned that we can do more to support our long-term care (LTC) homes in evolving to meet the changing needs of older Ontarians. Our long-term care homes provide care to some of the most vulnerable older adults in our society whose care needs require a safe and highly supportive care environment.

We also learned that while a LTC home used to be a one-way destination for persons entering them, more of them are starting to provide a variety of short-term care services that are allowing a greater number of older Ontarians to eventually return home to the community as well.

As the needs and care preferences of older Ontarians evolve, we will need to better understand what types of care and care environments we will require. Furthermore, we will need to ensure that LTC home staff are equipped with the right combination of knowledge and skills to ensure they can provide the best possible care to their residents at all times.

Key Recommendations:

- The Ministry of Health and Long-Term Care should undertake the development of an evidence-informed capacity planning process to meet the needs of current and future eligible long-term care (LTC) populations and others who could be better supported in supportive housing, in assisted living residential environments, or in their own homes with home care.

- The Ministry of Health and Long-Term Care should develop new LTC home-based service models to maximize capacity, increase programs to support older adults living in the community longer, and enhance programs to meet the needs of short- and long-stay residents. This could be more specifically accomplished by:
  a) Increasing short-stay respite and convalescent-care program capacity in LTC homes.
  b) Enabling LTC homes to provide higher levels of care to individuals with complex care needs.
  c) Exploring the ability of LTC homes to serve as community-care hubs that could provide community-oriented services, including home care, that may further assist local residents to age in place.

- The Ministry of Health and Long-Term Care should improve flow to and from LTC home long-stay and short-stay services by reviewing the existing application and transfer processes and policies to:
  a) consider increasing the number and type of homes selected, and
  b) better support potential residents – and when necessary, their substitute decision-makers and care coordinators – in the selection process.
• The Ministry of Health and Long-Term Care should support mechanisms to maximize the knowledge and skills of LTC home staff with additional training opportunities and support them in releasing their time to care through quality and process improvement initiatives through programs such as Residents First, the Behavioural Supports Ontario (BSO) Initiative, the Long-Term Care Best Practice Guideline Coordinator Initiative, and the new Centres for Learning Research and Innovation and Long-Term Care.

• The Ministry of Health and Long-Term Care should enhance the utilization of Nurse-Led Outreach Teams into LTC homes to expand the capability of these homes to effectively meet the care of patients with more complex conditions and proactively identify emerging acute or sub-acute health issues that could subsequently lead to an unscheduled transfer to an emergency department (ED) and hospital admission.

Addressing the Specialized Care Needs of Older Ontarians

Through our consultations, we learned that specialists in geriatric medicine, psychiatry, and palliative medicine prove their worth on a daily basis in supporting older Ontarians, their families, their caregivers, and health, social, and community care providers to better address complex and often inter-related health and social care issues that often threaten one’s ability to age in place and die with dignity.

We also learned that our last organized commitment to supporting the development of specialized geriatric services in Ontario came decades ago. While the current unequal provision of funding to support the provision of specialized geriatric, mental health, and palliative care services across Ontario’s Local Health Integration Networks (LHINs) is limiting the access of older Ontarians to the care they deserve, it is also limiting our ability to attract and recruit geriatricians, geriatric psychiatrists, and specialists in palliative care. We do have clear opportunities in front of us to optimize our resources to address these issues. Furthermore, we should also pursue opportunities to raise awareness amongst those working with older adults of other unique needs shared by older Ontarians in order to enhance the overall care we provide.

Key Recommendations:

• The Ministry of Health and Long-Term Care and its LHINs should establish a provincial working group of geriatricians, care of the elderly family physicians and specialist nurses, allied health professionals, and others to help develop a common provincial vision for the delivery of geriatric services and a prioritization plan to guide local staffing and funding of care models as resources become available.

• The Ministry of Health and Long-Term Care should support its LHINs to leverage the partnerships, momentum, and successes of their Behavioural Supports Ontario (BSO) Initiative to help define what core community geriatric mental health and addictions services need to be funded and delivered. Additionally, a standard approach to assessment, referral, and service delivery models needs to be developed and implemented within and across LHINs.
• The Ministry of Health and Long-Term Care should continue to support its LHINs in broadening the range of palliative care settings available in their regions, including within a patient’s home, hospice, and institutional care settings as well.

• The Ministry of Health and Long-Term Care should encourage the inclusion of questions regarding continence, sexual, oral and nutritional health, and the frequency of falls in all informal and formal tools used to assess the health of older adults.

Medications and Older Ontarians

Through our consultations, we learned that we need to do more to support older Ontarians, as the greatest users of medication in our society, to manage their medication needs. The need of older Ontarians to often take more than one medication each day – and often many each day – puts them at increased risk of adverse medication events due to side effects or medication interactions. We therefore need to do more to improve the knowledge of older Ontarians taking medication, to support safer prescribing practices, and the administration and review of an older person’s medication. We also have to start thinking about how to develop fairer and sustainable financing systems that can still allow us to ensure all Ontarians can access the pharmaceutical therapies they need, regardless of their ability to pay for them.

Key Recommendations:

• The Ministry of Health and Long-Term Care should identify trends regarding inappropriate combinations of drugs and develop best practice guidelines and knowledge transfer mechanisms to improve prescribing practices and reduce the harmful effects of medication interactions in older adults.

• The Ministry of Health and Long-Term Care should conduct a full review of its MedsCheck Program to understand how effective it has been and how this service can be improved to:
  a) better support patients managing with multiple medications, and
  b) provide more added value.

• The Ministry of Health and Long-Term Care should continue its work of reforming the Ontario Drug Benefit (ODB) Program to more directly link benefits to income rather than age, and thereby consider expanding this coverage for all Ontarians.
Caring for Caregivers

Through our consultations, we learned that we need to do more to support caregivers across our province, especially when their presence is the reason why so many older Ontarians have been – and will remain – able to age in their places of choice for as long as possible. However, it should also be noted that while older Ontarians are the greatest recipients of support from a caregiver, they are more likely to be serving as unpaid caregivers as well to both family members and friends. Although caregiving can be personally rewarding, it can also be stressful and expensive and can take an enormous toll on a caregiver’s health and well-being. All Ontarians stand to benefit when caregivers can be supported with information and access to a range of supports which will allow them to continue assisting those they care about.

Key Recommendations:

- The Ministry of Health and Long-Term Care should improve the awareness of services and supports available to unpaid caregivers with improved single points of access. In particular, the ministry should ensure that these single points of access recognize the unique identity and needs of unpaid caregivers that may require information to be presented differently.

- The Ministry of Health and Long-Term Care, in conjunction with the Ministry of Finance and the Ontario Seniors’ Secretariat, should promote the awareness and uptake of various programs (for example, financial benefits and tax credits supporting the financial burdens of unpaid caregiving).

- The Ministry of Health and Long-Term Care should encourage the standardization of services and supports offered through the Alzheimer Society’s First Link program and fully support the implementation of this program in every LHIN across Ontario. This will help ensure that this vital support program and service for older adults and unpaid caregivers affected by dementia is available to all.

Addressing Ageism and Elder Abuse

Through our consultations, we learned that, as a society, we don’t tend to value aging, and hence older Ontarians, as we should. While we have built a progressive society in many ways, overt forms of ageism and even “self-adopted ageism” amongst older Ontarians themselves, are still present. This restricts the options of some to lead healthy and productive lives.

We also learned that while the province has made combating elder abuse a priority, too many older Ontarians remain victims of abuse each year. Better educating Ontarians about what elder abuse is, how to prevent it and how to better support victims can ensure more older Ontarians can live longer and well with the dignity and respect they deserve.
Key Recommendations:

- The Government of Ontario, through the Ontario Seniors’ Secretariat, should adopt a process to ensure that legislation or policies which permit age to influence the access of older Ontarians to any specific service should be identified and reviewed in liaison with older user groups.

- The Government of Ontario should continue its current commitments to its Strategy to Combat Elder Abuse through the supporting partnership of the Ontario Seniors’ Secretariat, Ontario Victim Services Secretariat, Ministry of the Attorney General, and the Ontario Network for the Prevention of Elder Abuse (ONPEA) to support work that:
  a) Seeks to raise public awareness about the abuse and neglect of older adults;
  b) Provides training or front-line staff; and
  c) Coordinates community services to better assist victims of elder abuse in communities across the province.

Addressing the Unique Needs of Older Aboriginal Peoples in Ontario

Through our consultations, we learned that older Aboriginal peoples have unique needs that need to be addressed. The management of chronic diseases coupled with aging has proved to be challenging for Aboriginal peoples living across Ontario. Aboriginal people in Ontario start to struggle with geriatric issues at younger ages than the rest of our society. They also have more challenges to accessing culturally appropriate care and services like other Ontarians from diverse backgrounds as well. We need to make a commitment to better understand and address the unique needs of older Aboriginal people in Ontario.

Key Recommendation:

- The Ministry of Health and Long-Term Care, in partnership with the Ontario Seniors’ Secretariat and the Ministry of Aboriginal Affairs, should commit to a process to meaningfully engage on- and off-reserve Aboriginal peoples and their organizations across Ontario in the development of an Aboriginal Seniors Strategy.
Necessary Enablers to Support a Seniors Strategy for Ontario

Through our consultations, we learned that Ontario’s health, social, and community human resources need to be better prepared and supported to meet the needs of our aging population. The fact that we don’t require any of our schools in Ontario that train our future health, social, and community care providers to formally teach content related to caring for older adults is concerning. Those who are not exposed to caring for or working with older adults will be less confident in their knowledge and skills working with these patients and less prepared to meet their needs or even to choose these areas as a career. A strategy that provides the right education and training opportunities will ensure that Ontario gains an informed workforce that will have the necessary knowledge, skills, and confidence to identify issues of need amongst older adults while delivering them the right care, in the right place, at the right time.

We also learned that research and technology is providing new opportunities to deliver care more efficiently, while enabling increasing numbers of Ontarians to remain more independently at home. Advancing the use of technologies that permit care closer to, or even in the home, and that strengthen the development of integrated assessment, information and referral systems, should be prioritized.

Key Recommendations:

• The Ministry of Health and Long-Term Care in collaboration with the Ministry of Training, Colleges and Universities should support the preparedness of all future health and social care providers to meet the evolving care needs of older Ontarians by requiring that core training programs in Ontario for physicians, nurses, occupational therapists, physiotherapists, social workers, pharmacists, physician assistants, paramedics, personal support workers and other relevant health and social care providers include relevant content and clinical training opportunities in geriatrics.

• The Ministry of Health and Long-Term Care should finalize the development of its recently introduced Alternate Funding Plan (AFP) to support geriatricians in Ontario in a way that doesn’t restrict their numbers, or provide disincentives to those wishing to practice geriatrics.

• The Ministry of Health and Long-Term Care should provide more support to its Personal Support Worker (PSW) workforce by strengthening its new PSW Registry by requiring mandatory registration, requiring a common educational standard for all future registrants, and developing a complaints process that can protect the public and the profession.

• The Ministry of Health and Long-Term Care and its Local Health Integration Networks (LHINs) should require that health, social, and community services providers streamline their assessment and referral processes to:
  a) avoid duplication and burden for patients and clients, and
  b) to promote greater efficiency in the delivery of services.
Establishing the Mandate, Implementing the Strategy

Through our consultations, we learned that Ontario’s coming of age will undoubtedly change the way we do things and force us to make choices as a society as to how best meet the needs of our aging population. As our team sees it, we can react passively to the change ahead of us, or we can proactively anticipate and address these challenges as opportunities to do better. Ontario can be the best place to grow up and grow old, and its commitment to developing its first comprehensive Seniors Strategy can at least provide an initial direction forward based on our current needs, values, and preferences.

To realize a society free of ageism, where older Ontarians, their families, and their caregivers can access the right supports and services, in the right place, at the right time, and where no older Ontarian’s income limits their access to basic services, we need to come together as a province and recognize our opportunity to do better.

We learned through our consultations that the Ontario government and its ministries can play a greater leadership role in advancing the needs of older Ontarians. In advancing a Seniors Strategy, there are many things that will require intra- and interministerial coordination. There are other things that Ontario will need to work on with its municipal, federal, provincial, and territorial partners to also help advance the needs of older Ontarians and Canadians.

Governments can play a powerful role in setting up leadership and governance structures and establishing the rules of engagement that align incentives and accountabilities to allow and encourage different levels of government and sectoral providers to advance common interests. Given that we all have a vested interest in being better able to meet the needs of our aging populations, uniting around the development of a Seniors Strategy will represent an excellent opportunity to do so.

Adequate funding will be a critical enabler to support the successful implementation and ensure long-term sustainability of the strategic recommendations and goals outlined in this report. At the same time, it was clear during the development of these recommendations that they are being made during a period of enormous fiscal restraint. The Government of Ontario, however, is equally committed to ensuring the sustainability and efficiency of its health care system. To this end, each of the recommendations put forward have been applied against the principle of achieving value for Ontarians, and in some areas cost-savings through targeted investments that achieve process improvements, reduce inequities, and ultimately achieve better patient and system outcomes. Most importantly, the recommendations being made in this report have all been conceived with the notion that they can be achieved within existing budgets and resources.

The findings and recommendations presented in this report are but the first step. Indeed, from here the real work will begin. The next step will require direction from the Government of Ontario on its support towards implementing the recommendations outlined in this report. This should then lead to the establishment of clearly articulated implementation timelines and a monitoring system to ensure progress continues to be made.
Key Recommendations:

- The Ministry of Health and Long-Term Care’s Implementation Branch, in partnership with the Ontario Seniors’ Secretariat, should hold overall responsibility to oversee the implementation of the government’s Seniors Strategy. It should be required to report to the ministers quarterly on the progress, challenges, and opportunities being seen through the implementation of the Strategy and develop an annual report that can be shared with the public.

- The Ministry of Health and Long-Term Care should require each Local Health Integration Network (LHIN) to:
  a) appoint a member of its executive team to oversee the implementation of the Seniors Strategy; and
  b) establish a steering committee with a broad base of representation from local health, social, and community care providers, including public health and paramedical providers, local municipal officials, designated French Language Health Planning entities, patients, and caregivers, to help discuss and plan opportunities to further develop and implement services for older Ontarians in their regions.

The main body of this report presents considerably more detailed findings and recommendations that will enable the government to expand upon and provide some specific means of implementing the highlighted themes and recommendations set out in this executive summary.
Chapter 1: Supporting the Development of Elder Friendly Communities
In 2011, the Government of Ontario set out a bold new vision to make Ontario the healthiest place in North America to grow up and grow old. In achieving this vision, we are increasingly coming to recognize how much the communities we live in influence our ability to lead healthy, independent and productive lives. However, we are currently challenged with the fact that the way in which most of our cities, communities, and their services have traditionally been designed, organized, and delivered, often places older adults at a disadvantage, especially those with chronic health issues.

Understanding the Integral Elements of Elder Friendly Communities

In 2006, the World Health Organization (WHO) launched its age friendly communities initiative to promote a more thoughtful approach to the development of communities that could promote the health and well-being of people of all ages, and especially our aging population. This work helped to craft an ideal vision of what cities and communities across the world are striving to now to increasingly make a reality. An elder friendly community is one that recognizes the great diversity amongst older persons, promotes their inclusion and contributions in all areas of community life, respects their decisions and lifestyle choices, and anticipates and responds flexibly to aging-related needs and preferences. Essentially, they are places that encourage active aging by optimizing opportunities for health, participation, and security in order to enhance quality of life as people age.\(^\text{13}\)

As people age, we know that they will have a higher likelihood of requiring support from others to remain in their communities. This additional support could come from a partner, family members, or friends, or through formal home and community services that may be available in their communities. With fewer Ontarians living in intergenerational households or communities, or participating in regularly organized religious or social activities, a growing number of older Ontarians are living socially isolated lives, especially as they come to outlive their spouses, family members, and friends. For these individuals, without the support of home and community services and the presence of enabling living environments, the ability to age in their place of choice becomes an increasing challenge. Sometimes as a result this leads to them moving prematurely into a long-term care home setting.

Making our communities more elder friendly should therefore be understood as a practical response to promote the contributions and well-being of older residents who keep our communities thriving. Adapted environments and services that are accessible to, and inclusive of, older people with varying needs will further encourage them to engage more frequently in community activities. Furthermore, creating a culture that respects and includes older people as well will foster strong connections and personal empowerment.

Accommodating the needs of older people in our communities also makes it possible to better accommodate the needs of all groups, including those with disabilities and the very young. Indeed, as the late Bernard Isaacs, a renowned British geriatrician, famously stated, “Design for the young, and you exclude the old; design for the old and you include everyone.” This principle of universal design essentially allows for the creation of barrier-free environments that enhance and enable the mobility and independence of people with disabilities, young as well as old. Secure neighbourhoods further

allow people of all ages to venture out in confidence to participate in leisure, physical, and social activities. Furthermore, whole communities benefit from the participation of older people in volunteer or paid work. Families, friends, and caregivers also experience less stress when the older persons they care about have the community supports and health services they need.

Across Canada and Ontario, a number of communities have taken part in age friendly community development activities at various levels.\(^\text{14}\) Through these activities, participating communities have learned to assess their level of “age-friendliness,” how to integrate an aging perspective into urban planning, and how to create age friendly environments. The WHO has identified eight domains of community life that influence the quality of life and health of older persons.\(^\text{15}\) We believe that supporting the adoption of these eight domains into the design and development of our communities will help to support the needed transformation of our communities into elder friendly communities. The following pages will now explore these domains in greater detail: respect and social inclusion, social participation, communication and information, civic participation and employment, outdoor spaces and buildings, transportation, housing, and community support and health services.

**Respect and Social Inclusion**

One of Ontario’s greatest strengths is the diversity of its population. Indeed, the fact that over 40 per cent of older Ontarians have immigrated from elsewhere has clearly contributed to the diversity of the province. Older Ontarians come from a variety of ethnocultural and faith communities. We also have older Ontarians from our lesbian, gay, bisexual, transgender and queer communities, as well as those who display a range of physical or cognitive abilities.

In its review of the advantages and/or barriers to developing age friendly communities, the WHO interviewed older adults and found that most reported experiencing conflicting types of behaviour and attitudes towards them. Many felt they were often respected, recognized, and included, while others reported experiencing a lack of consideration at times in the communities and services they engaged with or within their own families.\(^\text{16}\) This clash has been explained by our changing societal and behavioural norms, a growing lack of contact between generations, and widespread ignorance about aging and older people. Language plays a pivotal role in the ability of older adults to communicate with other members of their community. It affects social inclusion, particularly for those who are unilingual in a language that is not spoken by the majority of their community members. Indeed, respect and social inclusion are also influenced by factors such as culture, gender, health and economic status.

The extent to which older adults participate in the social, civic, and economic life of their communities is closely linked to their experience of inclusion.\(^\text{17}\) Communities that recognize these issues and promote social participation and inclusion are better able to protect the health of their citizens, including those who are socially isolated.\(^\text{18}\) Indeed, active and involved older persons are less likely to experience social isolation and more likely to feel connected to their communities. An elder friendly community


\(^{16}\) Ibid.

\(^{17}\) Ibid.

will therefore be one that consistently considers the varying needs of all of its older members to ensure that public services, media, and faith communities are respectful of their different needs and is willing to accommodate them as well.

To support these efforts, the Ontario Seniors’ Secretariat is currently developing a guide to help communities undertake an assessment and develop strategies to become more age friendly, in partnership with the Accessibility Directorate of Ontario (ADO), members of the academic community, as well as other community stakeholders.

**Recommendation:**

1. The Government of Ontario should encourage all of its communities to consider the needs of all of its older members and to ensure that public services, media and faith communities are respectful of the diversity of needs amongst older persons and willing to accommodate them.

**Social Participation**

Social participation and social supports that allow us to maintain meaningful relationships with others are closely linked to good health and well-being throughout life.\(^9\) Therefore, providing opportunities to participate in leisure, social, cultural and spiritual activities gives older adults opportunities to feel respected and engaged and supports the maintenance or establishment of supportive and caring relationships.\(^20\)

Older Ontarians are particularly at risk of becoming socially isolated. We have become a society less likely to live in intergenerational households and communities, and less likely to participate regularly in traditional faith-based or social groups. Therefore, the increased social frailty that can develop with time as a result can put older Ontarians at particular risk of becoming socially isolated, especially if they outlive their spouses or partners, family members, or friends. A report focusing on aging in rural and remote areas of Canada, however, also noted that social isolation can be caused by having a lack of transportation options, amongst other factors.\(^21\) The latest Healthy Aging Survey noted that 27 per cent of its older Ontarian respondents reported they were not socially connected with others, while 17 per cent reported feeling isolated.\(^22\) We know that social isolation can have a significant effect on a person’s overall health and well-being, and therefore finding ways to minimize this in our communities should remain a priority.

There are many ways to encourage social participation in our societies. We are currently seeing an increasing numbers of older adults continue to participate in the workforce, while others pursue additional learning opportunities that are often made available for free or at reduced costs by local

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colleges and universities. Some who stop working take advantage of their increased free time to make even greater contributions in our communities as volunteers, or even as unpaid caregivers to friends and relatives of all ages. Many older adults also pursue meaningful social participation opportunities through engaging in social and physical leisure activities within and beyond their communities as well.

In Ontario, an increasing number of older adults are becoming members of centres across the province that offer programming that specifically caters to the needs of older adults. For many older adults, these centres have proven to be excellent places to encourage social participation, inclusion, and socialization through the strengthening and development of new friendships and connections with other older adults. Improving the availability and accessibility of affordable transportation options and the promotion of existing centres and the development of additional older adult centres across Ontario can help support increased social participation as well. For specialized populations of particularly frail older adults, including those with dementia, the availability of adult day programs, largely run by Community Support Services (CSS) agencies, is also valued, in particular by families and caregivers in providing respite for them, while providing increased socialization opportunities for these older adults as well. In 2011/12, 39,108 older Ontarians participated in day programs offered by CSS agencies.

In those cases where older adults cannot easily leave their own homes or participate in mainstream activities, we need to ensure there are social participation opportunities created for them. A number of CSS agencies across the province organize volunteers to participate in friendly visiting activities, either in person or on the phone, to support housebound older adults. In 2011/12, 49,866 older Ontarians benefitted from 1,237,015 friendly visits paid to them by volunteers working with CSS agencies.

In Focus:

The Home for Life Program, NSM LHIN

One example of a well-regarded program supporting the continued social engagement of frail older adults in the South Georgian Bay area is the North Simcoe Muskoka LHIN’s Home For Life Program. This volunteer-run program, funded through the Aging at Home Strategy, focuses on assisting housebound older adults to stay healthy at home, and reduces social isolation, depression, and avoidable hospitalizations by utilizing a “village” concept of neighbours helping one another. Volunteers engage the older adults they work with by providing socialization through friendly visiting sessions that focus on helping them to learn how to navigate the system, access and set up services that they may need to remain living at home, and also provide support with home exercise and computer training activities.23

23 County of Simcoe, Human Services Committee, County of Simcoe. 2012. Home for Life Briefing for the Minister of Health and Long-Term Care.
Recommendation:

2. The Government of Ontario should encourage all of its communities to support the maintenance and creation of opportunities that support older Ontarians to maintain and develop their social networks.

Civic Participation and Employment

Older Ontarians have acquired a wealth of experience and wisdom, which they should be encouraged to share with their communities. Therefore, promoting the development of ways to encourage and support continued, meaningful participation in the labour force, in volunteer activities, and in community decision-making processes will be integral to the future of any community.

The labour market participation of older Ontarians increased from 6.7 per cent in 2000 to 12.6 per cent in 2011. Encouraging this continued participation allows their wealth of experience and skills to be leveraged for longer periods of time. It can help to increase the overall productivity of various sectors where training new workers to the same standards as these older and more experienced workers can take a long period of time. Older adults already form the core component of our volunteer workforce and their experience, skills, and increased availability of time and flexibility in their schedules, allows them to often play important roles that can be of significant value to organizations. Their experience and skills also enables older adults to make significant contributions to community decision-making efforts.

Volunteerism is not only a way to stay socially engaged and physically active, but also a great way to combat social isolation and promote health. One study has shown that older volunteers are more active and burn more calories, they tend to watch less television, they tend to develop bigger social networks and also achieve better overall health outcomes compared to older non-volunteers. Clearly, volunteering and participating in the workforce are ways older adults can continue to make significant contributions well into their older ages. However, to optimize their participation in the workforce and/or as a volunteer, we also need to ensure that the physical environments where we encourage participation will also be one that supports older adults with functional limitations.

Recommendation:

3. The Government of Ontario should encourage all of its communities to support the maintenance and creation of opportunities that ensure older Ontarians have opportunities to participate in community decision-making, employment and volunteerism that caters to their abilities and interests.

Enhanced Spaces and Environments

While we know that not all older persons have functional limitations or disabilities, the prevalence of cognitive or functional limitations or disabilities in our society is highest amongst older populations. Therefore, we know that the design of physical spaces that does not anticipate the needs of any person with cognitive or functional limitations can create less inclusive environments that can discourage social participation and further enhance social isolation and their related consequences.

Some jurisdictions have moved to developing a more concerted approach to ensure that physical spaces, both indoor and outdoor, and services that are created and delivered in their communities are designed to meet the needs of the widest range of individuals under principles of what is often referred to as universal design. Universal design not only promotes accessibility, but it can also enhance safety by reducing the risk of accidents or injuries. It helps to eliminate design elements that otherwise tend to increase a person’s functional limitations while discouraging them from engaging with poorly designed environments or services. Furthermore, when universal and inclusive design principles are thought about and integrated at the start of the planning process, they can often be incorporated without increasing the overall costs of a project. What is important is that, when planning the development or redesign of spaces or services, jurisdictions ensure that consideration is given to all potential users and their unique needs, and how best to accommodate those right from the start.

A number of jurisdictions have also started to implement planning policies that prioritize the redevelopment of surplus public land or spaces close to other essential amenities and services to further support the housing and social needs of older persons. In providing enhanced accessibility to local amenities and services, these developments have helped older adults on limited incomes and those with functional limitations to stay active and engaged in their local communities and to maintain their independence in their own communities.

Recommendations:

4. The Government of Ontario should encourage all of its communities to adopt the principles of universal or inclusive design to guide the design and development of new buildings and services and the renovations of existing buildings and spaces.

5. The Government of Ontario should encourage its ministries and all communities across the province to adopt policies that encourage the prioritization of surplus land or spaces closer to other essential amenities and services to further support the public housing and social needs of older persons.
Housing Options to Support Aging In Place

Older Ontarians are clear on their preference to age in place and in their own communities for as long as possible. However, it is clear that the options in terms of programs and services we deliver in our communities can heavily influence an older person’s ability to age in the place of their choice. As we strive to create a province that is the healthiest place to grow up and grow old, we need to ask ourselves if older Ontarians have homes that are safe, affordable, and conveniently located while promoting independence as their functional needs change.

Assisted Living and Supportive Housing Services

When limited intermediate assisted living and supportive housing options exist in a community, the choice for a person to remain living in the community relies upon what care and supports they can rally in the community. For those, however, with limited financial means and whose needs surpass what local home and community supports and their families and caregivers can provide for them to stay independent in their own home, the default option is a placement in a long-term care home.

While 420 retirement homes have now been developed in Ontario to meet the increasing needs of older adults who prefer to live in a more supportive care environment, there are many older adults who cannot afford to live in one as an option to better address their needs. For these persons, the presence of supportive housing options becomes even more critical to help ensure that they are able to be supported to remain in their communities longer, since lower income older adults also have a higher likelihood of being institutionalized in long-term care homes. Therefore, ensuring the availability of a range of more affordable assisted living and supportive housing options in the community will be essential to support older adults who want to age in their homes and communities, and delay or avoid admission into long-term care homes.

In 2011-2012, 68,037 older Ontarians were provided care through assisted living and supportive housing programs. The supportive care services provided to those living in these units, usually through CSS agencies, can consist of personal support/attendant services, essential homemaking services, with staff available 24 hours a day to handle regularly scheduled and emergency care needs. While the care needs of many of these individuals are relatively high and would make them eligible for long-term care, the average cost per day of the care provided in these settings last year was $56.21 which translates to $10,716 annually.

If the government chooses to do nothing around the development of alternative assisted living and supportive housing options to long-term care, it will be required to nearly triple the current number of long-term care beds in Ontario to meet the predicted demands for long-term care over the next two decades alone. Given that the annual cost of assisted living and supportive housing is less than a quarter of the annual $47,940 provincial subsidy for long-term care, the obvious value proposition that this presents for the government that is also aligned with what our aging population wants should not be overlooked and obviates exploration. Therefore, the government should seriously consider

developing more of these alternatives that not only cost less, but are also more appropriate to meet the care needs of older Ontarians who also want to remain independent in their communities.

In fact, there is an example of a country that pursued this path with great success: Denmark. In facing the exact same demographic and fiscal imperatives a few decades ago, Denmark pursued a concerted effort to invest more in home and community care services as well as a wider mix of supportive housing options. This not only allowed them to avoid the need to build any new long-term care beds for close to two decades, but it also saw a reduction of 12 per cent in its expenditures on long-term care during this first decade. Therefore, it would make sense for Ontario to seriously consider developing a concerted plan to strategically invest future funding into less costly home and community support options that actually align better with our aging population’s evolving needs and preferences. More on this is discussed in Chapter 6.

Finally, whenever developing supportive housing for older adults or other populations with functional limitations, the necessity of having these facilities being conveniently located to transportation links, community facilities, and other services that support further social participation and engagement should always be considered.

**Home Adaptation Programs**

For many older Ontarians, aging in their own home would continue to be possible if they could be supported to adapt their residences to accommodate their evolving functional needs whenever possible. The Government of Ontario has adopted policies and mechanisms to help individuals adapt their residences. For example, the Ontario Renovates program that is now offered in most municipalities has enabled low-income older adults and their families to make small renovations that maintain the accessibility and livability of their own homes. Unfortunately, when this program was recently transferred to the municipalities, a quarter of them decided not to continue funding it, in favour of other supportive housing services, which has significantly limited the number of options for their residents to age in place. We heard that as a result of disbanding the program, some families were forced to prematurely admit their loved ones to a long-term care home. Therefore, finding a way to ensure that a program such as Ontario Renovates could become universal again would ensure all Ontarians can expect the same opportunities to age in place wherever they live.

In some parts of the province, CSS agencies have started to prioritize home maintenance and repair programs as part of the overall basket of services they provide. In 2011/12, 8,071 older Ontarians took advantage of low-cost services that ranged from yard maintenance to minor home renovations. For many of these individuals, the ability to have others do this work on their behalf has been integral to helping them stay in their own homes. However, these services are not provided throughout the province.

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A recent development that came out of the 2012 Ontario Budget was the announcement and eventual approval of the Healthy Homes Renovation Tax Credit. Given that an increasing number of older adults and their families will be looking to adapt their homes, this tax credit will allow a portion of the renovations to be covered, up to $1,500. While renovations can be quite costly, a number of Ontarians have told us this additional help will be welcome to further support their desire to age in place.

**Affordable Housing for Older Ontarians**

According to reports, almost one in five older adults live near the poverty line, and this is most common among older adults who live alone (especially women who are divorced or separated), women over 80 years of age, visible minorities and immigrants.\(^{30,31}\) Therefore, there is a need to encourage and maintain initiatives that work to provide greater support to lower income older persons – especially those who need more affordable housing options and those who for a variety of unforeseen circumstances may be facing eviction from their homes due to their inability to pay their rent or bills on time. Since 2003, the Government of Ontario has been supporting the creation of over 17,000 additional affordable rental housing units; and provided rental and down payment assistance to over 81,000 households in need.\(^{32}\) Currently, there are a total of 107,294 affordable rental housing units in Ontario, where rent is set at 80 per cent of the market rate, with just over 5,000 older adults currently living in them. Another 75,000 older Ontarian households are living in social housing, where rents are geared-to-income, showing the demand for this sort of housing for a population largely living on fixed-incomes.\(^{33}\)

In 2004, the Ministry of Municipal Affairs and Housing (MMAH) created the Provincial Rent Bank Program, which was designed to prevent the eviction of tenant households that had experienced short-term rent arrears. Since the program’s inception, a total of $44.5 million has helped prevent more than 32,100 low-income households from being evicted due to a missed rent payment. This program is now being consolidated with four other programs run through the Ministry of Community and Social Services as part of a larger recently announced initiative called the Community Homelessness Prevention Initiative (CHPI). In the coming year, municipal services will receive $246 million,\(^{34}\) along with the flexibility to use this funding to better meet the local needs of those who are homeless or at risk of becoming homeless. With poverty still an improving but ongoing concern for some older Ontarians, such programs that provide this type of financial assistance for older adults will continue to be needed so that if faced with such a situation, older Ontarians can receive the short-term support they need to stay at home and in their communities longer, rather than have to choose a crisis placement into a long-term care home or face homelessness.

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\(^{31}\) Ibid.


\(^{33}\) Ibid.

\(^{34}\) Ibid.
In 2011, the Government launched its Investment in Affordable Housing (IAH) program that will provide $480.6 million in federal and provincial funding over four years to create and repair approximately 7,000 affordable housing units across Ontario.\textsuperscript{35} This investment supports seven component programs, including the Ontario Renovates program. While older adults are a priority group in this initiative, as was previously mentioned, municipal service managers have been given the flexibility to select which program components they would like to participate in, based on local housing needs in their communities. Together, it is clear that without them, many older Ontarians would not have been able to age in place, or in their own communities with dignity and respect. Our challenge will be to ensure that as the needs for these services increase, we ensure that we keep them flexible enough to ensure whenever possible that no elder will be left behind.

\textbf{Recommendations:}

6. The Government of Ontario should encourage and support its communities to ensure that there continue to exist a variety of accessible housing options that are safe, affordable, and conveniently located while promoting independence as the functional needs of older Ontarians change.

7. The Government of Ontario should support its communities and citizens to ensure they have access to a variety of programs and supports that enable them to adapt their residences to accommodate their evolving functional needs so that they can continue to age in place whenever possible for as long as they desire.

8. The Ministry of Municipal Affairs and Housing should continue their commitments to their new Community Homelessness Prevention Initiative (CHPI).

\textsuperscript{35} Ibid.
Transportation Options to Support Older Ontarians

Supporting Older Drivers

For many older Ontarians, driving a motorized vehicle has become the primary method they have become reliant upon for travelling around for most of their lives. Therefore, for many older Ontarians, being able to drive is an important way of staying active, independent, and socially connected with others.

According to Statistics Canada, in 2009, 79 per cent of older men and 45 per cent of older women in Ontario reported that their main form of transportation was driving their own vehicle. Interestingly, less than 6 per cent used public transit and 3 per cent walked or used a bicycle, principally because as people get older, travelling as a passenger in a private vehicle becomes their main form of transportation.\(^{36}\) This study also showed that the vast majority of older adults who had a driver’s licence had good or very good visual and auditory capacities and cognitive abilities.

In general, older adults are safe drivers and are involved in fewer collisions than teenage drivers. However, as we age, we may experience cognitive or physical changes that can affect how well we drive. Indeed, the previously mentioned survey by Statistics Canada also demonstrated that of the older adults surveyed who reported not being able to see well enough to read the newspaper or to recognize a friend on the other side of the street, even with glasses, 19 per cent had a driver’s licence and half of them had driven a vehicle in the month prior to the survey. Of the older adults surveyed who had been diagnosed with Alzheimer’s disease or some other form of dementia, 28 per cent had a driver’s licence and nearly three quarters of them had driven a vehicle in the month prior to the survey.\(^{37}\) Ontario statistics show that drivers 80 years and better who are involved in fatal or injurious collisions are more likely to have been driving improperly. Older drivers who sustain injuries through a collision are also more likely to die from them.

In recognizing the need to better support older drivers in assessing their driving capabilities, the Ministry of Transport implemented a license renewal program that emphasizes giving older adults information on aging and how to be safer drivers. It also helps identify drivers who may be unsafe and who may need to limit or stop driving entirely. The current license renewal process requires all older persons to renew their driver’s licence once they turn 80 years of age and then every two years thereafter.\(^{38}\) The renewal process involves three components:

1. A written test to help encourage older adults prepare by refreshing their knowledge of traffic rules and road signs.
2. An accompanying Group Education Session to help improve their overall awareness of driving situations that older adults have the most problems with and how to avoid them.
3. A vision test to make sure that older drivers can see clearly when driving and that eyeglass prescriptions are also up-to-date.


\(^{37}\) Ibid.

If there are indications that an older person may pose a road safety risk, they will have to take a road test. However, having to take a road test does not mean that they will lose their licence. There is no charge for taking the test and the individuals will be allowed to try the test more than once if they are not successful on their first try.

In terms of identifying older drivers at risk because of underlying medical issues, we currently have a reactive system in Ontario that waits until a potential issue is identified, before requiring that the Ministry of Transportation be notified. Under Section 203 of the province’s Highway Traffic Act, physicians in Ontario are required to report any patient who is suffering from a condition that “may make it dangerous for the person to operate a motor vehicle.”39 Through this process, drivers who are reported as being at risk often have their driving privileges suspended, but are given an opportunity to work through a process to get them re-instated.

Given that physicians in Ontario are obligated under law to report drivers suspected of having impaired driving abilities, this process of mandatory reporting is also one that has been acknowledged to create tensions between physicians and their patients. Indeed, not all physicians are comfortable reporting their patients; in fact, many feel awkward in having to report their older patients out of fear that it would damage their relationships with their patients that is essential to the care they provide. According to Dr. Shawn Marshall at the Ottawa Hospital Rehabilitation Centre, “physicians are advocates for their patients and they feel torn unless it’s really, really obvious that the patient will not be able to drive.”40 And, in many cases, even if the physician wants to report their patient, they are often “ill-equipped and poorly trained to do so.”41 In fact, even though most provinces have mandatory reporting systems in place, physicians continue to lack the tools necessary to identify drivers at risk.

The challenge is that there is no straightforward test that can currently be employed to quickly assess an older person’s driving abilities. However, the Canadian Driving Research Initiative for Vehicular Safety in the Elderly (Candrive) is working to use the results of its research initiatives to develop and implement a validated, easy-to-use clinical screening tool that will allow physicians to assess medical fitness to drive in older adults.42 With this tool, it is hoped that the process of assessing patients and advising them when they need to retire from driving can be done in an objective and dignified manner that does not compromise the relationships between physicians and their patients.43

Through our consultations, the idea of considering the development of a graduated licensing system for older adults was also raised. It was suggested for example, that having older adults meet with their primary care provider to be medically certified as being fit to drive as part of their biennial testing and renewal process after the age of 80 could allow health care providers to be seen as partners in helping to work with their patients to support their and the public’s overall safety. Physicians could also support the process, perhaps by being able to suggest for whom a driving test should be considered as part of the renewal assessment process.

41 Ibid.
43 Ibid.
Recommendation:

9. The Ministry of Health and Long-Term Care in partnership with the Ministry of Transportation needs to further review and enhance its education and enforcement policies and initiatives to address public safety and retirement from driving for medically at-risk drivers in ways that are dignified and minimize negatively impacting patient-provider relationships.

Enhancing Transportation Options

When older adults decide to stop driving, it is imperative that we ensure that various alternative and accessible transportation options are in place. Older adults now typically outlive their decision to stop driving by more than a decade. Therefore, programs that help older adults maintain their independence and mobility, and allow them to travel wherever they want to go in the community safely, and in an accessible and affordable way, are extremely important.

In Focus:

**Grand River Transit, Kitchener-Waterloo, WW LHIN**

In many regions across Ontario, local municipalities and community agencies are coming up with innovative ways to better meet the transportation needs of older persons. In the Region of Waterloo, for example, Grand River Transit has developed various transit programs for the region's older residents.

MobilityPLUS is one program that offers a door-to-door accessible service to those who experience physical difficulty accessing conventional services. Approximately 10,000 free rides are provided each month to its registrants. Clients of MobilityPLUS can also utilize TaxiSCRIP, which offers users half-price taxi rides, or free rides on the regular transit system. In offering free rides to their MobilityPLUS Clients, Grand River Transit was able to increase the capacity of its MobilityPLUS Service and save on its overall costs by avoiding the tenfold cost of having to transport someone in a MobilityPLUS vehicle when they could choose the other option.

Waterloo has also developed a weekday commuter bus service to support older adults attending special day programs in the community. This is a hand-in-hand service for older adults with cognitive issues who, while being physically able, cannot travel safely independently.

Grand River Transit also offers a conventional fleet service that is fully low-floor accessible and provides free information sessions about all of its programs and services aimed at older adults. Interested residents are even given travel training – that is, one-to-one or group orientations for those who need support in learning how to use transport services. Furthermore, all Grand River Transit staff receive sensitivity training specific to the needs of people who are older or disabled.

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In Ontario, the CSS agencies play an important role in providing subsidized assisted transportation services to older adults who are not able to access other means of transport. These services support older adults to live independently in their communities and enable them to attend medical appointments, run errands, and attend social outings with their friends. In 2011/12, 123,795 older Ontarians benefitted from 1,720,602 rides through these programs. Nevertheless, our challenge in Ontario is that each program varies somewhat in the types of services they provide, while the cost of services varies greatly as well. These services are vital to helping people remain independent in the community, preventing social isolation, and ensuring that individuals can access the care they need. There are opportunities to learn from other jurisdictions on ways in which other non-profit, dignified, and consumer-oriented transportation systems have been developed.

**Recommendation:**

10. The Ministry of Health and Long-Term Care, in partnership with the Ministry of Transportation and through partnerships with LHINs, municipalities and Community Support Services agencies, need to further enhance the development and availability of non-profit, safe, dignified, and consumer-oriented transportation systems for older Ontarians across urban and wherever possible rural communities as well.

**Communications and Information**

As we strive to create a province that is the healthiest place to grow up and grow old, we need to ensure that older Ontarians, their families, and their caregivers are aware of the diverse range of programs and services available within their communities and communicate this information to them in accessible ways. In designing effective communication systems, we also need to ensure we understand what influences the ability of an older adult, their families, and their caregivers to access information and we should be sure we challenge our assumptions related to the communication preferences of older adults as well.

Currently, in addition to having a number of programs and services available in our communities, we have a number of information access points established to support them. However, many older adults, their families, and their caregivers are not sure which information access point is the right one, and sometimes may remain unaware of the best one to access for their needs. Furthermore, certain providers don’t necessarily know how best to access the right information around particular programs or services for their patients or clients.

Throughout our consultations, we heard how many individuals are overwhelmed by the sheer number of information access points. They indicated their preference for fewer points that would likely lead them to the range of programs and services they would like to interact with. In determining the best way to develop appropriate information access points, we will also have to keep in mind that the

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46 Ibid.
evolving needs and preferences of older adults and the ways they feel comfortable in communicating with others is rapidly evolving as well. While delivering information through the Internet is becoming a preferred mode of communication, we were reminded during our consultations that a reliance on web-based information assumes a basic level of literacy and a person’s ability to access the Internet. Therefore, we learned that the government must remain broad in its thinking around planning its communication strategies to ensure that we understand the different ways in which the changing older adult demographic wishes to access information and communicate with others. Therefore, a robust system of communication that includes an appropriate variety of print, phone, and Internet-based communication tools, that are available at any time and ideally in one’s language of choice, needs to be supported whenever possible and when it makes sense to do so.

“How many times do I hear ‘I had no idea these services existed,’ never mind where to access them, especially since increasingly our demographic is multicultural with people from other countries who have no or little concept of these services.”

– Seniors Strategy Survey Respondent

Over the past few years, Ontario has established some examples of robust information and referral services that could be leveraged to improve access to information around health, social, and community services for older adults, their families, and their caregivers. One such example is Ontario’s 211 telephone information service which is available provincewide. The service offers information to callers seeking information on health, social, and community services, mental health and addiction programs, government services, financial and income assistance, and employment services. It is available 24 hours a day, 7 days a week and in over 150 languages and dialects. Further discussion on the coordination of resources and information is provided in subsequent chapters as well.

**Recommendation:**

11. The Government of Ontario should encourage and support the development of communication systems to ensure that older Ontarians, their families, and caregivers are aware of the diverse range of programs and services available within their communities and ensure that information is communicated in accessible ways.
The eighth principle that underpins the concept of elder friendly communities is that older adults have access to the health, social and community services they need to stay healthy and independent. For the purposes of this report, in recognizing the heterogeneity of older Ontarians and how age does not always correlate to health status or needs, we decided to categorize the older population into four separate categories:

**Healthy Older Adults with Minimal or No Health Issues and Needs**
These older adults are not suffering from chronic health issues, and their overall health is stable. Their memory and cognitive abilities are good, and they can get around easily by themselves and take care of their own personal care needs. They are unlikely to be receiving any home care or community support services. In addition to being in mentally and physically good shape, they are likely to be active in their communities and have the support of a good social network.

**Older Adults with Chronic and Stable Health Issues and Needs**
Most of the older adults in this category have at least one chronic health issue, but their overall health remains relatively stable. For the most part, their memory and cognitive abilities are good, and they can get around easily by themselves and take care of their own personal care needs, although sometimes they may need assistance. To assist with their occasional needs, they will likely look to some of the community support services available locally in their communities or to their friends, families or neighbours to provide it. They are likely to be active in their communities and have the support of a good social network.

**Older Adults with Chronic and Unstable Health Issues and Needs**
Most of the older adults in this category likely have two or more chronic health issues, and their overall health remains relatively unstable. For the most part, their memory and cognitive abilities are good, and they can get around by themselves and take care of their own personal care needs, but they are more likely in need of assistance. They may be receiving some home care and community support services, and are more likely to look to their friends, families or neighbours to provide assistance. They are more likely to be interacting with various health, social, and community care providers, and thus are at increased risk of the complications that occur when care transitions are not handled well. They are less likely to be as active in their communities than those in the previous categories and their health issues may limit their abilities to maintain a good social network.
Older Adults with Complex Care Issues and Needs

Most of the older adults in this category likely have multiple chronic health issues, and their overall health is likely characterized as unstable and often necessitates urgent visits to the hospitals. They may be more likely to have memory and mood issues, and they likely need the assistance and support of others to get around and to help them manage their personal care needs and are more likely to be living in a residential care facility, supportive housing or are dependent on a lot of home care and community support services and the help of an unpaid caregiver. They are likely to be frequently interacting with various health, social, and community care providers at the same time. They are at significant risk of complications that occur when communication between their providers are not handled well, especially during care transitions that raise care coordination and medication management issues. They are not likely to be active in their communities as those in the previous categories and their complex health issues may severely limit their abilities to maintain a good social network through which they can rely on the social support of others.

The following chapters will more fully address this principle and outline in particular a number of recommendations that will promote healthy aging and support older Ontarians to age in the place of their choice and to receive the right care, in the right place, at the right time, and by the right provider.
Chapter 2: Promoting Health and Wellness
Living Longer, Living Well

Ontarians are now living longer than ever before. This is largely due to the significant increases in life expectancy we have gained as a society over the last number of years. While the average Ontarian could have expected to live to 51 years of age in 1900, today they can count on living until at least 79 and 82 years of age for men and women respectively, and these numbers are only predicted to climb. In fact, currently centenarians represent the second fastest growing age group, with their numbers expected to triple over the coming two decades.

The extent to which a longer life will be a healthier one rather than one that contains more years of chronic illness or disability will have a significant impact on the future demand for health and social services. While we can expect to live our later years in periods of both health and illness, the evidence is showing us that most of our gains in life expectancy appear to be occurring without disability and their associated health care expenditure. What has largely been attributed to this continuing trend, characterized as a “compression of morbidity,” is that the rate of decline in disabled life years continues to be a faster one than the increase in total expected years of life. This should help to lessen the upward demographic pressure of our aging population on health expenditures.

In Canada, the term “healthy aging” has been described as the process of optimizing opportunities for physical, social, and mental health to enable older adults to take an active part in our society without discrimination and to enjoy independence and quality of life. As such, there is much that can be done by governments through various policies, programs, and interventions to maintain and improve conditions that promote healthy aging.

The importance of older adults staying healthy is well understood. However, only 43 per cent of older Ontarians, even though it does represent an increase from 36.9 per cent a decade ago, reported having very good or excellent health in the most recent Canadian Healthy Aging Survey. This proportion decreases as age increased and only 36 per cent of those 85 years of age and better reported that their health was very good or excellent. To understand their responses better, the Healthy Aging Survey also examined a number of factors that have been shown to impact the health status of older adults, including their lifestyles, functional status, levels of social support, and satisfaction with life that are presented in Figure 2.1.
Figure 2.1 The Self-Reported Health Status of Older Ontarians

Figure 2.1 shows that even though 92 per cent of older Ontarians reported having at least one chronic condition, 87 per cent participated in recreational physical activities, 75 per cent partook in weekly social activities, and overall 77 per cent still perceived their health to be good or better, while 74 per cent reported being satisfied with life.

However, within this group 34 per cent were found to be at high nutritional risk, 31 per cent reported having issues with pain, 24 per cent reported having a functional impairment, and 13 per cent reported having poor oral health.

Furthermore, issues of support and isolation were also apparent for about a fifth of those surveyed, with 27 per cent reporting they were not socially connected with others, 20 per cent reporting they lacked support to carry out their cores, and 17 per cent reported feeling isolated.

The Healthy Aging Survey also compared the reported health status of its older respondents by various socioeconomic characteristics, including: household income and education, immigrant status, marital status and living arrangements, and whether they lived in an urban or rural area.
Table 2.1 shows the impact of these socioeconomic characteristics on their health. The checkmarks (✓) depict where the socioeconomic variables have a statistically significant positive impact on the health measures and the cross (‡) depicts a statistically significant negative impact.

**Table 2.1 The Impact of Socioeconomic Characteristics on Health Outcomes of Older Ontarians**

<table>
<thead>
<tr>
<th>Health measure</th>
<th>Socioeconomic variables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Having higher education</td>
</tr>
<tr>
<td></td>
<td>Being in the highest income quintile</td>
</tr>
<tr>
<td></td>
<td>Being an immigrant</td>
</tr>
<tr>
<td></td>
<td>Being married or common-law</td>
</tr>
<tr>
<td></td>
<td>Living with someone (i.e., not alone)</td>
</tr>
<tr>
<td></td>
<td>Living in a rural area</td>
</tr>
<tr>
<td>Overall health</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Perceived health</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Oral health</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Presence of chronic conditions</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Functioning</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Functional impairment</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Disability</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Presence of pain</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Ability to eat without discomfort</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Healthy life style</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>History of smoking</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Participation in leisure physical activities</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Nutritional risk</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Eating 5+ servings of fruit and vegetables a day</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Social support</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Weekly social activity</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Support for chores</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Support for personal problems</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Life satisfaction</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Have company</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Feelings of isolation</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
</tbody>
</table>

✓ Socioeconomic variables have a negative impact on health measures.
‡ Socioeconomic variables have a positive impact on health measures.
Source: Healthy Aging Survey, Statistics Canada, 2008/09
Some key findings from Table 2.1 show that older Ontarians 65 years and better from households, where one or more member has a postsecondary education, were significantly healthier than those older adults from households with less than secondary school graduation in 10 out of the 17 health measures included in this analysis. A similar pattern, with the exception of smoking status, was observed between older Ontarians with the highest income quintile versus those in the lowest income quintile. Older Ontarians who were married or in common-law partnerships were significantly healthier in 12 out of the 17 health measures. Similarly, those living with someone were significantly healthier than those living alone in 9 out of the 17 health measures. Interestingly, it should be noted that immigration status didn’t impact one’s health that much and that those older Ontarians living in rural areas were more likely than urban residents to have good oral health, to eat without discomfort, and to consume five or more servings of fruit and vegetables per day.

Together these results provide a positive and improving picture of the overall health status of older Ontarians. It is also clear that we need to encourage and support them in their efforts to stay healthy and in overcoming barriers to healthy aging. Mounting evidence suggests that there are a number of things we can do to promote living longer and living well. A recent landmark study demonstrated that in addition to living a healthy lifestyle, participating in regular physical activities and maintaining and building strong social networks are all significant predictors of overall survival even in the very elderly. Therefore, a Seniors Strategy should prioritize healthy aging by supporting more older Ontarians in living healthy and productive lives. This will be important when such an approach, supported by programs that promote health and wellness, can both delay and minimize the severity of chronic conditions and disabilities experienced later in life and reduce the overall demand for health, social, and community care services.

Currently, there are various dedicated programs and places in our communities that help older Ontarians maintain their independence and stay connected with others in their communities. Strategies and initiatives that create supportive environments for social engagement, physical activity, healthy eating, and safe living are highly cost-effective and can have a positive impact on the health and well-being of all ages and of older Ontarians in particular. Therefore, supporting the increased utilization of wellness and health promotion programs and resources by older adults should be encouraged to help further advance overall health outcomes and alleviate future needs for health, social, and community care services.

**Recommendation:**

12. The Government of Ontario, through its Seniors’ Secretariat, should actively portray and promote healthy aging and the benefits of staying active in one’s older age through physical activity, volunteer work, continuous learning, and meaningful employment.

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Health Promotion and Prevention Opportunities for Older Ontarians

Health Promotion Initiatives to Support Healthy Aging

Leveraging and expanding existing investments in health promotion and disease prevention will support independence and encourage the greater involvement of older adults within their communities. Ontario's Public Health Units, in partnership with other community organizations, have taken a leadership role in delivering a variety of health promotion and education programs that emphasize healthy lifestyles that try to address modifiable barriers to healthy aging through behavioural risk factor medication to reduce the burden of chronic diseases, avoiding injury through the prevention of falls, and reducing the risk of adverse medication events through promoting safer medication use.

“Educate, Educate, Educate. The sooner in life we become knowledgeable the more effective we can be in prevention and optimum health strategies and lifestyle choices.” – Seniors Strategy Survey Respondent

Those behavioural risk factors, including smoking, poor diet, alcohol consumption, and being overweight or obese often predispose individuals to health problems and can contribute to chronic conditions and poor general health, both directly and indirectly. In the Healthy Aging Survey 57 per cent of older Ontarians were overweight or obese, 34 per cent were considered to be at a high nutritional risk, 9 per cent were regular smokers and 4.5 per cent engaged in heavy drinking.

Therefore, with a growing interest in improving health and wellness of older Ontarians at the community level, a number of initiatives have been developed that present an opportunity to be leveraged to support and promote healthy aging.

The Healthy Communities Fund (HCF) is one initiative that has been designed to help fund projects that support health promotion priorities, including physical activity, healthy eating, mental health, the reduction of tobacco use and exposure, the prevention of alcohol/substance misuse, and the prevention of injuries. Each of these topics touched upon the essential elements of healthy aging, so this fund presents an opportunity to deliver programming in these areas specifically for older adults.

Seniors Information and Active Living Fairs, developed in partnership between the Older Adult Centres' Association of Ontario (OACAO) and the Ontario Seniors' Secretariat (OSS), represent another exemplary health promotion initiative that engages older Ontarians around adopting healthy aging practices and active lifestyles, while also raising awareness of additional supports and services that are available to help them live independently in the community. To date there have been close to 200 fairs held across the province, while last year 30 fairs were able to attract and engage 7,000 older Ontarians.

Over the past few years, the ministry has funded workshops across Ontario to provide persons with or at risk of developing chronic diseases an opportunity to learn how to better self-manage their overall health. In using the Stanford Chronic Disease Management Self-Management Program model, these workshops provided a consistent provincial standard of self-management support that has already
helped to empower and prepare older Ontarians to play a greater role in their management of chronic health issues, daily health care decisions, and risk factors.

**Essential Immunizations for Older Ontarians**

Every Ontarian, but especially older Ontarians, should be encouraged to protect themselves by obtaining the proper vaccinations. As people age, their immune systems weaken, which makes them even more susceptible to certain infectious diseases. While it is common knowledge that immunizations are important at an early age, we often forget that our protection against certain infectious diseases can weaken over time and that we become susceptible to others later in life. Maintaining an appropriate immunization schedule therefore needs to be viewed as a lifelong process that all older persons should be encouraged to participate in, just as we do with younger Ontarians.

The decision to publicly fund vaccines is determined by many complex factors such as patterns of disease, vaccine effectiveness and safety, program delivery, recommendations from national and provincial expert immunization groups, cost effectiveness, and impact on the health system. Currently influenza immunization rates are falling in Ontario, with 68.6 per cent of older Ontarians reporting they received the influenza vaccine in the previous year, compared to 74.2 per cent ten years earlier. Furthermore, the coverage rates for pneumococcal and tetanus immunization in Canada among older adults are much lower, at around 40 per cent per cent and 30 per cent respectively, even though they are publicly funded vaccines and have been shown to be effective in reducing late life illness and its associated morbidity and mortality.

Another vaccine that is targeted specifically towards older adults is the shingles vaccine. In Canada each year, there are 130,000 new cases of herpes zoster, or as it is commonly called shingles, which significantly affects quality of life and functional status, with an increasing risk for older adults. The discomfort of shingles can persist for months after the acute phase and it could lead to severe complications and even death. Evidence suggests that the shingles vaccine can reduce the development of herpes zoster by 50 per cent and postherpetic neuralgia by 67 per cent, and is likely to be cost-effective, especially for older adults 65 years and better. Yet it is underused, with less than 10 per cent of potential recipients being vaccinated. In this case, the low vaccination rate is largely due to the fact that the shingles vaccine is not publicly funded in any Canadian jurisdiction, including Ontario. This is principally because of its particular need to be kept frozen and stored at a specific temperature to remain potent, so the concern about potential wastage is too great at this time.


Overall, vaccination rates amongst older Ontarians can be further improved by bolstering our current education and communication efforts with the public and health care providers. It is important for everyone to realize the importance of obtaining the proper immunizations early to prevent illness and the risks of serious morbidity and mortality that can occur later due to the health complications that often accompany these infections amongst the older population. An opportunity to encourage the tracking of vaccination rates in future primary care quality frameworks may also help to promote these evidence-based interventions as part of routine practice.

Recommendations:

13. The Ministry of Health and Long-Term Care should support the development of a series of standardized guides and tools aimed at supporting older Ontarians in managing their own current and future care needs, preventing disease, and promoting wellness.

14. The Ministry of Health and Long-Term Care should build on existing public health and health promotion initiatives to encourage healthy aging and the active involvement of older Ontarians in the community. This should be accomplished by:

   a) Ensuring ministry-funded local self-management programs use the Stanford Chronic Disease Management Self-Management Program model across all Local Health Integration Networks (LHINs) to target and support older Ontarians with chronic health issues.

   b) Leverage existing investments such as the Healthy Communities Fund provincial grants stream to prioritize and enhance initiatives that help older Ontarians to stay healthy, including physical activities, healthy eating, recreational activities, etc.

   c) Expanding the number of “Seniors Information and Active Living Fairs” hosted annually while optimizing their programming to address the needs of different ethnocultural groups and populations with unique needs.

   d) Improving the uptake of publicly funded vaccines through the development of increased awareness, and improved access around these vaccines. Vaccination rates should be publicly reported at the Health Links, LHINs, and Public Health Unit levels.

   e) Improving the uptake of the shingles vaccine through the development of increased awareness. The option to publicly fund this vaccine should be reviewed when a more stable vaccine is available.
Improving Access to Information on Health, Social and Community Services

We heard overwhelmingly that there remains a need for the better coordination of information about the resources and services that are available for older Ontarians, their families, and their caregivers. In our consultations with older adults and caregivers, they routinely reported finding it to be a continuous challenge to access information, and to understand and navigate the various health, social, and community services that exist. This was even more of an issue for those for whom English is not their preferred language to communicate in.

The challenge in accessing information is only further intensified by the inherent complexity of our health, social, and community care systems. In addition, among adult age groups, older adults make up the smallest proportion of individuals with proficient health literacy skills. Older adults, their families, and their caregivers, further reported all too often becoming easily confused by the sheer number of information resources available with varying perspectives and their uncertainty of the validity of the information being presented to them. Therefore, addressing the myriad of information needs of older adults, their families, and their caregivers through the development of dedicated information channels would be a good first step to enable faster knowledge dissemination and more efficient sharing of information on services available to support them.

Recommendation:

15. The Ministry of Health and Long-Term Care should enhance 24/7 access to information about health, social and community services in as many languages as possible through a single provincewide phone line and web-based portal. This can be accomplished by:

   a) Establishing 211 as the single principal number Ontarians could call to gain access information about and referrals to health, social, and community service providers.

   b) Establishing a centrally maintained website like Your Health Care Options as the single web-based window to information about health, social, and community services.

Evolving the Role of Elderly Persons Centres in Ontario

While many Ontarians haven’t heard of them, for many of the 250,000 older adults who are members of Elderly Persons Centres (EPCs), these centres have come to represent a “home away from home.” Governed through the Elderly Persons Centres Act, this provincial program is administered through the Ministry of Health and Long-Term Care. It establishes partnerships with local municipalities, to support the maintenance, operations and programming of these centres, which have come to serve as vital community hubs that offer opportunities for older Ontarians to stay engaged in their communities through recreational, social, and informational activities. While they differ in size, a number of EPCs have also demonstrated their ability to serve as formal and informal points of access to information.

and support from existing health, social, and community care and support services. For this reason, EPCs have been highlighted as an entity that can help prevent older adults from entering the health care system unnecessarily.  

EPCs contribute significantly to the physical health and emotional well-being of older Ontarians by allowing them to remain socially connected while providing them with opportunities to remain active through programs that include a focus on health promotion and wellness. The Older Adult Centres’ Association of Ontario (OACAO), which represents many of the province’s 272 EPCs and others, reports that more than 65 per cent of its members visit their local centres daily or two to three times a week. Fitness and health promotion classes are among the top programming areas currently being utilized by older Ontarians at these centres, with high satisfaction rates being reported amongst users. In fact, over 90 per cent of members reported feeling more connected to others and over 80 per cent reported that they maintained or improved their health by participating in their local EPC programs.

“Community centres provide a vital range of services to seniors from exercise classes to information sessions on diabetes, nutrition, Alzheimer’s, etc. Please maintain these facilities for older adults.” – Seniors Strategy Survey Respondent

The need for healthy and supportive environments is at the core of healthy aging, and with more communities wishing to establish EPCs, the province should encourage more to be established, especially in rural/remote areas where access to recreational, social, and informational activities, as well as health care and community support services is more limited. Furthermore, in order to accurately reflect the evolving role of EPCs and to increase their visibility through consistent branding, the province should consider re-branding them as “Older Adult Centres,” which many of the older persons we consulted with indicated to us was a more preferential name.

EPCs should also be promoted as community hubs for older adults and those community organizations or health, social, and community care providers looking to engage meaningfully with older adults. It is also clear that we need to increase awareness, amongst health and social service providers, older adults, and the general public, of the existence and mandate of EPCs. Providing EPCs with the flexibility to become approved agencies under the Home Care and Community Services Act could also allow for them to receive direct funding from the Local Health Integration Networks (LHINs) to expand their capacity to deliver health and social services that may complement their other programs and activities.

With an aging population, a provincial expansion of the EPCs and an expansion of their capabilities could allow them to play a much greater role in the future delivery of health, social, and community care services while better meeting the particular needs of each community they serve. With current spending of $11.5 million annually to support 272 EPCs, these centres clearly represent an initiative that appears to be delivering a huge return on investment. Given the potential value and ability of EPCs to fill a greater role in the continuum of care, opportunities to enhance the appropriate integration of EPCs with the rest of the system should be explored, but not at the risk of losing the informal atmosphere and social aspects that attract many to these centres in the first place.

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Falls in older adults are common with 33 per cent of community-dwelling older adults and 50 per cent of those 80 years and better, report sustaining a fall on an annual basis. Falls are often attributed to a complex interaction of risk factors that include chronic and acute illness, mobility or balance issues, medication, and cognitive impairment. As well, older adults who live alone are at greater risk for falls.

Falls are also a growing concern because injuries from falls can threaten an older person’s mobility and confidence, along with their capacity for independent living. Thirty per cent of older adults who fell reported being worried that they might fall again, and of those, more than 40 per cent stopped participating in activities they used to do as a result of this concern. This helps to explain why falls are a significant driver of long-term care home admissions, with 40 per cent prompted as a result of a fall. Falls also represent a leading cause of hospital admissions for trauma and deaths amongst older Ontarians.

In 2011-12, there were 107,858 falls-related emergency department visits made by older adults in Ontario, which represents a seven per cent increase over the past decade. What is encouraging is that while 26,602 older adults were hospitalized last year as a result of a fall, which often require longer than usual hospital admissions, this represents a 12 per cent decrease over the past decade when taking population aging into account. This probably is also due to the fact that rates of hospitalization with hip fractures have also decreased by 20 per cent over the past decade when also taking population aging into account.

Nevertheless, there has been a growing interest in developing falls prevention strategies to help older adults reduce their risk factors for and the overall incidence of falls, understanding that this could also significantly reduce their overall burden on the health care system. Indeed, the evidence suggests that a reduction in falls by 20 per cent could result in an estimated 4,000 fewer hospital stays in Ontario, leading to an estimated savings of between $115 million to $157 million.

In 2010, Ontario’s LHINs and Public Health Units partnered to start developing an Integrated Provincial Falls Prevention Framework. Most falls are avoidable with proper education, awareness, screening, assessment, intervention, and prevention activities. Therefore, the framework recommends that while the causes of falls can be multifactorial in nature, one of the best ways to prevent falls is to encourage the participation of older adults in regular physical activities, especially those that maintain and improve balance and strength.

This work is now promoting the idea that even more falls prevention classes should be made available and that these classes should occur in community settings that are publicly accessible using a standardized curriculum. Across Ontario, EPCs deliver a significant number of group exercise classes that are free and designed to cater to the needs of older adults. With falls prevention being an important part of helping older Ontarians stay healthy and stay home longer, a number of centres are now starting to offer falls prevention classes as well. Therefore, as the province looks to its EPCs to play a greater role in public health and health promotion activities, these centres could be well positioned to offer more exercise and falls prevention classes in partnership with local Community Support Services (CSS) agencies and others.

**Recommendations:**

16. The Ministry of Health and Long-Term Care should support its LHINs to develop more positive and collaborative relationships with their respective Municipal Councils to increase the number of and strengthen the role of Elderly Persons Centres (EPCs) in Ontario. This should be accomplished by:

   a) Increasing the number of EPCs and rebranding them as “Older Adult Centres” (OACs) to develop a more consistent identity for them to increase their visibility and enhance the public’s understanding of their role.

   b) Promoting the role EPCs can play as community hubs for older Ontarians and for those community organizations or health, social, and community care providers looking to engage meaningfully with older adults.

17. The Ministry of Health and Long-Term Care should consider approving as approved agencies under the Home Care and Community Services Act, 1994 the charitable corporations that currently operate EPCs so that these corporations can become the direct providers of a wider range of programs/activities.

18. The Ministry of Health and Long-Term Care should increase the availability of accessible exercise, falls prevention and health promotion classes across the province. This should be accomplished by:

   a) Having LHINs work with their local Public Health Units to fund a single community/provider organization to serve as a lead agency to deliver this programming according to provincially guided curriculums and standards.

   b) Expanding opportunities to deliver these programs in EPCs and in other publicly accessible venues in the community. EPCs should serve as the venue for at least 25 per cent of the classes funded in each LHIN to help foster better links between them and health, social, and community care providers.
Poverty Reduction for Older Ontarians

The Canadian Government in general and the Government of Ontario in particular have made a great deal of progress to ensure that older Ontarians do not fall into poverty. Over the past few decades, the province has seen its rate of lower income older Ontarians fall from a high of 33 per cent in 1978 to a low of two per cent in 1995. More recently, this rate climbed to 8.8 per cent in 2008, because of the recent economic downturn. It has since come down to 8.1 per cent in 2010, compared to 12.3 per cent nationally, and appears to be continuing to decrease overall once again in Ontario. The overall drop over the last thirty years has largely been attributed to the maturation of the nation’s retirement income system during which the real average after-tax income of older households increased from $46,900 to $56,200 during this time period. Nevertheless, real gender discrepancies still exist as the average after-tax income for older men continues to be higher than that for older women, at $38,100 and $30,700 respectively.

Overall, poverty rates in older Ontarians remain well below those of children and adults. However, one in five older Canadians still live near the poverty line and have difficulty making ends meet. The most common groups affected by poverty are older adults living alone (especially women who are divorced or separated), visible minorities, immigrants, and very old women who may have never had the opportunity to contribute to a pension. Other older Ontarians, due to their choice to serve as an unpaid caregiver for a family member during their working years, may also have limited their earning and savings potentials and their later-life eligibility for full pension benefits.

Low incomes constrain personal choices, the most significant one being around shopping for food. This ultimately impacts on nutritional status, with inevitable broad implications for a person’s health, which is a serious concern when at least 92 per cent of older adults report living with at least one chronic illness. As the care needs of these older Ontarians increase over time, this makes lower income older adults more reliant on outside sources of help to continue living independently. This is critical as older adults with low incomes are at increased risk of being institutionalized in long-term care homes. In light of our current demographic imperative, these issues merit the need for responsive policies and services to prevent older adults from living in poverty.

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Pensions, Income Supplements, and Tax Credits

Despite the efforts made by the provincial and federal governments to increase the participation rate in their income security and benefit programs for older adults, there are still a number of Ontarians that do not take advantage of available pensions, income supplements, and tax credits. This has largely been attributed to the fact that they may be unaware that they are entitled to them, or they may not know how to apply for these benefits. In fact, close to 300,000 older adults in Canada who are eligible for the Guaranteed Income Supplement (GIS), one of the main revenue sources for older adults, did not receive these benefits.\(^{85}\) This is particularly important for older Ontarians as the province established its supplemental Guaranteed Annual Income System (GAINS) to ensure a guaranteed minimum income for all older Ontarians.

To further reduce the economic burden on low-income Ontarians, including older adults, the 2009 Poverty Reduction Act introduced a number of additional government initiatives as part of Ontario’s Poverty Reduction Strategy.\(^{86}\) To simplify access to important tax credits, the Ontario Trillium Benefit was introduced for low- to moderate-income older adults through which the Ontario Sales Tax Credit, Ontario Energy and Property Tax Credit, and Northern Ontario Energy Credit payments are combined into a single and overall enhanced benefit payment that is now delivered on a monthly basis to them.

Many older Ontarians also wish to remain in their homes as long as they are able. However, as home values have continued to rise, while the majority of older adults remain on fixed incomes, many have been experiencing a greater burden of higher property taxes as a result. With an increasing proportion of their assets being tied up in their homes, increasing numbers of older adults have reported feeling pressured to sell their homes to pay for additional living or care needs, which runs counter to their first preference to age in place. To address this issue in line with its Aging at Home Strategy, Ontario’s Poverty Reduction Strategy invested $1 billion over five years into a new Senior Homeowners’ Property Tax Grant to provide low- to moderate-income older Ontario homeowners with up to $500 a year to pay their property taxes.

The government also introduced its Seniors’ Property Tax Deferral Program as another measure to help older low-income adults stay longer in their own homes. This program allows them to defer both the municipal and educational portions of their property taxes, with the deferred amount being repaid on the future sale or transfer of the home, and the province covering the interest costs of the deferred property tax. Additionally, as was mentioned in Chapter 1, the new Healthy Homes Renovation Tax Credit will give older adults and their families up to $1,500 to help adapt their homes to further support their growing desire to age in place. Meanwhile, the recently announced combined investment of $481 million by the provincial and federal governments for the Investment in Affordable Housing for Ontario program will help to further improve access to adequate, suitable, and affordable housing for older Ontarians as well.

Collectively, these programs will allow many older Ontarians to continue to live at home or in their communities with dignity and respect. Therefore, these sorts of initiatives should receive continuous


support from the provincial government and its municipalities, especially given the more expensive alternative living and care costs we would have to fund if older Ontarians were forced prematurely to move into institutional care environments without these measures in place.

**Assisting Low-Income Older Ontarians to Age with “Independence at Home”**

Many older adults, their families, their caregivers, and their health, social, and community care providers spoke to us about how sometimes the cost of a piece of equipment, a minor home modification, or dealing with an unexpected or unmanageable expense could mean the difference between aging in place or having to be prematurely admitted to a long-term care home. Indeed, a number of care providers spoke about how having a non-traditional cost could result in a gridlock situation where an older person may even remain in hospital with an Alternate Level of Care (ALC) designation until they could find a way to pay for a minor personal cost that would allow them to return home. In the meantime, the cost of having to stay in a high-cost environment was resulting in a greater overall expense to the system. Therefore, it was clearly recognized during the consultations that having access to flexible funds to help lower-income older adults facilitate their care transitions is vital and needs to be available within every Local Health Integration Network (LHIN).

Although programs like the Community Homelessness Prevention Initiative (CHPI) and the Ontario Renovates Program are two programs that could provide support, they are not consistently administered now across all municipal jurisdictions. Furthermore, they sometimes do not have the full flexibility to meet the immediate needs of an individual to support a transition in their care. Already LHINs like Erie St. Clair and Central East have independently used their Aging at Home Strategy funds to establish discretionary Resettlement or Aging at Home funds that have proved invaluable in helping them to support the transitions of patients and keep or return more people in or to their homes. Therefore, we believe that creating an Independence at Home Fund consistently available across each LHIN, administered by a lead CSS agency with minimal red tape, would likely further meaningfully impact our ALC numbers as well as our long-term care wait lists that have remained stagnant over the past year. This fund could support the purchasing of basic medical equipment or supplies, making minor home modifications, paying rent/mortgage and utility arrears, first and last month’s rent, moving costs, or the purchasing of new furniture and other things that will support older Ontarians’ capacity for independent living.

**Recommendation:**

19. The Ministry of Health and Long-Term Care should encourage and support the LHINs to develop flexible Independence at Home funding allocations to cover the costs of patients needing non-traditional health, social, or community-based services to support them returning home or avoiding a premature admission to a hospital or long-term care home.
Working Towards the Future Sustainability of our Programs

The future sustainability of our overall health, social, and community care system may eventually require that services should be determined not by age or assets, but rather through a more transparent income-based means-testing system. As many other jurisdictions have implemented co-payment systems to improve the sustainability of their programs, we will likely need to start examining this option more closely as well. As we discuss this further in future chapters, the basic premise we need to ensure at the heart of our discussion is that our aim should be to create financing systems that will allow people to always get the care they need. This means ensuring that low-income older Ontarians will not pay for services that they would otherwise not be able to afford, especially when their inability to fund care at home places them at the highest risk of institutionalization.87

The experiences of other provinces have also shown that making these programs universal and not asset-based seems to be the fairest way to help persons to contribute to certain aspects of their care, like the cost of their medication or the home and community care services they receive. At the same time, there is enough jurisdictional evidence to tell us that means-testing the delivery of primary or acute health care services often causes people to delay getting the care they need. Therefore, as we will inevitably be faced with these discussions as we look to figure out how to maintain the sustainability of our health, social, and community care systems, it will be integral that we always maintain the principles of equity at the heart of these discussions.

Finally, two recent government Commissions – the Commission for the Reform of Ontario’s Public Services and the Commission for the Review of Social Assistance in Ontario – explored the impact of current income-based benefit structures on low-income Ontarians and provided recommendations to the government that included reviewing the existing benefits and tax transfer systems to improve client outcomes in an efficient manner. The findings will be valuable in understanding the best approaches to administer benefit programs in the future, to better streamline and coordinate social assistance to improve the fairness of the system, and most importantly, to remove barriers in finding a pathway out of poverty for every Ontarian.88

**Recommendations:**

20. The Government of Ontario should support efforts to ensure all eligible older Ontarians receive the retirement and age-related benefits they are entitled to and maintain its current and future commitments to financially support low- and moderate-income older Ontarians.


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Chapter 3: Strengthening Primary Care for Older Ontarians
Enhancing Access to Primary Care

With advancements in medicine, a greater number of older Ontarians are living for longer periods of time in relatively good health. However, as one grows older, the likelihood that their overall health may become increasingly complicated and frail grows if they acquire more chronic health conditions, functional and cognitive impairments. For these frail older Ontarians, who struggle with complex and often inter-related health and social care issues, and have to work with a diverse range of health, social, and community care providers, their overall care is further challenged by inadequate co-ordination and communication across the continuum of care. This is a significant issue, especially for the estimated 100,000 community-dwelling frail older adults that are currently living in Ontario,89 with a portion of them being homebound as well. The reality is that frailty, when paired with inadequate comprehensive primary care, often means more trips to see a physician, more prescribed medications, more visits to the emergency department, and more hospital admissions.90

Over the past decade, Ontario has made significant gains in improving the delivery of and access to primary care services. Through the expansion of and the creation of new primary care delivery models, more primary care physicians and nurse practitioners are now working as part of integrated and interprofessional teams with nurses, physician assistants, social workers, pharmacists, therapists, and others. In offering a more team-based approach to care, the growth of Family Health Teams (FHTs), Community Health Centres (CHCs), Nurse Practitioner-Led Clinics (NPLCs) and Aboriginal Health Access Centres (AHACs) in particular have been able to help ensure that over 2.1 million more Ontarians now have a primary care provider compared to a decade ago.91 While more Ontarians than ever before have access to a primary care provider, too many older adults are still finding it a challenge to access the high quality primary care that they require.

Health Care Connect

In 2009, Ontario launched the Health Care Connect program to improve access to primary care providers throughout the province. Health Care Connect teams, located in every Local Health Integration Network (LHIN), help Ontarians who are without a primary care provider to find one who is accepting new patients in their community. To further address the needs of frail or medically complex patients, Health Care Connect staff prioritize attaching these more complex and vulnerable patients first.

Since Health Care Connect was launched in February 2009, a total of 227,342 patients – with 28,570 of them being older Ontarians – have registered with the program as of September 2012. Furthermore, 9.6 per cent of all those who registered were categorized as being complex and vulnerable patients. Overall, 73 per cent of all registered patients and 74 per cent of all designated complex and vulnerable patients have been referred to a primary care provider. For older Ontarians using Health Care Connect, 82.7 per cent have been referred and 88 per cent of complex and vulnerable older adults have been referred to a primary care provider.

While Health Care Connect has been successful in connecting a large portion of Ontarians to primary care providers, and in particular older patients, there are still gaps in addressing the primary care access needs of older Ontarians. According to the 2011 Primary Care Access Survey, 97.6 per cent of Ontarians that were 75 years and better did have a primary care provider. This, however, still equates to at least 19,000 Ontarians 75 years and better who did not have one.\footnote{Government of Ontario. Ministry of Health and Long-Term Care. 2011. \textit{Primary Care Access Survey, Waves 20 to 23 (October 2010 to September 2011).} Toronto, Ontario.}

\textit{“My family doctor is retiring. I’ve been looking for a family doctor for quite some time now.”} – Senior Strategy Survey Respondent

When older Ontarians outlive the careers of their former primary care providers, many told us how it becomes particularly difficult for them to access a new provider. The fact that older patients are likely to have more complex and often inter-related health and social care needs does indeed make it hard for them to find primary care providers willing to accept them. Furthermore, those who are particularly frail and homebound have the greatest difficulty in continuing to access routine primary care services. At the same time, we noted as we toured the province that there were CHCs and FHTs that reported being below their negotiated patient capacity targets, including in areas where access to primary care for older adults was a particular problem. This in many ways helped to highlight a clear opportunity to resolve existing access to care issues in certain areas where this was also the case and where CHCs have a specific commitment to meeting the needs of vulnerable populations.

Indeed, Health Care Connect data has noted that wait times from the time of being registered to actually being referred to a primary care provider through the program averaged 43 days in 2011. While there are some LHINs that have been successful at attaching patients in less than 30 days, there remain some areas of the province that are taking well beyond that time. For a frail older adult, however, waiting over a month to be attached to a new primary care provider is problematic, when many have prescriptions that need to be renewed, or new or chronic health and social care needs that may need to be addressed in a timelier manner. With pharmacists recently being granted the ability to renew prescriptions for chronic conditions, this will support these patients better now to a certain extent. Nevertheless, many of the patients and their families or caregivers we spoke to in these situations simply said that they still would have to resort to accessing other forms of care through walk-in clinics and or even emergency departments, sometimes further fragmenting or complicating their overall care. Given their particular needs, which would often be best served through a primary care team, we have to do better as a province to ensure older Ontarians can get access to the comprehensive primary care they require.
Recommendations:

22. The Ministry of Health and Long-Term Care should promote and develop mechanisms in accordance with legislative/regulatory frameworks to advance the goal that all older Ontarians who want a primary care provider will have one. It must also be acknowledged that older adults with complex and often inter-related health and social care needs often benefit from an interprofessional team-based approach to their care.

23. The Ministry of Health and Long-Term Care should review the Health Care Connect Program to determine how it can better support the attachment of older adults to a primary care provider. This should also include reviewing the incentive payment structure to physicians who accept patients through the program and exploring the routine monitoring and public reporting at a LHIN level of HCC Roster Size for all older adults, referral and attachment rates and wait times.

24. The Ministry of Health and Long-Term Care should support expansion of opportunities to maximize the capacity of Community Health Centres (CHCs), Family Health Teams (FHTs), Nurse Practitioner-Led Clinics (NPLCs) and Aboriginal Health Access Centres (AHACs) to better respond to the needs of frail and complex vulnerable older adults in their communities who may be unattached to primary care.

25. The Ministry of Health and Long-Term Care should ensure mechanisms are in place to a) monitor older adults’ access to primary care and b) modify accountability agreements, performance targets and other mechanisms to improve access and attachment to primary care services as required.

Enhancing Quality in Primary Care

During our consultations, we also learned that for too many Ontarians, having a primary care provider does not necessarily mean one has access to their provider when needed. Ontario data from the 2011 Commonwealth Fund International Policy Survey of Sicker Adults noted that only 50 per cent of sicker adults could see a doctor or nurse the same or next day and 37 per cent of sicker adults went to the hospital emergency department for a condition that they thought could have been treated by their regular doctor if they had been available. Indeed, for too many older Ontarians, the ability to obtain same or next day appointments or after-hours care from their primary care provider remains a challenge.

The past decade has seen Ontario move decisively towards investing more in the delivery of team-based primary care. Studies have found that team-based care is most effective in delivering better patient, provider, and system outcomes, especially for patients with mental health or multiple

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chronic health issues. However, some recent Ontario studies have also shown that the possible benefits of team-based primary care can be lost or even reversed for teams where same day, next day, or after-hours access is not being provided. In these cases, emergency department utilization by their patients was even higher than it should have otherwise been.

“A much greater use of TEAMS of health professionals, rather than only doctors is needed when so many have complex physical, emotional and social needs.” – Seniors Strategy Survey Respondent

Ontario should continue to invest in the provision of more team-based primary care; however, it needs to do a better job at monitoring and ensuring that those aspects that influence the overall quality of care, including access to care, are being addressed as well. For older patients receiving primary care, it is important that their particular health needs are prioritized as well. For example, receiving an annual influenza vaccination is a well-regarded standard of care for older adults; however, as previously mentioned, rates of other publicly funded vaccines, like the pneumonia vaccination, are half of what they should be in Ontario. Older Ontarians also need to be encouraged and supported in their primary care settings to establish advance care plans, given the greater likelihood that they may encounter circumstances where important care decisions will need to be made.

For Ontario hospitals, the requirement to develop Quality Improvement Plans has led to a greater focus on identifying and addressing quality of care issues. As a result, there is an opportunity to look at the implementation of Quality Improvement Plans in primary care to advance the monitoring and addressing of relevant quality of care issues that matter to all patients in this sector, and for frail older patients in particular.

**Recommendation:**

26. The Ministry of Health and Long-Term Care should ensure that its development of Quality Improvement Plans in Primary Care and Health Links support a core focus around the care of older Ontarians – with an emphasis on supporting primary care access for older adults, and focusing attention on areas of care that influence the health and well-being of older adults. See Appendix B for a list of proposed indicators, that could also be publicly reported, that can help to assess the quality of primary care that an older adult receives.

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95 Ibid.
Enhancing Communication to Support Transitions and the Coordination of Care

Enhancing Communication between Primary Care Providers and Care Coordinators

There exists a high likelihood that frail older adults will require more intensive support from their primary care provider along with the support of a community-based care coordinator to help organize home care and community support services to help them maintain their independence.

We heard too often, though, from both primary and community care providers, that it is more often the exception than the rule that Community Care Access Centre (CCAC) care coordinators are working in an integrated way with primary care providers. What is also clear is that the disconnect between these two groups of professionals does not support the communication of important information that could allow them to better support the older adults they are working with. While both groups of professionals desire a more integrated working relationship, it is also clear that current voluntary efforts to encourage more coordinated care are not producing desired results. Therefore, we feel that the ministry will need to use regulation to require communication between care coordinators and primary care providers to help foster more integration in the same way that has been done with specialists and pharmacists working with primary care providers. This idea was one that primary providers particularly welcomed. In the following chapter, the importance of care coordination and further recommendations to enhance it are discussed in greater detail.

Recommendation:

27. The Ministry of Health and Long-Term Care should mandate that care coordinators from the Community Care Access Centres (CCACs), Community Support Services (CSS) and Community Mental Health agencies providing care or service coordination support roles must identify and notify a patient’s primary care provider of their name, their role, contact details, and the services being coordinated for their patient/client. Patients identified by these workers as being without a primary care provider but wanting one, must be supported to register with Health Care Connect by these care coordinators in accordance with applicable legislative/regulatory frameworks.

Enhancing Communication between Primary Care Providers and Hospitals

When an older patient is treated during an acute care episode, it is not uncommon for them to be prescribed new medications or to have existing ones changed. There also may be important follow-up plans that need to be supported or carried out by the primary care provider. Most importantly, the primary care provider may have valuable information about their patient that may be unknown to acute care providers that could help overall assist with managing their patient’s care during an acute care episode. In a similar way that care coordinators and primary care providers are not and do not routinely work in an integrated manner, the same is the case for hospitals and primary care providers.
We heard too often that primary care providers are not made aware when their patients are treated at a hospital. This could partly explain why rates of follow-up within seven days of an acute care discharge and readmission rates within 30 days are not at desired rates across the province. What is clear is that the disconnect between hospitals and primary care providers does not support the communication of important information that could allow them to better support the older adults they are working with.

Hospitals and primary care providers also desire a more integrated working relationship. However, voluntary efforts to encourage more coordinated care are not producing desired results. Therefore, using regulation around communication between hospitals and primary care providers will likely be a needed mechanism to help foster the delivery of more seamless and integrated care across the care continuum. In Chapter 6, the importance of maintaining continuity in the care of an older patient during and around an acute hospitalization or emergency department visit is discussed in greater detail.

**Recommendation:**

28. The Ministry of Health and Long-Term Care should mandate that hospitals and other institutional providers must support the primary care needs of its patients in the following ways:

   a) When hospitals admit a patient, they must notify the patient’s identified primary care provider within 24 hours, providing the reason for admission and a discharge summary on the date of discharge.

   b) Patients identified as being without a primary care provider but wanting one, must be supported to register by the institutional care team with Health Care Connect on admission to hospital or during a visit to an Emergency Department.

**Enhancing the Delivery of More Home-Based Primary Care for the Homebound**

*The Growing Need for More Home-Based Primary Care in Ontario*

It has been well demonstrated that in comparison to the overall population of older adults, those who are frail and homebound often suffer from higher rates of complex comorbidities, including dementia and functional impairments. Furthermore, the needs of this population are generally not well served by traditional office-based primary care, as many are not seen regularly by primary care physicians due to a host of challenges they face in accessing care. As a result, many homebound older adults often resort to less ideal episodic care alternatives, such as accessing emergency departments or one-off home-visit physician services; health interventions that do not offer the continuity of care that could prevent medical escalations.

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Consequently, in being amongst the most vulnerable and marginalized patient populations, frail homebound older adults, when compared to other older adults, are twice as likely to require hospitalization, where further functional deterioration usually ensues. As a result, the chance of being permanently admitted to a long-term care home increases. In total, potentially avoidable emergency department visits, hospital admissions, and long-term care admissions all cost these patients and the system more than that of providing preventative comprehensive primary care. Therefore, as the number of frail older adults with complex conditions steadily rises, the need to consider how primary care is structured to better support these patients becomes increasingly important, as does the integration of health, social and community care systems.

As the needs of this population steadily mount, there has been a continuous decline in the number of physicians performing house calls in Canada. In Ontario, however, this has not been the case; in fact, around half of its primary care providers and a number of specialists provide home-based care to tens of thousands of patients each year. In 2011-2012, 5,850 family physicians and 553 specialists performed a total of 228,159 house calls to 89,740 distinct patients, with the vast majority being older adults. The number of patients being provided house calls in Ontario has also continually increased over the last five years from when 83,337 distinct patients were seen in 2007-2008. This volume of house calls is still a far cry from the forties, when physicians delivered over a third of their care to patients in their homes. Conceivably, house calls became less frequent as physicians developed an increasing reliance on technology and traditional fee-for-service payment models, which continually reward high-volume and short-duration episodes of care. Barriers to providing house calls are now well documented, with time constraints, inadequate remuneration, transportation, and safety concerns raised repeatedly among practicing primary care providers.

Several studies that have examined the efficacy of home-based primary care clearly demonstrate its ability to deliver improved patient satisfaction, quality of life, and patient outcomes. While the provision of home-based primary care is indisputably a resource-intensive model, in addition to offering greater convenience and access to ongoing primary care, the value of this care lies in the overall reduction of costs achieved through the prevention of more costly health expenditures related to unscheduled hospitalizations, avoidable emergency department visits, and long-term care admissions. The evidence also shows that a team-based approach to care is required to deliver the best outcomes. Indeed, home-based primary care should be facilitated by family physician or nurse practitioner-led

interprofessional teams, supported by allied health and social care professionals, including care co-ordinators, and preferably offer after-hours availability for urgent care issues.\textsuperscript{109,110}

\section*{In Focus:}

\textbf{The House Calls Program, Toronto, TC-LHIN}

The most exemplary home-based primary care model in Ontario is the House Calls Program operating in the Toronto Central LHIN. Initially established in 2007 as a pilot project embedded in a Community Support Services (CSS) agency, House Calls became a fully funded program in 2009 through the Aging at Home Strategy. The goal of the program, which exclusively serves frail homebound older adults, is to support patients and their caregivers to remain safely in the community for as long as possible, while simultaneously delivering better overall patient and system outcomes that include reduced hospitalizations and emergency department visits, and an enhanced ability to die at home.\textsuperscript{111}

The program’s primary care team is comprised of three family physicians, one nurse practitioner, one social worker, two occupational therapists, one physiotherapist, two team coordinators and has the added support of two CCAC care coordinator liaisons, a geriatrician and a geriatric psychiatrist. This program is also embedded in SPRINT, a CSS agency, to ensure its patients’ care can further benefit from additional services, including homemaking, Meals on Wheels, adult day programs, transportation services, and friendly visiting staff and volunteers who serve as the “eyes and ears” for the team.

House Calls cares for close to 400 patients a year and has an average daily census approaching 250 patients who are on average 87 years of age. This program, described as a “mobile family health team,” has demonstrated a 29 per cent reduction in unscheduled hospital readmissions at three months, compared to the overall TC-LHIN rate for patients it enrols immediately after an index-hospitalization, while 67 per cent of its patients were able to die at home.

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Evolving Models to Support the Delivery of Home-Based Primary Care

The advent of new and expanded primary care team-based care models such as Family Health Teams (FHTs), Community Health Centres (CHCs), and Nurse Practitioner-Led Clinics (NPLCs) has seen an increase in the provision of house calls in these settings as well, while those amongst specialist and solo or non-team-based primary care physicians has actually decreased. With evidence demonstrating that comprehensive home-based primary care be ideally provided by an interprofessional team, the future growth of house calls through these practice settings should be encouraged and supported.

While some FHTs and CHCs have developed robust home-based primary care programs, others have indicated that they have not prioritized the provision of comprehensive home-based primary care in their settings due to a lack of interest in some cases and their need for guidance and support in establishing capacity to deliver such models of care. What is clear is that the need for home-based primary care amongst frail older patients will only increase in the coming decades. Therefore, encouraging and supporting the development of home-based primary care models that allow providers to feel capable and comfortable in extending this type of care to their patients needs to be prioritized.

Maintaining and even improving existing remuneration to support primary care providers who provide ongoing home-based primary care to patients will certainly encourage the expansion of house calls in Ontario. At the same time, promoting the new Care of the Elderly Alternate Funding Plan (AFP), which will provide a competitive salary to those primary care providers who start spending at least 50 per cent or more of their time providing comprehensive ongoing home-based primary care, will also allow for the development of a new group of primary care specialists in the provision of this sort of care as well as for those older patients who require it.

Recommendation:

29. The Ministry of Health and Long-Term Care should maintain and improve funding levels to support the provision of house calls through primary care providers. To this end the ministry should:

   a) Improve physician compensation for the provision of house calls and promote the new Care of the Elderly AFP to support those primary care providers who want to provide ongoing home-based primary care to frail older adults as a significant part of their day-to-day practices.

   b) Support all primary care providers providing home-based primary care to frail older adults with a stable and scalable funding mechanism to support the development of interprofessional teams to deliver this care.
Chapter 4: Enhancing the Provision of Home and Community Care Services to Support Aging in Place
Meeting the Current and Future Community Care Needs of Older Ontarians

With more and more older Ontarians wanting to remain independent in their homes for as long as possible, the subsequent demand for home care and community support services from both public and private sector providers has been unprecedented and will only continue to grow.

“If the government continues to advocate for older Ontarians to stay in their homes then the services have to be there.” – Seniors Strategy Survey Respondent

For older Ontarians, the availability of professional services like nursing, therapy, and personal support with bathing, dressing, and homemaking can mean the difference between being able to remain at home and having to seek residential care in a retirement or long-term care home. Current demand for our publicly financed long-term care system is exceeding its existing capacity. Furthermore, the projected need for additional long-term care beds over the next 20 years would require existing bed counts to triple if no changes were made to the way we provide home and community care. Therefore, the value of a robust home and community care sector has never been so appreciated.

Other nations facing similar issues have generally prioritized and focused their health system investments into the provision of a more robust home and community sector. Denmark, which faced similar demographic and fiscal imperatives years ago, proceeded to prioritize investments in their home and community care sector and in the development of more assisted living and supportive housing units. Doing so allowed them not only to contain health care costs, but it greatly reduced the overall demand for long-term care. In fact, Denmark was able to avoid building any new long-term care homes for close to 20 years and also saw a reduction of 12 per cent in its expenditures on long-term care during the first decade.

Earlier this year, the Government of Ontario signalled its continued interest in expanding the provision of publicly funded home care and community support services by committing to increasing its investments in this sector by four per cent per year for the next three years – the largest increases received by any health care sector. While more funding will be essential, the sector also needs a clear vision and direction on how future home and community care services should be financed, organized, and delivered. The ministry is now embarking on an ambitious and needed plan to advance primary care integration and the development of more integrated Health Links at the level of each Local Health Integration Network (LHIN). An effective strategy to better integrate the provision of home care and community supports with the care provided by other sectors will further enable more older Ontarians to age in the place of their choice and reduce the overall demand and pressure for more expensive institutional care.

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113 German Institute for Economic Research. Schulz, E. 2010. The Long-Term Care System in Denmark. Berlin, Germany.
The Organization of Home and Community Care Service Provision

The provision of home and community care services across the province varies but is generally organized through the province’s network of 14 Community Care Access Centres (CCACs) and 644 Community Support Services (CSS) agencies. In Ontario, CCACs help to arrange and broker the provision of skilled professional services through contracted service providers who can support a person’s clinical and personal care needs at home. CSS agencies are publicly supported to provide a basket of subsidized home and community support services that include day programs, Meals on Wheels, friendly visiting, and transportation. Additionally, some CSS agencies are also approved to provide personal support and homemaking services. Older Ontarians, their families, and their caregivers, can also purchase additional professional and non-professional supports through for-profit and not-for-profit home care agencies and non-profit CSS agencies that may also provide contracted home and community care services through the CCACs and the LHINs.

Community Care Access Centres

The establishment of CCACs in Ontario in the nineties created greater consistency across the province in the approach to the provision of client home care and coordination, including administrative functions such as planning, funding, and contracting home care services across the province. With the creation of LHINs, CCACs were reorganized in 2007 to align with LHIN boundaries, thereby reducing the number of CCACs from 42 to 14. While integrating CCACs within the LHINs was considered at that time, the new CCACs were designed instead as separate entities reporting to the LHINs.

Over the past decade, funding to CCACs has increased by 69 per cent while the number of clients they serve has increased by 83 per cent. In 2011-2012, CCACs received over $2.1 billion in funding from the ministry and their corresponding LHINs, and employed approximately 6,053 individuals, including some 3,500 care coordinators to arrange care for 616,000 Ontarians overall and around 300,000 people during any given month. Approximately 60 per cent of CCAC clients are older Ontarians, while 20 per cent are persons with very complex needs. Services provided last year through CCACs included:

- 20 million hours of personal care provided by personal support workers,
- 6 million visits by nurses providing 1.7 million nursing shifts
- 1.2 million visits from therapists
- 0.4 million visits from other allied health providers such as social work, nutritional, psychotherapy, and respite support, and
- 2.1 million visits from care coordinators who oversaw all of this care.

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When individuals request home care services, care coordinators, who are regulated health professionals, predominantly with nursing backgrounds, assess their needs using a standardized RAI Home Care (HC) assessment instrument to determine their eligibility for available services; they develop a plan of care and then arrange for home and community care services on behalf of their clients through both not-for-profit and for-profit contracted home health care service providers. The services CCACs oversee include nursing, personal care and support, physiotherapy and occupational therapy, speech language pathology, dietetics, and social work services. CCACs also provide information and referral services to the public on community-related services provided by them and others, and also manage all assessments for and admissions to long-term care homes and have the authority to manage the placement of persons into adult day programs, supportive housing, complex continuing care beds, and rehabilitation beds in public hospitals, but they have not necessarily taken on this role in most jurisdictions.

**Community Support Services**

Within the home and community care sector, 644 not-for-profit community support services (CSS) agencies of varying size employed 24,011 staff and leveraged the support of 100,000 volunteers to deliver services to support 814,459 mostly older community-dwelling Ontarians last year such as:

- personal support and homemaking,
- services provided in supportive housing environments
- Meals on Wheels
- transportation programs
- respite and adult day programs, and
- other services.

In 2011-2012, CSS agencies provided Ontarians with a range of services including: 3,874,009 hours of personal support and homemaking services, 2,763,285 meals through Meals on Wheels programs, 1,720,602 rides through transportation services, and 1,237,015 friendly visits at home. They also provided 68,037 persons with supportive housing services and served 39,108 persons in adult day programs.121

Most CSS agencies receive between 50 per cent to 70 per cent of their resources from LHINs and other sources of public funding which total $661 million annually. These funds are then supplemented by $140 million in annual support provided through charitable donations and means-tested client co-payments. Meanwhile, the value of the 4.373 million hours of service provided by its 100,000 volunteers last year has been valued at $71,330,920.

When individuals request more intensive home and community services, care coordinators in this sector, who are not usually regulated health professionals, assess their needs using a standardized interRAI Community Health Assessment (CHA) instrument to determine their eligibility for available services. They then develop a plan of care and arrange the home and community support services that

their organization specifically provides on behalf of their clients, and refers or links them to others agencies or the CCACs if additional service needs are identified. CSS agencies also provide information and referral services to the public on community-related services provided by them and others.

**Current Challenges and Opportunities in the Delivery of Home and Community Care**

With a growing interest in shifting care to the community and supporting aging in place, CCACs and CSS agencies are also increasingly supporting more older adults with complex and often inter-related health and social care needs to remain in or return to their homes, especially after a hospitalization. With increased funding over the past three years, primarily through the Aging at Home Strategy, 12,500 more Ontarians with very complex needs are being supported to live at home with the help of services from the CCACs and CSS agencies. These additional investments have also allowed long-term care wait lists to be reduced by 6,400 patients, while wait times for placements into long-term care homes in Ontario have also dropped from 100 days to 93 days. The resulting estimated savings of supporting more persons at home rather than in long-term care is $210 million when home care remains a fraction of the cost of institutional care.

Nevertheless, the demand for publicly funded and subsidized home care and community supports continues to rise. The 2010 Auditor General’s report spoke to inequities in how CCACs were, and continue to be funded, and, as a result, in the care that is being provided to Ontarians. With funding still being based primarily on historical allocations rather than locally assessed client needs, per capita funding still varies significantly, especially amongst the areas that have experienced significant changes in their local populations. This has made it a significant challenge for CCACs to comply with the ministry policy that requires CCACs to administer programs in a consistent manner to ensure fair and equitable access no matter where someone lives in the province.

The result is that, across the province, service provision varies as does service prioritization criteria, the availability of services, and the chance that someone will even receive services that they are approved to receive in a timely manner. In 2010, the Auditor General noted that 11 of the 14 CCACs reported having established wait lists for services due to a lack of financial resources or a shortage of specialist resources. At that time, there were over 10,000 people waiting to receive various services for upwards of months. With further increases in funding, this number, as of November 2012, has now declined to 6,100 across 10 of the 14 CCACs, three of which reported having more than 1,000 people waiting for services. While there are no clients on wait lists for nursing services in Ontario, 3,300 of the clients were waiting for personal support with the remainder waiting for in-home therapy and social work services. Together, the factors that have also led some CCACs to establish wait lists for services have actually diminished the confidence of Ontarians in publicly funded home and community care services. At the same time, they have limited the CCACs’ ability to respond to appropriate calls for them to administer programs, like those under the Home First banner, in a more consistent manner with standard service guidelines.

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124 Ibid.
CSS agencies have also struggled with the growing call for them to administer their common programs in a consistent manner even within a LHIN. With so many agencies varying in size, mandate, levels of funding, volunteer support, and service definitions, this has diminished their ability to ensure fair and equitable access to the core programming that they collectively provide across the province. Increasingly, LHINs have been requesting that their CSS agencies develop standard program and operational definitions, eligibility criteria, unit costs, and means-testing standards to determine client fees for services. The development of lead agency funding and delivery models to support common service provision by a number of CSS agencies has helped improve service consistency. Indeed, while there has been progress made on this front in a few LHINs, having this work completed at a provincial level as well would allow the ministry and its LHINs to better plan and support the provision of services by these agencies.

Developing more consistent service quality standards across the province will support older Ontarians, their families, and caregivers to better understand their available, publicly funded care options and what their own obligations would be when planning their future care needs.

The ministry is supporting the home care sector to improve contract management between CCACs and home care providers to ensure outcome-based performance and transparency are the drivers for the best care delivery at the best price. With these improvements, competitive procurement will only apply under limited circumstances; for example, if a service provider is not providing quality care. With CCACs and service providers looking to be more efficient with the service hours they provide clients, support is increasingly being brokered or arranged in blocks of time that may be insufficient to meet the care needs of certain clients, when little flexibility exists to provide the care that may actually be needed. The result has been a growing number of complaints from older adults, their families, and their caregivers, along with Personal Support Workers (PSWs) that a greater focus on task-based care may be occurring at times in a way that is not in line with the actual needs and wishes of the client, and in a way that also diminishes the autonomy of personal support workers and the quality of their working environment. Some clients have also indicated that they are reluctant to raise the issue with their care coordinator for fear that their hours may be cut if they complain. What is clear is that we have to remember that quality and cost-effective care is a delicate balance that we all need to work harder to achieve.

**Recommendations:**

30. The Ministry of Health and Long-Term Care should require that all LHINs, especially those sharing regions or working relationships with regional health care providers, should also seek to standardize policies and procedures guiding prioritization and availability of services and the allocation of resources to also improve public confidence that the provision of and allocation of LHIN services is being done in a consistent and equitable manner across the province of Ontario.

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31. The Ministry of Health and Long-Term Care should mandate that all CCACs develop consistent service quality across the province, including standardizing core programming policies and procedures, assessment and eligibility criteria, and related service levels, to improve public confidence that the provision and allocation of CCAC services is consistent and equitable across the province.

32. The Ministry of Health and Long-Term Care should reinforce that CCACs and their contracted service providers should broker and implement task-based care assignments with caution, understanding that not all clients can fit into allocated service time provisions (e.g., the “15-minute bath”). Care plans should be developed according to the actual needs and wishes of the client in a way that also respects the autonomy of personal support workers and the quality of their working environment. The ministry should ensure that CCACs introduce client and staff satisfaction metrics that monitor and report on this issue.

33. The Ministry of Health and Long-Term Care should mandate that all CSS Agencies should standardize their core programming/operational policies and procedures, eligibility criteria, fee schedules, and systems of means-testing.

See Appendix B for a list of proposed indicators, that could also be publicly reported, that can help to assess and monitor the supply of and timely access to home care services.

Towards an Integrated and Collaborative Community Care Model

Within almost every LHIN, CCACs and/or CSS agencies were found to be managing wait lists for their services, often forcing individuals with the lowest identified needs to wait significant periods of time before they receive care. Yet, as many older adults, families, and caregivers, as well as home care and community support providers recognize, the ability to provide even low-needs patients some basic home care and community supports in a timely way can help prevent their health or personal care needs from substantially increasing.

With ever-limited resources, CCACs across the province have been finding their resources increasingly concentrated around meeting the needs of their patients with complex needs. To better serve those individuals with lower needs, CCACs have been increasingly working with CSS agencies in their LHINs to transfer the coordination and provision of care for these individuals to select CSS agencies providing personal support services. This work has led to some serious discussions about whether CSS agencies should take on a more formal role within the home and community care sector in managing the wait lists and care needs of clients assessed as being at low-risk and having more basic needs. This would allow CCACs to focus their efforts on those clients assessed as being at high-risk and having more complex and clinically oriented care needs.

“More preventive health and home care services can ensure individuals do not become frail and ill prematurely, and thus consume even more health care dollars.” – Seniors Strategy Survey Respondent
With the forthcoming development of Health Links in Ontario, to improve the patient care journey – especially for Ontarians with complex needs – will be a top priority and will require all providers to work together to the best of their individual strengths. Through this process, structural questions will likely materialize and should be thought through carefully around allowing other providers who are interested in pursuing innovative models of better integrated community care, to do so. Achieving greater flexibility in who coordinates care for various types of clients and patients, while strengthening the options for home and community care delivery, could help ensure that the goal of providing the right care, at the right time, and in the right place will be achieved.

Indeed, there likely will be an opportunity early in the future planning of home and community care service delivery in this province to consider better delineating roles and responsibilities between CSS and CCAC providers. This delineation should be based around client needs with a goal of strengthening a preventative focus in the delivery of publicly funded home care and community support services. This could be achieved by allowing LHINs to further their current work with CCACs and CSS agencies through their existing Collaborative Care Model Initiatives. These partnerships have seen the transfer of funds from CCACs to selected CSS agencies that provide personal support and homemaking services. These CSS agencies then take on the service responsibility and care coordination functions for managing low-risk clients in their LHINs.

The current Collaborative Care Model work has determined that using the interRAI Method of Assigning Priority Levels (MAPLe) designations is a reliable and accurate way to determine the types of clients that CSS agencies could take the lead with – low-risk clients being defined by having MAPLe designations of 1 to 2 on a 5-level scale that can be determined easily with any community-based interRAI needs assessment tools. Through this work, the function and level of care coordination required can be based on client acuity. Therefore, CCAC care coordinators, as regulated health professionals, would be assigned to primarily work with clients who have higher degrees of clinical complexity, while CSS care coordinators, who do not necessarily need to be regulated health professionals, would be assigned to primarily work with clients who have lower degrees of clinical complexity. This model also complements the population-based client care model with standards of care, including care co-ordination, based on the needs of specific client populations and sub-populations. After first being implemented successfully by the Toronto Central CCAC, this is now being implemented by all other CCACs in Ontario. Figure 4.1 outlines the conceptual framework for this collaborative care model to care coordination.
A Summary of the Key Descriptors and Characteristics Associated with Each of the Population Groups

Healthy Older Adults

- The health status of these older adults is stable and they do not likely have a chronic health issue that affects their functional abilities.
- They are able to care for their own personal care needs and unlikely to be receiving the assistance of home care or community support services, and rather may be providing these themselves to others as unpaid caregivers or volunteers.
- These older adults want to stay healthy, active and engaged, and often look towards information sources that can help them easily navigate the system themselves.

Older Adults with Chronic and Stable Health Issues and Needs (MAPLe 1-2)

- These older adults typically have at least one chronic health issue yet their overall health remains relatively stable. These patients benefit from access to routine primary care services.
- They are generally able to manage their own personal care although may need some assistance from time to time and will likely look to the assistance of some home care or community support services as well as their friends, family or neighbours to provide support.
Older Adults with Chronic and Unstable Health Issues and Needs (MAPLe 3-4)

- Most of the older adults in this category likely have two or more chronic health issues, and their overall health remains relatively stable, but are prone to periods of instability with their health that can lead to unnecessary urgent visits to hospitals if they cannot obtain timely access to their local primary and specialist care providers. They are likely interacting with a number of health, social and community care providers and are at risk of complications that occur with transitions that are not coordinated effectively. These patients benefit from comprehensive team-based primary care.

- For the most part these older adults can live independently in the community and manage their personal care needs but often benefit from the assistance of home care and community support services and/or an unpaid caregiver.

Older Adults with Complex Care Issues & Needs (MAPLe 4-5)

- Most of the older adults in this category have multiple chronic health issues and their overall health is likely characterized as unstable and often necessitates urgent visits to hospitals. They likely need the assistance and support of others to get around and help manage personal care needs. They are likely living in residential care, supportive housing or may be homebound or very cognitively or physically frail and dependent on intensive home care and community support services and/or an unpaid caregiver if living in the community.

- They have frequent interactions with various health, social, and community care providers and are at risk of complications that may occur when communication between providers, particularly during care transitions are not coordinated effectively. These patients benefit the most from comprehensive team-based primary care.

Coordinating Care and Enhancing Navigation Across the Continuum

The following two sections outline the key components and interactions required to support effective implementation of the conceptual framework.

Establishing partnerships between primary care providers and community care coordinators ensures that individuals with chronic and complex conditions have a comprehensive care plan that coordinates medical as well as social/functional aspects of their care and clarifies the roles and responsibilities of each provider and organization involved in the person’s circle of care to the patient, their family, caregivers and as well as to each other.

More Specific Roles and Responsibilities would ensure that:

- **Primary Care Providers** will be responsible for coordinating primary, specialist and post-acute care medical needs in partnership with community care c-ordinators.

- **CCAC Care Coordinators** will support primary care providers by leading the coordination of the integrated delivery of home care and community support services teams for persons with more complex needs.

- **CSS Care Coordinators** will support primary care providers by leading the coordination of the integrated delivery of community and personal support services for persons with non-complex needs.
Recommendations:

34. The Ministry of Health and Long-Term Care should encourage its CCACs to complete their implementations of the population-based client care model of service provision that allows designated care coordinators to particularly focus on the needs of elders with complex needs.

35. The Ministry of Health and Long-Term Care should support the LHINs, their CCACs and CSS agencies to formalize a Standardized Collaborative Care Model that can allow acuity-based wait list and care coordination assignments between CCACs and select CSS agencies, thus allowing both sectors to provide publicly funded personal support services in each LHIN. This will allow both sector organizations to play to their strengths and better address client needs.

Promoting a Lead Community Care Coordination Model

Within an enhanced and integrated care coordination model, where care coordination becomes based around acuity and needs, there needs to be a mechanism to ensure that, if a client's needs change, the right care coordinator is leading their care. For example, if a client with high needs evolves to become one with low needs, there would be a clear method to transfer their care coordination from a CCAC care coordinator to a CSS care coordinator and vice versa. In the Hamilton Haldimand Niagara Brant LHIN, it was noted that this is already being attempted through the development of a lead care co-ordination model that even involves Community Mental Health Agency care coordinators.

Essentially, a client who needs services from multiple agencies will have a care coordinator within each agency to help organize the care for which that agency is responsible. However, these care co-ordinators agree to play a supporting role to the care coordinator from the agency that is required to be the most involved in the client's care at a given time. Within an enhanced and collaborative care coordination model like this, or others that may emerge with time, what was made clear through our consultations was the importance of ensuring that the primary care provider always remains informed and engaged at the centre of the client's care.

Advancing Enhanced Care Coordination Practices

Enhanced and integrated care coordination needs to be understood as a comprehensive and systematic process which involves screening, assessing, planning, arranging, coordinating, and monitoring the outcomes of a care plan that often links services/resources within and beyond the health care sector. It is also a proactive process that aims to improve care appropriateness, consistency, choice, and flexibility in service delivery, efficiency, positive patient outcomes, and collaboration between providers. The evidence is also clear that a lack of care coordination and poor transitions between care settings can often lead to delays or lapses in care, unnecessary specialist referrals, duplicate testing, adverse drug events, avoidable costs that are usually associated with failed transitions between the community and hospitals and emergency departments, patient and caregiver dissatisfaction, or other problems that cause unfavourable impacts or endanger a patient's overall health and well-being.
The common characteristics of successful care coordination programs include: a comprehensive multidisciplinary assessment of medical, functional, and psychosocial needs with ongoing follow up; the proactive coordination of care across providers, preventative focus; intensive health education and support for lifestyle modifications; and the monitoring of a patient’s progress between visits. Furthermore, studies show that all successful programs of integrated care for frail older adults provide care coordination and interprofessional care supported by the use of common assessment and care planning instruments and integrated data systems. Ideally, primary care providers will act as the ‘hub’ for managing the complex and often inter-related health and social care needs of their patients. However, to ensure effective coordination of their patient’s overall care, primary care providers must be able to integrate input from multiple sources into a comprehensive, person-centred care plan that promotes greater communication and information flow across all service providers. Therefore, the need to provide and coordinate care, in partnership with CCAC and CCS providers, becomes obvious.

**Supporting the Integration of Primary and Community Care**

With the integration of primary and community care being a goal that many feel is necessary and long overdue, an analysis of what the potential barriers and opportunities to achieve such a desired level of integration becomes important, especially in the care of older patients. The most significant challenge to developing more enhanced and integrated care coordination models or promoting primary care integration is the fact that CCACs continue to struggle with being proactive in forming meaningful relationships with primary care providers, including those in Community Health Centres (CHCs), as Family Health Teams (FHTs), and other solo or team-based care environments. Currently in Ontario, only a fraction of the province’s 12,000 primary care providers are formally linked with local CCAC care coordinators and even less so with CSS care coordinators.

Primary care providers often report being unaware of the services their patients may be receiving in the community, even if they have referred their patients to be assessed for services by a local CCAC or CSS agency. Therefore, when issues come up that may necessitate more home and community care, in many cases it is not clear to primary care providers how best to contact their patient’s care coordinator. Furthermore, primary care providers we spoke with throughout the province often discussed being unaware of the array of appropriate home and community care options that could benefit their patients by preventing more acute care needs down the road.

This lack of full integration particularly impacts individuals with complex and often inter-related health and social care issues. These are the people who move most regularly from one part of the health care system to another and benefit the most from home and community care services. In developing an enhanced and integrated care coordination model, it appears that a first step in its development will be the need to require anyone performing care coordination in the community to identify a person’s primary care provider and to notify the primary care provider about who they are, how they can be contacted, and how they are supporting the primary care provider’s patient. Changes in care plans

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should also prompt the need for further updates as well. The Ontario Medical Association (OMA) recommended this in its written submission around the development of the Seniors Strategy, indicating that “physicians believe that community care is a ‘black hole’ where information provided about patient urgency is ignored and feedback about the care being received (or not) by their patients is scanty or absent altogether.” Indeed, most front-line primary care providers with whom we talked raised these same concerns, unless they had the rare privilege of having a care coordinator embedded in their practice. Just as other regulated health professionals are compelled through regulation to notify primary care providers in certain circumstances, the same requirement should be instituted for care coordinators. The OMA also suggested that time benchmarks should be established for care co-ordinators to provide primary care providers with a report about their patients, along with a provision that requires primary care providers to respond to CSS and CCAC requests in a timely fashion as well.

**Recommendations:**

36. The Ministry of Health and Long-Term Care should mandate that CCAC and CSS Care Coordination functions embed and standardize a mechanism for timely and ongoing communication, information sharing, and updating of a patient’s/client’s status with their identified Primary Care Provider.

37. The Ministry of Health and Long-Term Care should mandate that CCACs should support the development of mandatory CCAC Care Coordinator and Primary Care Provider linkages to enhance formal and informal communication and understanding between the two sectors.

**Improving the Sharing of Information Within a Person’s Circle of Care**

The development of Health Links that will emphasize enhanced and integrated care coordination among health, social, and community professionals will necessitate that those providers who are part of a patient’s circle of care should have access to all the information that can assist them in their activities. However, despite using interRAI client assessments, front-line CCAC and CSS agency care coordinators expressed their frustration around not being able to easily check to see if previous assessments had been conducted on a client by a care coordinator from the other provider agency and, if so, to view those completed assessments. This sometimes results in the same client having to undergo a duplicative assessment, while the valuable time of the care coordinator gets wasted as well.

To rectify this issue, the ministry has invested funds to create a community-based assessment information repository called the Integrated Assessment Record (IAR). The goal of the IAR is to have all client assessments conducted by CCACs and CSS agencies uploaded to this system so that all service and care providers involved in a client’s circle of care can view these prior assessments. Unfortunately, the entire home and community care sector is not yet interfacing with this system. Therefore, it may

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130 Ibid.
be necessary for the ministry to consider mandating that all providers in the sector interface with the system to support the better overall integration of care.

**Recommendation:**

38. The Ministry of Health and Long-Term Care should mandate that CCACs and CSS providers place client assessments (i.e., RAI-HCs, CHA) on the IAR in order to facilitate access to assessments and service information by other service providers and clinicians that are, or become, members of a patient’s circle of care.

**Upgrading Current Assessment and Care Planning Instruments and Protocols**

Supporting the CCACs to upgrade their current version of client assessment instrument (the RAI HC) to the latest version (the interRAI HC) will allow CCACs to benefit from the enhanced care planning protocols that the instrument generates and ensure a full alignment with the work of CSS agencies who use the interRAI CHA. Good care planning protocols are important to support the correct identification of client needs and understanding of what will be required to address those needs.

While interRAI assessments generate scores using specific assessment scales, the development and use of the RAI Score by some CCACs to guide care planning decisions is somewhat problematic. This is because this score is generated as an additive product of other scores and is not a validated way to measure client needs. Therefore, making care planning decisions using this score can be problematic at times, especially when it doesn't properly project a client’s actual needs. CCAC care coordinators raised this issue with us repeatedly, as did primary and other community care providers, who felt that the determination of client services based on the RAI Score in some cases ignored other obviating reasons why the client still required a certain level of service, as well as ignoring their professional judgement. While the use of the RAI Score should be abandoned in Ontario, supporting the CCACs to upgrade their current outdated interRAI instrument will help their coordinators take advantage of its updated care planning protocols.

**Recommendations:**

39. The Ministry of Health and Long-Term Care should support CCACs to upgrade their client assessment tool (the RAI HC 2.0) to the interRAI Home Care to allow its full compatibility with the CSS-based interRAI CHA and to take advantage of the enhanced care planning protocols associated with this latest version of the tool.

40. The Ministry of Health and Long-Term Care should mandate that CCACs eliminate the use of the non-validated RAI Score in determining client eligibility for services, as it does not accurately reflect client needs.
Improving the Provision of Community Information and Referral Services

It has been concerning to learn that a number of Ontarians, whether they be patients, caregivers, or health and social care professionals, remain unaware of the services provided by CCACs and CSS agencies and how best to access them. This was made evident through earlier studies which have shown that upwards of half of the long-stay Alternate Level of Care (ALC) patients waiting for long-term care home placements in hospitals were not connected to CCAC services before being admitted to hospital, despite having multiple contacts with the health care system in the prior year. Furthermore, a significant proportion of older Ontarians only have CCAC services initiated after hospitalization, rather than in a more proactive and preventative framework that may reduce the future risk of hospitalization and improve the person's continuity of care.

What has become apparent to many is that the current system for providing information and referral services needs to be used by all health, social, and community care providers in a much more consistent and accessible way. Indeed, many of the older adults, their families, and their caregivers told us that it remains unclear on where best to access reliable information about health, social, and community services in a way that is accessible as well. Furthermore, while CCACs have launched various forms of information and referral services, CSS agencies and other health, social, and community care providers have reported that they do not always feel that CCACs are resourced or positioned well enough to keep track of the available health, social, and community options in their jurisdictions. In some instances, this limited information sharing and referral ability of some CCACs and other information sources has led some LHINs to support their CSS providers in creating their own unique information and referral systems such as the Community Navigation and Access Program (CNAP) in the Toronto Central LHIN or the Care Dove Information and Referral System in the Waterloo Wellington LHIN.

With the ministry’s investment in its Your Health Care Options website, and its recently announced plans to upgrade its information sharing capabilities, along with the development and recent expansion of the Government of Ontario’s 211 telephone information and referral help line, there clearly exist opportunities for greater collaboration in the area of information and referral services. Getting the health, social, and community care sectors to appreciate the emerging opportunities to offer more integrated and accessible information and referral services through a mutually agreed upon clear and dedicated source of information that can also be well advertised will also help to ensure efforts across providers are not duplicative and that Ontarians can easily access the information and advice they need.

Recommendation:

41. The Ministry of Health and Long-Term Care should require that all CCACs and CSS agencies should participate in informational and referral activities. CSS agencies and CCACs should be required to work with 211 to enhance this service as the initial single point of contact for information and referral services related to health, social, and community services in Ontario (see Recommendation 15).

The Future Implications of Primary Care Integration on CCACs and CSS Agencies

In its Action Plan for Health Care earlier this year, the ministry signalled that it wants its LHINs to oversee the organization and integration of primary care into its broader service planning and delivery oversight roles, similar to the way they currently oversee the hospital, long-term care, and community care sectors. This will be another enabler as the government embarks on establishing Health Links in its LHINs to support the further integration of care for identified populations of patients.

With primary care integration now becoming a core priority of the ministry and its LHINs, there has emerged a lot of discussion around the future role and functions of CCACs and the opportunity to better align them and their work within existing LHIN structures. While arguments have been made in support of the dissolution of CCACs, it needs to be recognized that CCACs hold important functions and responsibilities that are integral to maintaining the efficiency of our health care system. Nevertheless, given that both LHINs and CCACs were designed to be planning bodies that commission and oversee the provision of care, it is understandable why the Commission on the Reform of Ontario’s Public Services strongly recommended that improving the alignment between CCACs and the LHINs or even providing the LHINs with more flexibility to govern or even integrate the functions of CCACs into an enhanced LHIN structure may be seen as a more pragmatic option to pursue. If a structural reform is pursued, it should be noted that the process could be highly disruptive and disappointing in the end, unless the value proposition in doing so is not clearly understood and articulated.

In understanding that enhancing the provision of primary care will require it to be more integrated with the provision of home and community care services, the implementation of the Health Links may still serve as an appropriate opportunity to revisit the roles and functions of CCACs and the LHINs. As Health Links evolve, LHINs may need to be empowered to plan and fund the best integrated models of care by allowing, where appropriate, care coordination and service allocation functions to be embedded and delivered by primary care bodies like FHTs, CHCs, and through specialized hospital care models.

Recently CCACs have been taking on more roles in the actual provision of care. It is not clear, however, if they possess the correct infrastructure and capacity to deliver direct care and if this


further contradicts their original mandate to develop a more objective purchaser-provider split delivery model. With the CCACs taking a more direct role in the delivery of front-line patient care, this has prompted criticism from community health services providers who feel this may be placing CCACs in an unfair state of competition with them, with no clear mechanism established to supervise the CCACs’ ability to deliver effective or quality patient and client care. This blurring of roles has prompted these health services providers to argue that they should also be allowed to take a more direct role in care coordination as well.

With an evolving health care landscape, there is a clear need for clarity around mandates, roles, and processes to oversee and deliver care. Therefore, considering how the roles and functions of CCACs could be better defined and aligned or even evolved to work within existing LHIN structures, in a way that promotes a more integrated and strengthened primary and community care system, should be welcomed. Furthermore, any opportunities this could create to repurpose some funding from administrative functions to direct care provision should be welcomed as well, but again only if a clear value proposition can be articulated.

**Recommendations:**

42. The Ministry of Health and Long-Term Care should work with LHINs and CCACs to support them in considering and pursuing options to improve their functional and operational alignments. This could allow LHINs and their CCACs the opportunity to further centralize and integrate administrative and operational functions as appropriate to yield efficiencies that could be re-invested into providing more care while also improving overall resource utilization.

43. The Ministry of Health and Long-Term Care should provide LHINs with the opportunity and flexibility (where the capacity exists) to decide upon who coordinates care for various types of patients and their various needs in their regions.

**Financing Home and Community Care for the Future**

In developing our modern health and welfare programs, Canadians have a tradition of implementing universal non-means-tested programs related to the delivery of health, social, and community care services; this is an approach almost entirely absent in the United States. Increasingly, however, when compared to other nations with universal health care systems, we are finding ourselves struggling more with maintaining the sustainability of our health, social, and community care services. While the evidence is clear that co-payments for primary or acute care health services can discourage people from accessing the very care they need, the same has not been demonstrated in the case of home and community care services. Therefore, the question is, if we explore alternative ways of financing home and community care services, can we do so in a way that will ensure we can all get the care we need in a way that is safe and protects the most vulnerable in our society?

One of the great things that unites us as Ontarians and Canadians is that we prefer a communitarian approach when it comes to our health care system. None of us know what the future may hold for our
health; therefore, we have committed to creating a system that can be there to meet anyone’s needs regardless of their ability to pay. The challenge that we and other jurisdictions have struggled with is when the care we can collectively afford is not adequate to meet future or, more importantly, even to meet current demands.

One thing we heard this summer loud and clear is that our current home and community care system is grossly underfunded. Despite the fact that almost one quarter of older Ontarians receive some type of home care (paid, unpaid, or both), according to the most recent Healthy Aging Survey, 4 per cent or approximately 175,000 of older Ontarians still reported having unmet home care needs. As was mentioned earlier, those only receiving unpaid home care support were the most likely to report unmet home care needs.135

In managing tight budgets, CCACs are often forced to make choices around the amount of services that can be offered. These choices neither appeal to care coordinators or their clients if needs dictate more care. Indeed, we often heard that, with only more hours, we could support even more people to age in place, but we don’t have enough care available. This perhaps explains why ALC rates have remained steady now for close to a year and show no current signs of dropping, when those remaining in hospitals increasingly tend to represent those whose needs we can’t currently support at home with our existing home and community care resources.

So how do we move forward in creating a system that will be able to meet our current and future needs as a province and while it protects the most vulnerable in our society? The first option is simply to increase our taxes, although most people aren’t in favour of doing that, especially in our current economy. The second option is to cut certain services altogether, so that the province can use its limited resources to cover fewer services more adequately, although what we heard from Ontarians is that the home and community care services we currently cover are essential and, in fact, are not even as robust as what other jurisdictions offer. The third option is to seriously consider introducing a system where Ontarians would start contributing towards the cost of their services where an ability to do so exists.

**Exploring Income-Based Home Care Service Delivery Models**

The idea of contributing to the costs of one’s home and community care is not a foreign one in this province. A more problematic issue is that the government’s current approach to sharing the costs of financing one’s care in the community is inconsistent and not as comprehensive in its overall approach as it needs to be. For example, professional clinical and personal care services are provided at no cost through CCACs. In Ontario, CSS agencies are also subsidized by the government and many provide subsidized personal care services depending on one’s overall ability to pay; otherwise, the services they provide are not provided at no cost, unless a local CCAC is contracting them to provide those personal care services.

The challenge, for a number of older adults, has been that, as CCAC budgets have been getting tighter due to the rising numbers of high needs clients, those older adults, with more basic preventative needs, like homemaking, are being referred to CSS providers, which inevitably means that these older adults are being forced to pay for services that they may have, in the past, received free of charge. While all of these services are privately available through various health service providers, it appears that our current publicly funded system has become a two-tiered one that values downstream rather than upstream care, and does not fully take into account the inability of some low-income older adults to pay even for a portion of preventative home care services through CSS agencies that would better support their overall independence.

In other jurisdictions, to tackle current and future demands for home care services, an increasingly popular approach has been to introduce income-based client rates for all publicly funded home and community care services. This, however, has been the long-standing approach used in six of Canada’s 10 provinces in the administration of their home care programs (see Table 4.1) and has been well received by the public. In British Columbia, to make the process straightforward and transparent, when clients are assessed for services, they are asked to sign a consent form that allows the home care authority to verify their income with Revenue Canada. The client then pays a modest income-based daily rate for their care, unrelated to how much their service levels change. The same system applies to long-term care and assisted living services.

**Table 4.1 Description of Income-Based Home Care Service Delivery Models in Canada**

<table>
<thead>
<tr>
<th>Province</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>Home support is income tested with the exception of two weeks post-acute home support or for palliative care.</td>
</tr>
<tr>
<td>Alberta</td>
<td>Assessed professional case management, professional health, personal care and caregiver support services are provided without charge. A consistent provincial process and fee schedule is under development to determine client charges for home and community support services.</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>For meals, homemaking and home maintenance, fees are charged (according to income testing) to clients after their first 10 units of service in a month. Subsequent units of service are charged based on client’s adjusted monthly income.</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Income testing for long-term supportive and residential care services according to net income. Client contribution required based on income testing for home support services through Social Development.</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Has no fees for clients whose net income falls within or below the designated Home Care Nova Scotia client income category or who are in receipt of income-tested government benefits (e.g., Guaranteed Income Supplement, Income Assistance, Family Benefits). No fees charged for nursing services or personal care services provided by RNs or Licenced Practical Nurses or for physician services provided through Medical Services Insurance.</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>No income testing for those requiring professional health services or short-term acute home support but applies a financial assessment for long-term home support services.</td>
</tr>
</tbody>
</table>

Source: Canadian Home Care Association. Report provided to Ministry of Health and Long-Term Care, 2012.
In Australia, a similar system exists that charges income-based rates and caps a client’s annual and lifetime amounts, the amounts that they would also be expected to contribute to the cost of their care. The key principle that should be mentioned with regard to all of these models is that low-income older adults do not pay for their services and the extra revenue that is collected by the home care authorities has allowed thousands of more people to receive care and in a much more comprehensive way as well.136

The key for Ontario is to understand that, despite significant recent investments in home and community care, the reality is that we currently need to be spending more on home and community services to support our overall vision for our health care system. Therefore, having an honest conversation about what we can do to strengthen the provision of the home and community care services we make available through our CCACs and CSS agencies, in a transparent way, that can start to once again focus on care that is both preventative and supportive, will allow more Ontarians the opportunity to age in place with the care they need.

**Recommendation:**

44. The Ministry of Health and Long-Term Care should explore the implications of developing an income-based system towards the provision of home care and community support services based on the experiences and learnings of other jurisdictions. Framing this exploration with the goal of a system that can prioritize the principles of access, equity, choice, quality, and value will be integral to this process.

**Direct Funding Models**

The past decade has seen growing consumer demand for having greater flexibility and control in managing the personal health care services that are available to them. At the same time, governments have increasingly focused on finding ways to develop more efficient ways of providing quality home care and community support services. This has led to the consideration and development of a number of self-directed funding models to better meet the evolving needs of a broad range of home and community care clients, their families, and their caregivers.

The philosophy of empowerment behind self-directed care assigns individuals, their families, and caregivers, across all age groups, more choice and control over what home and community care services they request to support their needs, who provides the services, and how these services are delivered. In these models, home and community care resources are made available to users through the provision of direct financial payments and/or vouchers.

In Ontario, government-funded home and community care is provided through a network of service provider agencies with the help of CCAC and CSS agency care coordinators whose role it is to assess needs and then develop packages of care based on the services to which they have access. Increasingly,

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care coordinators are finding themselves working with much more engaged clients, families, and caregivers who desire a more flexible client and caregiver-centred approach to the provision of home and community care that goes beyond the provision of professional care services. It is clear that self-directed funding options hold the potential to improve the utilization of scarce resources through cost and service delivery efficiencies, as well as to improve the client experience and health outcomes. The potential and enhanced ability of these self-directed funding options to help keep people out of hospital and long-term care homes should therefore prompt future considerations around the evolution of funding models to support home and community care provision in Ontario to consider this delivery model as well.

In Ontario, some research has already shown that direct funding models can result in lower unit costs for the same or increased levels of service. For example, Ontario’s Self-Managed Attendant Services Direct Funding Pilot Program\textsuperscript{137} for adults with a permanent physical disability concluded the program was cost-effective due to the lower unit costs it achieved in the provision of services and through its more efficient use of services. Another study examining the impact of direct funding models found that hospital inpatient and long-term care costs were 30 per cent and 64 per cent lower respectively for those clients using self-directed care as a result of reduced utilization of these services.\textsuperscript{138}

Self-directed care models that allow full flexibility around how funds are used have been found to contribute to a reduction in health human resource pressures due to the potential to leverage the care provided by unpaid caregivers like family members, friends, and neighbours whom the recipient trusts to meet their personal care needs. In this way, these models can be particularly effective in supporting individuals living in remote rural and northern areas that may have limited access to home and community care personnel.

Overall, the qualitative research examining self-directed funding models has been positive; care recipients report being more satisfied with, and have a higher perceived quality of care, with services they choose rather than those brokered for them and an associated higher emotional, social, and physical state of well-being.\textsuperscript{139,140} Caregivers also report similar positive effects with regard to their overall quality of life, with no evidence of negative impacts.\textsuperscript{141} The psychological well-being of caregivers was also found to be particularly associated with specific elements of self-directed funding programs, such as: the overall flexibility and funding levels of the service package received, having a regular arrangement with trained providers, and having the opportunity to take a break from providing ongoing care to their care recipient.

Over the last decade, self-directed funding models have been adopted internationally in the provision of home and community care for people with disabilities. Increasingly, the expansion of these funding models to support the needs of frail older adults is being explored as well, including in Ontario’s

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\textsuperscript{140} University of Saskatchewan. Community University Institute for Social Research. Chopin, NS and Findlay, IM. 2010. \textit{Exploring Key Informants’ Experiences with Self-Directed Funding: A Research Report}. Saskatoon, Saskatchewan.

more rural and northern communities. While a common, widely applicable approach supporting self-directed funding models for older adults has yet to emerge, it is clear that the success of such models relies on having well-defined eligibility and responsibility requirements, well-informed and supported clients, families, and caregivers who understand their full range of options available and the parameters associated with each, and the full implications of making certain decisions around their care.

In other jurisdictions, a preferred model of provision has been to rest the administration of the funding and reporting requirements with a care coordinator, but developing a collaborative care planning model that truly empowers the care recipient in ensuring their personal needs and preferences around their care can be met. In understanding that self-directed funding options can offer an array of approaches which differ in terms of level of decision-making, individual autonomy, professional/agency involvement, responsibilities of the client versus the coordinating agency, and many other elements, it will be important that any future models established in Ontario to support the provision of care to older adults ensures that all of these factors be considered in their development.

**Recommendation:**

45. The Ministry of Health and Long-Term Care should explore developing Direct Funding Models that empower older Ontarians (or persons acting on behalf of them) to take a leadership role in purchasing and/or organizing their care to meet their care needs in their own homes instead of receiving care arranged through an approved agency. Offering a direct funding program that gives consumers greater flexibility and control over their health care services will support the ministry’s goal of person-centred care.

**Developing an Assess and Restore Framework to Support Aging in Place**

In Ontario, 45 per cent of community-dwelling older adults have been described as “frail” or “at risk” for functional loss. The loss of one’s functional abilities represents the largest threat to an older individual’s independence, often necessitating increased support from families, friends, and caregivers, as well as the need for formal home care and community supports to maintain one’s overall capacity for independent living. When these supports are insufficient to meet an individual’s functional needs, the need for residential and assisted living care environments, long-term care home or hospital care intensifies, depending on the older adult’s level of clinical complexity and need. Currently, an estimated 26 per cent of older adults who are 75 years and better receive some form of institutional care each year in Ontario.

When an acute health crisis occurs that precipitates a hospital admission, the risk of functional loss among older adults grows. Acute care hospitalizations account for 73 per cent of all institutional care received by those 75 years and better each year in Ontario. When older adults become ill, increased fatigue and weakness are not uncommon. Added to this, the loss of bone and muscle mass that typically follows immobilization helps to explain why over a third of older adults discharged from hospitals experience an overall functional loss compared to their baseline level of functioning, and why 50 per cent of these individuals never recover the function they lost. This potentially precludes
these older adults from ever living independently at home.\textsuperscript{142} For older adults with diminished capacity, bed rest can cause a functional loss of up to five per cent a day, compared to 10 per cent a week in younger individuals.\textsuperscript{143} It is this loss of skill essential for performing the basic activities of daily living – such as walking, toileting, or bathing – that decreases community independence and increases the likelihood of premature and avoidable institutional admission. This avoidable functional decline and debility among frail older adults following extended hospitalization is in part also responsible for adverse outcomes such as increased lengths of stay, delayed and difficult discharges, readmissions, the loss of capacity for independent living, an increased risk of institutionalization, and even death. Many of these adverse outcomes from hospitalization are preventable.

Although hospital care that prioritizes more elder friendly practices, such as early mobilization, can mitigate some of this loss of function, some frail older patients will inevitably suffer from a functional loss during a hospital stay to such a degree that, without restorative interventions, they will become unable to return to independent living in the community. Furthermore, it is a reality that beyond the functional loss caused as a result of an extended hospitalization, community-dwelling older adults may also present to hospital health services providers in a deconditioned state, due to the effects of an acute or chronic illness. This can further complicate the course of a person’s care and their discharge options.

Therefore, having timely access to targeted and appropriate assessment, prevention, and restorative care services is critical to minimizing the frequency and extent of functional loss experienced by at-risk older adults. Dr. David Walker concluded, following his careful analysis of the Alternate Level of Care (ALC) issue in Ontario, that an “assess and restore” philosophy must become central to the care delivered to older adults and that the health care system should include the provision of programs aimed at restoring and reactivating an older patient’s level of functioning while in hospital, including opportunities for older adults to be transferred home with appropriate ongoing enhanced supports. His report prompted LHIN investments in the creation of specialized assess and restore services across the province. These services have been credited as one of the key factors in helping steady the numbers of patients with ALC designations in the province over the past year.

The province needs an organized, provincewide response that targets these at-risk older adults and that reverses current “default” responses to this vulnerable group of individuals. This response must acknowledge the older adult’s restorative capacity, despite apparent functional limitations, and the benefits of specific service interventions that are person-centred, coordinated, targeted, effective, and timely.

The provincial response should also be premised on the evidence that, for certain medical conditions and for older adults, “time is function” and the clinical and functional trajectory of an older adult who has experienced recent functional loss in association with an acute event is indeed modifiable. The early identification of individuals at risk, valid and aligned assessment processes, timely referral, and targeted, effective interventions readily available across the care continuum – and especially in

the community – will be critical to increasing the probability that older Ontarians retain the level of function they need to maximize their opportunities for independent living.

Evolving the philosophy of “assess and restore” into one that equally emphasizes and prioritizes prevention is a clear call to action in the provincial Seniors Strategy. Given the challenge of reversing the effects of deconditioning and its functional sequela once established, opportunities to promote the prevention of functional loss must be prioritized. For those who may require inpatient care, the approach should help rationalize existing and overly complex “sub-acute” and geriatric rehabilitative care services that are linked with varying operational and funding parameters and processes that impede access and flow of patients to and through these services. Ontario, for example, is the only province in Canada with a designated complex continuing care sector and, over the past decade, variation in the type of care provided with respect to length of stay, amount of rehabilitative and medical care provided, and discharge destination amongst other factors has grown.

Today many hospital beds with a “complex continuing care” designation deliver a significant amount of short-term, restorative care often assumed to be the domain of the rehabilitative care sector. In addition, the long-term care (LTC) sector has implemented convalescent care services, which appear to overlap with the services delivered in inpatient rehabilitation care settings. An opportunity to evolve our post-acute care and LTC sectors to better respond to the needs of the frail older adults, reinforced by payment systems that reimburse providers by the actual care received in a bed, will improve access for this vulnerable population cohort and improve the overall sustainability of the system.

At the same time, it should be recognized that not everyone who experiences a functional loss will benefit from this assess and restore approach. Indeed, this approach must be targeted at the subset of frail older adults who have experienced a recent functional decline that puts them at risk of losing independence, for whom the functional loss is reversible and who can benefit from a period of sub-acute and/or inpatient geriatric rehabilitative care and for whom a discharge home is currently not a safe or cost-effective option. If the functional decline is not reversible, other services focusing on functional adaptation or maintenance may be more appropriate.

**Defining the Elements of a Provincial Assess and Restore Framework**

Suggested preliminary concepts and relationships for a provincial Assess and Restore (and Prevent) approach are illustrated in Figure 4.2 below. In this approach, entry into assess and restore begins in elder friendly communities and senior friendly hospitals with simple but reliable risk-screening tools that are usable by informal and formal caregivers in a range of settings, including the person’s own home, primary care providers’ offices, emergency departments, and acute care beds in hospital. These tools, tied to simple self-referral processes, would enable persons who have been identified as being at low-risk for institutionalization from loss of functional independence to be referred to community-based preventative exercise, activation, and falls prevention services delivered in Elderly Persons Centres and other local community settings.

A person identified as at-risk, by contrast, is referred to his or her CCAC, which, in coordination with the primary care provider, takes responsibility for more formally assessing care needs (e.g., using existing interRAI tools) and subsequently navigating him or her to the appropriate care setting and
provider(s). When an assessment indicates that an at-risk older adult is most appropriately cared for in a hospital or long-term care-based setting because it would not be safe or cost-effective to provide the required care though home- or clinic-based care services, the person would be matched to the restorative care services most appropriate for them:

- **sub-acute convalescent care**: for older adults with the physical and cognitive capacity to participate in “light” restorative activities, e.g., up to an hour a day of activation therapy
- **inpatient geriatric rehabilitation**: for older adults with enough physical and cognitive capacity to engage in higher-intensity restorative activities, including rehabilitative care delivered directly by regulated health professionals
- **sub-acute complex care**: for older adults who need a “cool-down” period after an acute treatment or illness, e.g., to resolve medication imbalances or allow post-surgical delirium to lift; restoration is focused on getting ready for more active care; services include daily medical oversight and access to 24/7 nursing.

Finally, once a patient has achieved their clinical and/or functional goals and is ready to return to the community, the CCAC, working with the primary care provider, would connect them with the appropriate continuing and preventative care providers.

**Figure 4.2 A Proposed Assess and Restore Framework to Support Aging in Place**
This proposed approach will require upstream investments in resources directed toward screening, prevention, and in-home and community-based rehabilitative services, more proactive early mobilization strategies in hospitals, and more streamlined inpatient rehabilitative services. Since at-risk older adults cross many of the traditional health care sectors, this approach must join up and make explicit the roles and responsibilities of the many care providers involved with these persons.

For example, in this model, all hospitals should establish “early mobilization” efforts with timely interventions that maximize restoration of functional capacity as standard practice. Requiring patients to be mobilized up to a chair with all their meals, emphasizing that the mobilization of older patients is everyone’s responsibility and that all patients, caregivers and staff should be encouraged to support the mobilization of older patients in institutional settings to prevent functional decline; inviting therapists early into a patient’s care especially if a decline in functional abilities from a person’s baseline has been detected; and making available therapy services seven days a week are just some examples of how this approach could look at the front lines of care.

The evidence supports that this overall approach will likely not only be cost-neutral, but will likely be cost-saving for the overall system due to likely reductions in emergency department visits, hospitalizations, demand for home care and assisted living supports, and placements into long-term care homes. It is anticipated that this more rationalized cross-sectoral approach will also expose efficiencies and opportunities for getting even more value from the myriad of existing assess and restore type services that, today, are highly variable in scope, results, and process.

**Recommendations:**

**Enhanced Screening and Detection of Functional Loss**

46. The Ministry of Health and Long-Term Care should support the development of an evidence-informed simple screening tool that can be self-administered or administered by a health or social care provider to help an older adult or caregiver determine whether the support of a local exercise or falls prevention class may be beneficial vs. a more formalized assessment by a community-based care coordinator.

47. The Ministry of Health and Long-Term Care and LHINs should ensure through various mechanisms (e.g., accountability agreements) that hospitals complete routine early screening and documentation of an older patient’s Activities of Daily Living (ADLs) functioning at and prior to their admission to facilitate the identification of those who have experienced a functional loss.

48. The Ministry of Health and Long-Term Care and LHINs should ensure through various mechanisms (i.e., accountability agreements, policy guidelines, etc.) that CCAC discharge planners engage in a process whereby patients being considered for a long-term care placement from hospital or home are evaluated to determine whether a course of restorative therapy in an appropriate setting may help them regain their capacity for independent living.
Enhanced Assess and Restore Services Provision

49. The Ministry of Health and Long-Term Care should enhance access to clinic-based physiotherapy services in every LHIN, especially for patients on limited incomes who often forgo this therapy when prescribed due to their limited financial means.

50. The Ministry of Health and Long-Term Care should support LHINs to increase the availability and accessibility of sub-acute and geriatric rehabilitative care programs and support entry to them directly from the community, not only from hospital, and ensure timely access to assess and restore services, both inpatient and community-based. Through various mechanisms, including accountability agreements, the LHINs should support the systemic adoption of best practices in the utilization of assess and restore services regardless of location.

51. The Ministry of Health and Long-Term Care should encourage CCACs to accelerate the implementation of their plans to manage the placement of persons into rehabilitation and complex continuing care beds and day programs using consistent admission criteria and assessment tools such as the interRAI Post-Acute Care instrument, facilitated by automated systems such as Resource Matching and Referral.

52. The Ministry of Health and Long-Term Care should allow flexibility in the classification and funding for care which falls outside a quality-based procedure to ensure older adults with complex conditions receive the right level and duration of sub-acute and rehabilitative care required to achieve optimal outcomes. This direction will be optimally supported by ministry policies that:

a) Simplify the classification of sub-acute care for older adults into two categories of bedded care: sub-acute complex and sub-acute convalescent care, and that the delivery of these services be aligned across long-term care homes, complex continuing care, and small and rural hospitals.

b) Standardize the scope and expectations of inpatient geriatric rehabilitation programs in Ontario and rationalize these services with other existing service delivery models.

c) Establish explicit roles and relationships between sub-acute care and geriatric rehabilitative care services delivered through inpatient rehabilitative care settings, including expedited referral and admission processes.

d) Link funding rate per bed per day to the care classification type and the associated requirements.

e) Do not set an upper limit to the number of days a person may be eligible for one of these sub-acute or geriatric rehabilitative categories of care and require that a patient’s need for that or a different type of care be reviewed every 30 days.

53. The Ministry of Health and Long-Term Care should improve access to short-stay programs in long-term care homes (LTCH) by simplifying and expediting the referral process (i.e., remove the requirement for capacity assessments of patients requiring convalescent care). (See Senior Friendly Hospital and LTCH Environments sections).
54. The Ministry of Health and Long-Term Care, in collaboration with the LHINs, should facilitate the delivery changes required to fully implement best practice rehabilitative care pathways for patients who are recovering from a hip and knee replacement, hip fracture, and stroke, as identified in the Health System Funding Reform.

Expanding Community-Based Supportive Housing Alternatives to Long-Term Care Homes

Assisted Living and Supportive Housing Services

The past few years have seen a growing recognition of the importance of assisted living and supportive housing services to provide older adults the opportunity to maintain their independence in their communities despite having higher care needs. While various types of supportive housing and assisted living environments have been in existence for years, it wasn’t until the Aging at Home Strategy that significant funds became available to allow LHINs to provide more of this type of care, especially to lower-income older adults in their regions who otherwise might have to be prematurely placed into a long-term care home. Indeed, until Aging at Home, in some LHINs there were no supportive housing options available in certain regions of Ontario. Currently, the LHINs fund a variety of assisted living and supportive housing programs such as the Assisted Living Services for High Risk Seniors, and the Assisted Living Services in Supportive Housing Policy related to persons with Physical Disabilities, acquired brain injuries, Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). In 2011-2012, 68,037 mostly older clients were provided with assisted living and supportive housing services.

“Supportive housing should be the alternative to long-term care for most seniors with chronic conditions.” – Seniors Strategy Survey Respondent

In Ontario, assisted living and supportive housing services are designed to provide support to people with special needs – including older adults. These persons generally require supportive living services at a greater frequency or intensity than could be provided with traditional care offered through CCAC home care services. At the same time, these individuals do not need the constant clinical monitoring or supervision that is provided in long-term care homes. These programs have evolved over the past few years to support clients by providing either on-site personal support services for older adults living as tenants in designated residential buildings, such as an older adults’ apartment building, or within a neighbourhood setting that could even allow them to access this level of care in their own homes – as long as these are in close proximity to their care providers. These different delivery models have been called “hub” and “spoke” forms of assisted living and supportive housing services that work particularly well in more urban settings. Here, care for many adults requiring these services (but wishing to remain in their own homes even when receiving them in the community) can be clustered within a small geographical area, making these services practical and efficient to deliver.
Most assisted living and supportive housing services programs are operated by not-for-profit organizations, including CSS agencies, with the provision of supportive care services often being subsidized through the ministry and its LHINs; this allows some individuals to receive personal support/attendant and essential homemaking services at no charge. For the housing component of the service, if one is not living in one’s own home, there is generally a tenant-landlord relationship established wherein the client is expected to pay rent based on their income as well as other common costs of living within the community. The supportive care services that could be provided in an assisted living and supportive housing services environment vary according to identified need, but can include personal support/attendant services and essential homemaking services with staff available 24 hours a day to handle regularly scheduled and emergency care needs. These services also aim to promote wellness and improve the health of their residents by providing a level of service that enables them, despite their illnesses or physical limitations, to live in the community with a high degree of independence, and to be integrated into community life as much as possible. In many instances, these models have been shown to delay institutionalization for even relatively high needs clients.

**The Value Proposition of an Assisted Living and Supportive Housing Strategy**

Despite the proven success of these models of care, there still exists no consistent established funding mechanism to support either the development of additional supportive housing units or to fund the care associated with them. This is in contrast to that of our long-term care system, where new bed development and care funding envelopes are defined with an infrastructure to support the development of additional long-term care spaces when the corresponding funding is made available. With supportive housing however, the development of new units is usually funded through the Ministry of Municipal Affairs and Housing while care is funded through the Ministry of Health and Long-Term Care. Therefore, the successful establishment of new supportive housing units relies heavily on increased coordination across ministries and the simultaneous alignment of interests and the availability of funds. Despite there being tens of thousands of supportive housing units in Ontario, there remains an incredible need for this sort of living environment. What is even more compelling is the fact that the annual $10,716 care envelope for those living in supportive housing environments tends to be at least a quarter of the annual $47,940 cost of caring for a person in a long-term care home.

Greater investments in home and community care, supportive housing, and assisted living services will significantly obviate the need to build long-term care beds at a much greater cost.\(^{144}\) This approach saw a significant decrease in the demand for long-term care in countries, such as Denmark, that pursued the implementation of these policies.\(^{145}\) Therefore, there exists an opportunity to build an equally robust financing mechanism for supportive housing in Ontario that can be tied to capacity planning efforts for given LHINs. This could start to allow these regions to build the type of supportive environments that would be most needed in their areas at a likely better overall cost that could help to rebalance care options so they could better meet the actual needs of the population and likely at a lower overall cost.

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With the ability to redevelop some older long-term care beds to the latest standards proving to be a greater than anticipated challenge, this may also pose an opportunity to allow older facilities and their beds to be repurposed into a more assisted living and supportive housing environment.

**Recommendation:**

55. The Ministry of Health and Long-Term Care, in partnership with the Ministry of Municipal Affairs and Housing, should encourage the development of more Assisted Living and Supportive Housing Units as alternatives to long-term care home placement for those who would benefit most from these environments. This could be accomplished by:

   a) Exploring the feasibility of re-purposing older long-term care homes identified for redevelopment into supportive housing units in accordance with LHIN plans to create such local alternatives.

   b) Developing – in line with future capacity planning requirements – an equivalent alternative funding model that supports the creation of Long-Term Care Home Beds with one that could support the development of Assisted Living/Supportive Housing Units instead to stem the future demand for far more resource-intensive long-term care settings given that there currently exists fewer supportive housing options and a greater unmet need for this type of housing for frail older adults.

See Appendix B for a list of proposed indicators, that could also be publicly reported, that can help to assess and monitor the supply of and timely access to assisted living and supportive housing services.

56. The Ministry of Health and Long-Term Care should encourage the development of cluster care models that allow more efficient use of community care staff capacity, and enhance continuity of care and a better work-life balance for community-based professionals, especially Personal Support Workers. The ministry should reinforce that CCACs and CSS agencies should broker and/or implement task-based care assignments with caution.
Promoting Safer Retirement Home Care

Increasingly, a number of older Ontarians have been choosing retirement residences as their preferred living environment. Many choose retirement home living for many different reasons, and the accommodations and lifestyles they offer can cater to a number of different needs and preferences. Currently, in Ontario, there are 420 retirement residences providing 43,380 residential units.

Until recently, retirement homes acting as private residences where individuals would pay for their accommodations and care services were not subject to any regulatory standards. This is unlike long-term care homes, which are highly regulated. To recognize that retirement homes are more than just residences, but also places where people choose to live to receive personal and clinical care as well, the government chose to introduce legislation a few years ago to help ensure this growing residential and care option could meet the high standards that individuals and, in particular, vulnerable older adults, require to live with dignity and respect.

The 2010 Retirement Homes Act now regulates all retirement homes in Ontario defined as residential complexes with:

- one or more rental units of living accommodation that are occupied primarily by persons 65 years and better;
- are occupied, or intended to be occupied, by at least six people not related to the operator; and
- make at least two care services set out in the act available, directly or indirectly, to its residents.

The act also has allowed the creation of a regulatory authority with the power to license homes and conduct inspections, investigations, and enforcement, including issuing financial penalties or revoking licenses if necessary. It further establishes mandatory care and safety standards, and requires emergency plans, infection control and prevention programs, assessment of care needs and care planning, police background checks, and training for staff.

Finally, the act establishes residents’ rights, including the right to know the true cost of care and accommodation and the right to live in an environment that promotes a zero tolerance policy towards abuse or neglect.

Prior to becoming regulated under the act, a number of health, social, and community care providers were understandably reluctant to recommend or endorse retirement residences as housing options for their patients or clients. While some reluctance remains, through the act and its powers it is hoped that both professionals and individuals will be able to trust that these homes are providing a high standard of accommodation and care to those who can afford this community living option. Just as it will be important to ensure that older Ontarians and their families are aware of these living options, it will be important to ensure that they understand all of their other housing and care options and the costs associated with each – from staying in their own homes and receiving home care, to living in a supportive housing or even a long-term care home.

In being supported to make informed decisions, we also need to ensure that older Ontarians living in retirement homes are made aware that, while living in a private residence, they are still able to access government-funded or subsidized home care and community support services through CCACs or CSS.
agencies, regardless of their ability to pay. This last point is particularly important as some older adults reported to us that they were charged excessive costs to receive care that they were not informed they could have accessed for free through their local CCAC. In other cases, older adults may have been informed that they may not be eligible for CCAC services because they could afford to pay privately for their care. Clearly, in the interest of equity, every Ontarian has the right to know what their full range of options are in order to make informed decisions around supporting their care needs and preferences.

**Recommendations:**

57. The Retirement Homes Regulations Authority should continue with its current regulatory implementation and enforcement plan rollout under the 2010 act that should see all aspects of the act fully in place by 2014.

58. The Government of Ontario should continue with its legislated commitment to a five-year review of the effectiveness of the act to further support and enhance the experiences and safety of retirement home residents.

59. The Government of Ontario should continue to support efforts to ensure retirement home residents are aware of the availability of and their eligibility for CCAC and CSS agency services within retirement home settings.

**The Elder Foster Care Model**

The foster care system that many Ontarians would be familiar with is the one designed to find homes for abandoned and abused children. However, in the United States and elsewhere, foster care is becoming an increasingly popular way to support older adults to remain in home settings and the communities they know, within the embrace of a family. With monthly costs averaging about $1,000 to support an older adult in foster care, many jurisdictions are finding this model to be one that can both save money and afford older adults greater freedom in choosing a safe and comfortable place to live.

In the United States, it is estimated that tens of thousands of older adults of varying ages and conditions are living in foster homes. Interestingly, adult foster care services are already available here in Ontario, although there hasn’t been much of an emphasis on this type of care. While the province of Ontario sets mandatory standards of care and issues licenses for agencies that provide foster care for children, no mandatory standards for the provision of adult foster care appear to exist in Ontario, although some agencies are approving their homes for adults under the same standards and protocols used for placing children.

Like foster care for children, foster care for older adults involves paying a person or a family to take in other people and provide them a home with someone to watch over them and attend to their basic needs. Unlike children, who are placed in foster care when others decide it is best, older adults choose this care for themselves. Usually a government agency or a non-profit organization brings the family and the participant together. While concerns about personal safety are often considered, there have been few cases of abuse ever reported in other jurisdictions. For many frail older adults whose needs
don’t require long-term care, but who may not be living in a situation that could support care in their own homes because they have no family, they need more supervision than they could personally afford or they live in substandard homes that are unsafe or unsanitary, elder foster care models create homes where they can be cared for when staying in the community and not in an institution; this is important to them.

Interestingly, we discovered during our consultations that, until recently, in the Niagara Region, a formal elder foster care program was being operated for financially marginalized, medically stable older adults with limited social supports who were seen to be at risk of a premature long-term care placement. Through this supportive housing program, individuals within the community with available rooms within their homes and a genuine interest in supporting older adults were paired up with one or more older adults. In recruiting caregivers in this model, many were found to have served as foster parents in their earlier days, but now found this program to be a more complementary fit. Those providing the foster care would do so through a contract agreement with the local region in partnership with the operator of a local long-term care home to ensure quality in care and access to recreational and other supportive programs and professional advice that provided support for the foster caregiver. While this program recently came to an end, there still appears to be enormous potential to formalize this type of care model to allow it to become established as another realistic option for care that older adults in Ontario may come to increasingly desire.

Recommendation:

60. The Ministry of Health and Long-Term Care should explore the feasibility of introducing a more formalized “Foster Home” model for older Ontarians without existing caregivers who wish to remain in the community in a home setting with a new caregiver.
Chapter 5: Improving Acute Care for Elders
Why We Need an Acute Care for Elders Strategy

Older Ontarians, compared to the rest of the population, not only use hospital services more often, but also in different ways. Although representing only 14.6 per cent of the provincial population, older adults account for 20 per cent of all emergency department visits, 40.4 per cent of all hospitalizations, and 58.8 per cent of all hospital days across the province,\(^{146}\) as older adults tend to experience longer lengths of stay compared to the average when hospitalized.\(^{147}\) Older adults are also more likely than others to present to emergency departments (EDs) with urgent or critical issues and are at least twice as likely to be admitted to the hospital from the ED, although most are still treated and discharged back into the community.\(^{148}\)

While older adults represent the greatest users of hospital services overall, a number of longitudinal studies have consistently demonstrated that only a small proportion of older adults are actually high users of hospital services. In Wolinsky et al’s landmark study,\(^{149}\) the hospitalization patterns of 7,527 older individuals, who were at least 70 years and older, were followed for close to a decade. They found that 42.6 per cent of these individuals were never hospitalized, while an additional 24.6 per cent were categorized as consistently low users – being hospitalized only once over that period. The remainder, however, were found to be higher users, with 4.8 per cent being categorized as consistently high users and 6.8 per cent as inconsistently high users. For these latter groups, the presence of three factors appeared to characterize these high users: having multiple chronic conditions, having functional impairments that make one more dependent, and being socially frail in having inadequate social and community supports at home. Therefore, understanding that the typical older patients that often present to hospitals are characterized with more complex and often inter-related health and social care issues, compared to younger patients, raises the understanding why their care necessitates a different overall approach.

The Hazards of Hospitalization

Most older adults access hospital services when a health issue forces them to present to an ED. The clinical complexity of older patients contributes to the challenges that emergency physicians, nurses, and other professionals face in providing their care. It has long been recognized that within this population, common diseases more often present atypically; comorbidities can confound standard approaches, including the interpretation of common diagnostic tests; polypharmacy is ubiquitous; depleted physiologic reserves and impaired cognition must be anticipated; and traditional social

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support systems may be compromised.\textsuperscript{150} It is no wonder that such patients are more difficult and time-consuming to assess and manage in the ED compared with younger patients.\textsuperscript{151,152}

Furthermore, although older patients tend to receive the most resource-intensive care of any age group within EDs, their problems are less likely to be accurately diagnosed, partly because the actualization of many of the earlier-listed and long-established principles related to working with older patients into current routine practices has been slow. Consequently, they are more likely to be discharged from EDs with unrecognized and untreated problems.\textsuperscript{153,154,155} Other factors contribute to suboptimal care delivery. Providing optimal assessment and discharge planning tends to be more complicated for older patients in ED settings, where time pressures and the need to maintain rapid patient throughput are considered essential.\textsuperscript{156} A relative lack of knowledge among ED professional staff in geriatric principles of care and practice may compound the strain of trying to adequately address the often complex and inter-related health and social care needs of older patients.\textsuperscript{157} All these factors may help account for the higher rates of adverse outcomes, including ED revisitation, hospitalization, functional decline, and death, that are experienced by older adults compared with others within months of an index ED visit.\textsuperscript{158}

Our main problem is that while the patients have changed, our systems have not. Our current acute care models, for example, were developed years ago when most adults tended not to live past 65 years or be living with chronic illnesses and usually had only one active issue that brought them to hospital.\textsuperscript{159} While this model still functions well for younger patients, it is increasingly recognized that the way in which acute hospital services are currently resourced, organized, and delivered often disadvantages older adults with chronic health problems.\textsuperscript{160}

We are also coming to understand how the loss of functional reserve experienced by many older adults together with our traditional models of care, in addition to being costly, renders many older patients particularly at risk for adverse outcomes such as falls, delirium, medication interactions, functional decline and death, in part due to their higher rates of polymorbidity and polypharmacy and a tendency to require longer hospitalizations.\textsuperscript{161} All of these factors contribute to increased lengths of stay, readmissions, and the loss of their capacity for independent living, which often necessitates

patients requiring a new Alternate Level of Care (ALC). Indeed, hospitalized older adults currently comprise 79 per cent of all ALC-designated patients in Ontario. As of October 2012, there were 3,343 older ALC patients in acute and post-acute care settings, of whom 55 per cent were waiting to be placed in a long-term care home, while 12 per cent were waiting to go home with Community Care Access Centre (CCAC) services. These figures make sense when one considers that one in three older adults discharged from hospital leaves functioning at a higher level of disability than when he or she entered, with half of these individuals unable to ever recover the function lost. However, what is most concerning is that most of us still have not come to appreciate that many of these adverse outcomes are preventable.

**Establishing a New Direction for the Acute Care Sector**

Although there is certainly a need for reforms in primary and community-based care, older adults will still require hospitalization even under the best of circumstances. Therefore, there is an opportunity to reduce disease burden, improve access and capacity, and ultimately promote health through the development, linkage, and implementation of innovative care models within and beyond acute care settings. Early attempts made to provide guidance to hospitals on establishing geriatric services often relied more on compelling anecdotes than compelling evidence, and rarely demonstrated the efficacy of these services. However, research over the past two decades has improved our understanding of risk factors for adverse outcomes and effective interventions that can prevent such outcomes. We now know that implementing specific models and point-of-care interventions in locations such as the emergency department and inpatient, transitional, outpatient and community care settings can improve overall outcomes and reduce lengths of stay, admissions, readmissions, and inappropriate resource use. These models thereby improve the overall capacity and efficiency of the system.

However, implementing innovative models of care that challenge deeply ingrained traditional ways of providing care has proved to be a significant challenge. It is also important to acknowledge that

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acute care providers are under considerable pressure to reduce overall costs given the implementation of new health system funding reforms through the current Action Plan for Health Care. In such an atmosphere, the opportunity for innovation in health service delivery can be limited to simply “doing the same with less.” With annual per capita growth rates in acute care costs increasing the fastest for older adults, and given that this growth rate is expected to continue to rise, it is imperative that we focus our efforts around developing new cost-conscious models that are able to meet the complex needs of older patients across the care continuum, improve the overall capacity and efficiency of the system, and, whenever possible, provide care that is less costly and closer to home.

Promoting Alternatives to Hospital-Based Care

An Evolving Role for Community Paramedicine

When older adults become acutely ill in the community, the first care providers they have come to expect and depend upon are typically paramedics. Older adults are the highest users of paramedical and ambulance services in Canada. However, it is important to note that, while the majority of the calls that paramedics respond to are medically necessary, they are neither time sensitive nor immediately life-threatening. In particular, paramedics often find that the older adults they are most likely to engage with are the small subset of individuals who are struggling with polymorbidity, functional impairments, and social frailty.

What further complicates matters is that there is no requirement for paramedics, like any other health or social care professionals in Ontario, to obtain formal training in how to assess and manage issues common to the elderly. While paramedics are highly skilled and highly regulated health professionals, the profession is by and large still mandated and therefore oriented and engaged in providing emergency response and transfer services. The reality is that paramedics are increasingly seeing older persons in pre-crisis situations who need more supportive types of interventions to help them age in place. For example, while one of the greatest non-urgent call-outs is for lift assists, many paramedics know that the time invested by the right combination of professionals in investigating and addressing the underlying causes of the falls patients suffer would reduce the incidence of both future falls, injuries, hospitalizations and eventual placements into long-term care homes. The challenge is that paramedics, through the way their services have been traditionally organized and structured, often work in isolation to other health, social and community care professionals, at a time when care services and providers need to be more integrated to better meet the needs of an aging population.

Community Paramedicine Models

The need to work differently to better meet the needs of patients has given strength to the growing community paramedicine movement across Ontario and beyond. In allowing paramedics to engage in more non-traditional roles and to assist in supporting the health care needs of vulnerable persons, growing evidence is also showing that community paramedicine programs can meaningfully reduce emergency calls to paramedic services, which in turn reduces emergency department visits and hospitalizations.

Hamilton, Ottawa, Niagara, Toronto and Renfrew County are some examples of areas where community paramedicine programs in Ontario are starting to demonstrate better patient and system outcomes. The success of these programs has been largely based on allowing paramedics to broaden their traditional scope of practice through models that achieve better integration with other health, social, and community care providers.

It has been noted that some of the greatest users of Emergency Medical Services (EMS) are vulnerable older adults who are often isolated and disconnected from traditional care providers. As a result, a number of services across Ontario have launched Community Referrals by EMS (CREMS) programs as a way to link individuals with unmet needs with community care providers to better assess and manage their needs. In most cases, older adults are unaware of the services available within their communities or, in other cases, they simply do not recognize their need for assistance or that they could benefit from home care and community support services. The CREMS program provides clients with the opportunity to receive valuable health, social, and community care supports in their homes, improving their quality of life and maintaining their independence. By connecting patients with care and support, CREMS helps to address and resolve the chronic or developing issues that could be occurring in a person’s life.

Where evidence has been collected, these programs have not only worked well to link patients to existing community supports, but they have also showed remarkable drops in subsequent calls and transports to EDs. In 2011, Toronto EMS’ CREMS Program identified 904 adults as likely to benefit from a CCAC referral, and for whom one was made. In evaluating the effect of the program six months before and after a referral was made, a 50.6 per cent (2,715 versus 1,340) drop in the number of 911 calls made and a 64.8 per cent (1,654 versus 582) drop in the number of ED transports that occurred was observed, with savings of approximately $321,600 realized from the reduced transports alone. The ability to provide this relatively straightforward service without a requirement for additional paramedical resources has helped many of these services to stem the growing demand for ambulance services as well.

The Ottawa and Renfrew County Paramedicine Services have further aided the development of community paramedicine services by supporting the research and development of the three-item Paramedics assessing Elders at Risk for Independence Loss (PERIL) Risk Assessment Tool. The PERIL Risk Assessment Tool is able to identify older adults who are at high risk of experiencing...

180 Ibid.
harmful outcomes like death, hospitalization, or a return to the ED after an initial encounter with an EMS paramedic. The tool itself assigns one point to an affirmative answer to any of the three following questions:

1. Given the current home situation, are there any problems that would prevent this client from being safely discharged home from the ED, or contribute to recurrent EMS/ED use?
2. Does the client usually need someone to help him/her on a regular basis?
3. Has the patient made any 911 calls in the past 30 days?

This validated and simple three-item screening tool can easily be incorporated into routine practices and allows any paramedic to assess their patient's risk of calling 911, being hospitalized, or dying within the next 30 days. Already, some paramedics in the province are now using the PERIL Risk Assessment Tool to identify high-risk patients with scores of two or more out of three to determine who should be referred on for further follow-up in the community through a CREMS Program or other services.

**In Focus:**

**Community Paramedicine Aging at Home Program, County of Renfrew, Champlain LHIN**

While waiting for placement in a long-term care home, older adults make frequent contact with the health care system and have high rates of emergency department use.\(^{181}\) As a result, in the rural town of Deep River, Ontario, the County of Renfrew Paramedic Service launched a unique community paramedicine program with funding from the Champlain Local Health Integration Network (LHIN) to support older adults who are eligible for or awaiting a long-term home placement to stay in their own homes longer.\(^{182}\) Through this cost-effective program, paramedics in association with other community partners, developed a system to provide 24-hour flexible and proactive supportive and enhanced home-based primary and community care services to these older adults, that reduced overall ED and hospital utilization, and improved the status of patients that allowed delayed or even completely avoided eventual admissions to the local long-term care home.\(^{183}\)

Overall, it is clear that significant benefits could likely be realized by making the adoption of the PERIL Risk Assessment Tool and the development of CREMS program standards of paramedicine practice across Ontario that can further deliver better patient and system outcomes in a more integrated way. Furthermore, in areas where capacity exists to offer preventative or outreach services or additional resources can be secured to provide this capacity, the additional benefits that community paramedics with expanded scopes of practice can deliver are already starting to raise interest in the potential roles that paramedics can play. This is particularly the case in more rural and northern settings where health

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human resources are especially scarce. Further evaluation of them could help to build support for their spread as well, especially where a value proposition can be developed as well.

It should also be acknowledged that the growth of community paramedicine services across the province has been and will be challenged by being both provincially and municipally funded services whose priorities are locally influenced and whose boundaries are not co-terminous with those of Local Health Integration Networks (LHINs), Community Care Access Centres (CCACs) and other health, social, and community care providers. Nevertheless, the growing realization that community paramedicine models can result in better patient, system, and fiscal outcomes will likely, with the support of leaders in the profession, see the further development and spread of these models across the province over time.\(^{184}\) Finally, mandating that core paramedicine training and continuing education must include relevant content that will aid in understanding and managing the needs of older adults will be essential to progress the work of this profession as well.

**Recommendations:**

61. The Ministry of Health and Long-Term Care, in collaboration with LHINs and local municipal Emergency Medical Services (EMS) programs, should explore the development and expansion of Community Paramedicine programs across Ontario and especially in northern and rural communities that could better support high-users of EMS to avoid ED visits and hospitalizations, and potentially delay entry into a long-term care home as well. Implementation should:

   a) Include the Community Referrals by EMS (CREMS) Program that refers older adults identified as being at high risk of poor outcomes with a referral to a CCAC care coordinator.

   b) Support the use of the three-Item Paramedics assessing Elders at Risk of Independence Loss (PERIL) Risk Assessment Tool to identify older Ontarians at the highest risk for recurrent ED use, hospitalization, or death within one month and refer them to their primary care provider and/or a CCAC care coordinator for further assessment and management.

**The Hospital at Home Model**

If faced with a choice to obtain safe, high-quality, hospital-level care in the comfort of one’s home during an acute illness versus in the hospital, the majority of older adults would opt to receive their care at home.\(^{185}\) In fact, in studies comparing the outcomes of older adults receiving hospital-level care at home for common illnesses versus routine in-hospital care, it has now been clearly demonstrated that Hospital at Home patients are less likely to experience clinical complications such as delirium and functional decline, are more likely to be alive at six months, and along with their families are more likely to be satisfied and less stressed with the care they receive, which can cost nearly one third less overall.


In North America, the Hospital at Home model was developed by researchers at the Johns Hopkins University Schools of Medicine and Public Health as an innovative model that sought to provide older adults the opportunity to receive hospital-level care at home as a complete replacement for acute hospital care. After arriving at an emergency department, the model offers eligible older patients, who require hospital admission for certain medical conditions like community-acquired pneumonia, congestive heart failure and chronic obstructive pulmonary disease, cellulitis, dehydration, urinary tract infection/urosepsis, deep venous thrombosis and pulmonary embolism, the opportunity to receive their treatment and ongoing care at home. Patients who would be deemed eligible to receive hospital-level care at home typically include 30 per cent of older patients with the previously stated conditions, are typically assessed as being at a low-risk of clinical deterioration with proper care, and are less likely to require highly technical hospital-based procedures or consultations. Not only were better care outcomes realized at lower overall costs, but patients and family members were found to judge the quality of the care provided through the Hospital at Home model to be better than the care provided in an acute hospital. Furthermore, they found that their relationships with the physicians and other health providers were more satisfactory overall and that they actually preferred the Hospital at Home admission and discharge process versus the usual hospital processes, possibly due to improved communication levels that are essential in the Hospital at Home model.

The Hospital at Home Model has four principal components:

1. **Assessment**: the clinician determines that the patient has an acute illness that could be treated at home.
2. **Transportation**: the patient is then transported home with a nurse or physician and any necessary equipment.
3. **Home Care**: the designated nurse remains with the patient and provides the necessary care with the support of an on-call physician and in conjunction with the patient’s primary care provider.
4. **Discharge**: the care team, including the patient, family or caregiver, and physician, develop a discharge and follow-up care plan.

In Australia, the State of Victoria has also experienced similar results from their Hospital at Home model which has now become an established model of acute care that is highly valued by patients and caregivers, and used to treat a range of conditions. With nearly all state hospitals offering this care, in 2008-2009 32,462 patients received care through this model. While representing just 2.5 per cent of all inpatient admissions, and five per cent of all inpatient bed days in the state that year, analyses have shown that the model has saved the state the overall costs of having to build a 500-bed hospital. All in all, the program has been a remarkable success in demonstrating equal or better health outcomes as compared to routine in-hospital care for most patient groups and has significantly expanded the

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189 Ibid.
overall capacity of the acute care system by reducing the need for hospital capital expansion and making better use of existing hospital infrastructure.\textsuperscript{192}

In Canada, there have been a few small-scale trials of models substituting acute care services in hospital with acute care being provided in the home. However, these models appear to vary in the type of clients they served, the model designs, and resources utilized. Many of these early trials were not entirely substitution models, so they resulted in duplication of homecare services and were not developed in a sustainable way that could be integrated into the overall health care system.\textsuperscript{193}

Since these former trials took place, a more robust and well-researched and tested Hospital at Home model has emerged. Meanwhile, the home and community care landscape in Ontario has significantly changed with a more advanced system now in place that can offer highly skilled nursing and other health professional care services through the province’s CCACs. Therefore, testing and establishing a Hospital at Home model in Ontario that is based on the learnings of other jurisdictions, includes consultation with key stakeholders, considers existing resources, and identifies clear outcome measures to determine the appropriate implementation approach should be explored. Given the model’s demonstrated ability to improve patient and system outcomes, a model like this could realize a significant reduction in hospitalization, ALC and subsequent long-term care home admission rates, while further delivering the goal of the Action Plan to provide more care for Ontarians at home.

Recommendation:

62. The Ministry of Health and Long-Term Care, in collaboration with LHINs, should support the development and launch of the Hospital at Home model in Ontario. A successful proof of concept of this model in Ontario will provide the information required to further implement this model across the province if deemed successful.

\textsuperscript{193} Ibid.
Safer and Senior Friendly EDs and Hospitals

While older adults have long represented the greatest users of hospital services in Ontario, until a few years ago, only a handful of hospitals were prioritizing their care. With a growing recognition that attending to the unique needs of older hospitalized patients can deliver significant patient, provider, and system benefits, the LHINs committed their support in 2010 to further the implementation of a Senior Friendly Hospital Strategy as part of a broader commitment to enhance the care of older adults within hospitals.

To identify common themes in relation to the care of older adults in hospitals across the province, including promising practices and opportunities for organization and system-level improvement, the LHINs had all 155 hospitals in Ontario that treat older adults participate in a self-assessment process with the support of the Regional Geriatric Programs of Ontario. The overall findings of this process were compelling. While there exists a growing recognition around the necessity to introduce elder friendly care in hospitals and emergency departments, the provincewide self-assessment exercise revealed that only 49 per cent of Ontario hospitals reported having implemented care protocols to address areas of confirmed risk to older adults. However, this may be a reflection of the fact that only 39 per cent of Ontario hospitals had established specific goals related to the provision of elder friendly care within their strategic plans; only 30 per cent had made a commitment at the board level to becoming elder friendly organizations; and only 31 per cent of hospitals had developed committee structures to lead the development and implementation of elder friendly care initiatives.

In considering the best evidence that relates to caring for older adults in hospitals, the Senior Friendly Hospital Initiative allowed the LHINs to endorse a series of 12 overall recommendations across five domains, outlined in Table 5.1, to support its hospitals in developing their capabilities to deliver better care for their older patients. It also proposed a framework for LHINs to support their hospitals in implementing these recommendations as part of broader system planning efforts to improve the overall care of older adults.

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Table 5.1 Recommendations for Hospitals to Support the Development of Senior Friendly Hospitals

<table>
<thead>
<tr>
<th>Organizational Support</th>
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<tbody>
<tr>
<td>1. Establish board and/or strategic plan commitments for a Senior Friendly Hospital.</td>
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<tr>
<td>2. Designate a senior executive/medical leader in the hospital to lead and be responsible for senior friendly initiatives across the organization.</td>
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<tr>
<td>3. Train and empower a clinical geriatrics champion(s) to act as a peer resource and to support practice and policy change across the organization.</td>
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<tr>
<td>4. Commit to the training and development of human resources via seniors-focused skill development.</td>
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<tr>
<th>Processes of Care</th>
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<tr>
<td>5. Implement interprofessional protocols across hospital departments to optimize the physical, cognitive, and psychosocial function of older patients. These processes should include high-risk screening, prevention measures, management strategies, and monitoring/evaluation processes.</td>
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<tr>
<td>6. Support transitions in care by implementing practices and developing partnerships that promote interorganizational collaboration with community and post-acute services.</td>
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<tr>
<th>Emotional and Behavioural Environment</th>
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<td>7. Provide all staff, both clinical and non-clinical, with sensitivity training to promote a senior friendly culture throughout the hospital’s operations.</td>
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<tr>
<td>8. Apply a senior friendly lens to patient-centred care and diversity practices, so that the hospital promotes maximal involvement of older patients and families/caregivers in their care consistent with their personal values (e.g., cultural, linguistic, spiritual).</td>
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<tr>
<th>Ethics in Clinical Care and Research</th>
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<tr>
<td>9. Provide access to a clinical ethicist or ethics consultation service to support staff, patients, and families in challenging ethical situations.</td>
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<tr>
<td>10. Develop formal practices and policies to ensure that the autonomy and capacity of older patients are observed.</td>
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<tr>
<th>Physical Environment</th>
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<tr>
<td>11. Utilize senior friendly design resources, in addition to accessibility guidelines, to inform physical environment planning, supply chain and procurement activities, and ongoing maintenance.</td>
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<tr>
<td>12. Conduct regular audits of the physical environment and implement improvements informed by senior friendly design principles and by personnel trained on the clinical needs of frail populations.</td>
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The survey findings also led to the recommendation being made that the clinical priorities of functional decline, delirium, and transitions in care be made system-wide priorities for all hospitals caring for older adults. In recognizing the importance of these issues, action plans that could accomplish the following for each issue were suggested:

1. **Functional Decline**: Implement interprofessional early mobilization protocols across hospital departments to optimize physical function.
2. **Delirium**: Implement interprofessional delirium screening, prevention, and management protocols across hospital departments to optimize cognitive function.
3. **Transitions in Care**: Support transitions in care by implementing practices and developing partnerships that promote interorganizational collaboration with community and post-acute services.

The LHIN’s self-assessment process was able to identify promising practices that in particular addressed issues of functional decline, delirium, and transitions in care. It further allowed a select group of hospitals to be identified that were leading the province in these areas and demonstrating improved patient, provider and system outcomes as a result of their initiatives.

**In Focus:**

**Mount Sinai Hospital as a Prototypical Senior Friendly Hospital, Toronto, TC-LHIN**

Mount Sinai Hospital in Toronto took the lead in Ontario to become its first acute care academic health sciences centre to make geriatrics one of its core strategic priorities with a mandate to deliver excellence in patient care, teaching, and research activities related to the care of older adults.

Mount Sinai, like other leading hospitals in this area, saw its clinical and administrative leaders and front-line providers come together through a Geriatrics Steering Committee that has now been meeting monthly for over five years. Through its work, the Committee successfully advocated that the care of older adults be deemed a strategic priority with meaningful hospital support, and oversaw the implementation of specific evidence-informed models and point-of-care interventions across its continuum of care that aim to improve patient, provider, and system outcomes.

Under its Acute Care for Elders (ACE) Strategy, it implemented a series of the evidence-informed but tailored interventions (i.e., ISAR, GEM, ACE, Orthogeriatrics, HELP, NICHE, etc.) all of which are highlighted in Table 5.2. However, the hospital went one step further in linking all of the models to create a more seamless integrated service delivery model that spans the continuum of care and is enabled by an interprofessional collaborative and team-based approach to care and a number of information technology innovations. The hospital has also demonstrated the importance and success that a collaboration with community partners like the Toronto Central Community Care Access Centre (CCAC) and local Community Support Services (CSS) agencies can have in helping to transition and keep a greater number of older adults at home.

To sustain and monitor its approach, Mount Sinai established a multi-year action plan, which measures its progress using a balanced scorecard featuring key metrics and a benchmarking system that has allowed the hospital to compare its performance against regional comparators on a quarterly basis and to identify where further improvements can be made. As a result of this approach, the hospital has seen a decrease in its lengths of stay and readmissions, as well as an increase in the rates of the patients able to return home while achieving higher levels of patient satisfaction.195

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Table 5.2 Examples of Evidence-Based Senior Friendly Hospital Interventions

<table>
<thead>
<tr>
<th>High-Risk Screening Tools</th>
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<tr>
<td>Evidence-based screening tools like Identification of Seniors at Risk (ISAR) and the interRAI Assessment Urgency Algorithm (AUA) have been designed for use with older adults presenting to the ED to quickly and effectively identify those who are at an increased risk of a variety of adverse outcomes, including functional decline, readmission and institutionalization. Use of these tools must be linked to follow-up processes, including a formal clinical evaluation.</td>
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<tr>
<th>Geriatric Emergency Management (GEM) Nurses Model</th>
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<tr>
<td>GEM nurses are ED-based advance practice nurses who exclusively focus on assessing and addressing the needs of frail older patients while helping to connect them with specialized geriatrics services and home care and community support services as required. GEM nurses have been found to be helpful in preventing unnecessary admissions, while also facilitating the care of older patients who may need further in-hospital assessment and support.</td>
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<tr>
<th>Hospital at Home</th>
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<tr>
<td>The Hospital at Home model provides acute hospital-level care in a patient's home to substitute for acute hospital care. Patients receive physician and nursing care and diagnostic and therapeutic interventions usually provided in the hospital, commensurate with their illness severity. This model delivers equivalent care for a lower cost, with fewer adverse events like delirium or functional decline, and higher satisfaction levels. This model can also be deployed to facilitate early discharge from the acute care hospital.</td>
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<thead>
<tr>
<th>Acute Care for Elders (ACE) Units</th>
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<tr>
<td>ACE Units operate within a specially designated ward of the hospital that aims to combine geriatric assessments, quality improvement, a specially planned environment, interprofessional team rounds, frequent medical care reviews, and comprehensive discharge planning. ACE Units have been shown to reduce lengths of stay, readmissions, and long-term care placements and help hospitalized older adults maintain functional independence in basic activities of daily living.</td>
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<tr>
<th>Orthogeriatrics Services</th>
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<tr>
<td>Orthogeriatrics is a co-management model that brings geriatricians and orthopaedic surgeons together in the care of older patients with hip fractures. In enhancing the care of these patients with comprehensive geriatric assessments at the time of admission, and ongoing support through the length of stay, these models have shown an ability to reduce the incidence of delirium and thus shorten lengths of stay.</td>
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Hospital Elder Life Program (HELP)

HELP is a volunteer-based model designed to prevent delirium by keeping hospitalized older patients oriented to their surroundings; meeting their needs for nutrition, fluids, and sleep, and keeping them mobile within the limits of their physical condition. HELP has been shown to be effective at reducing the incidence of delirium and functional decline in hospitals.

Care Transitions Intervention Model

In this model, hospital patients are assigned with a transitions “coach” who helps patients learn self-management skills beginning at discharge. The coach, a specially trained nurse, helps patients learn to manage multiple prescriptions, follow post-hospital recommendations, and present their health care providers the information they need.

Nursing Improving Care for Health System Elders (NICHE)

NICHE provides clinical and organizational tools and educational resources to support a systematic change in the culture of health care facilities. NICHE supports organizations to achieve patient-centred care for hospitalized older adult patients. NICHE has been used by numerous hospitals across North America and other health care settings to foster system-wide improvements in the care of older people.

The British Columbia 48/6 Approach

Other jurisdictions have also developed strategies to support the delivery of elder friendly hospital care. British Columbia, for example, has implemented its 48/6 Model of Care for Hospitalized Seniors. The 48/6 model is a best practices integrated care model for hospitalized older adults. In this model, patients are screened and assessed within 48 hours of admission around six inter-related areas of focus:

1. Bowel and Bladder Management
2. Cognitive Functioning
3. Functional Mobility
4. Medication Management
5. Nutrition and Hydration
6. Pain Management

Based on the results of these assessments, care plans are developed in collaboration with the patient, in order to facilitate a safe and timely discharge back home whenever possible.

The 48/6 approach requires continued monitoring of all six care areas through the duration of a patient’s hospital stay to ensure that any identified issues are managed appropriately. Early findings have shown that this integrated care approach can help patients maintain a greater degree of functionality, resulting in more timely discharges to the home or community.


The LHIN’s Senior Friendly Hospital Initiative, along with our consultations this summer with hospitals across Ontario, demonstrated that there are a number of hospitals, particularly small and rural community hospitals, that feel they lack the expertise to advance these care strategies. To provide sector-level assistance, the Regional Geriatrics Programs of Ontario launched a Senior Friendly Hospital Toolkit to support hospitals at all stages of development, which many have found useful. In the past, the ministry has supported hospitals in implementing new innovative practices with a coaching implementation model. In particular, where these models have proven to be particularly successful is where they have been led/endorsed by the field and its leaders and where an opportunity to identify and address local nuances and implementation challenges is provided as well.

In line with this approach, the LHINs, in partnership with Mount Sinai Hospital, the Ontario Hospital Association, the Registered Nurses Association of Ontario, Nurses for Improving the Care of Health System Elders, IVEY Center for International Health, and the ministry have come together this fall to develop their Elder Friendly Collaborative for Hospitals in Ontario (ECHO) Initiative to build on previous work and establish an innovative peer-to-peer coaching and knowledge translation/exchange program to promote the adoption and successful implementation of elder friendly care models and processes in acute care hospitals across Ontario. The goal of this initiative is to establish a lead Senior Friendly Hospital in each LHIN with the goal that they can then help serve as future leaders to support other hospitals in their regions advance this overall focus of care.

**Enhanced Emergency Department (ED) Care**

Within EDs across Ontario, there has also been a significant amount of work undertaken to improve the care of older adults. With EDs being busy and noisy places, the time spent waiting to receive care or to be transferred to a more appropriate care environment after being assessed can significantly impact an older patient’s overall quality of care.208

The ministry has invested more than $359.5 million over the last four years to help EDs provide care in a more timely way. Overall, the program has been successful in reducing the median length of stay of older patients in the ED by 16 per cent from 14.7 to 12.4 hours, while the median time older patients spent waiting for an inpatient bed has also decreased 23 per cent from a median wait time of 6.1 to 4.7 hours.

EDs across the province have also been working to adapt their care processes and environments to better meet the needs of the older patients they serve. Mount Sinai and St. Michael’s hospitals for example, established their ED Geriatric Mental Health Initiatives, which provides specific training for front-line physicians, nurses, and other health and social care providers around issues like recognizing and managing issues related to dementia, delirium, depression and other mental health issues in older patients presenting to EDs.

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Geriatric Emergency Management (GEM) Nurses

Perhaps one of the most impactful initiatives has been the hiring of dozens of Geriatric Emergency Management (GEM) nurses and placing CCAC care coordinators in EDs across the province. GEM nurses are ED-based advance practice nurses who exclusively focus on identifying, assessing, and working with frail older adults who present to EDs with complex medical, functional, and/or psychosocial issues and are identified as being at high risk of losing their ability to live independently in the community.

Through their assessments, GEM nurses prepare a list of recommendations and work collaboratively with patients, their families, and their caregivers, to help connect them and their primary care providers with referrals to specialized geriatrics services and other home care and community support services that can help maintain their independence to ensure a smooth transition back to the community that reduces the likelihood of repeat ED visits and hospitalizations.

GEM nurses have also been helpful in connecting older patients identified as being without primary care with local primary care providers, while also facilitating the care of older patients who may need further in-hospital assessment and support. While GEM nursing practices could be better standardized, using more evidence-based approaches to guide the work they do, it is clear that an investment in these positions has helped EDs across the province further improve the care of older adults in these settings.

Leveraging the work of EDs with other recently announced community nursing investments in Rapid Response Nurses and Telehomecare Nurses, as well as more established programs like the Long-Term Care Nurse Led Outreach Teams and the Home at Last Program, all described more elsewhere, will better enhance transitions to home and linkages to other community-based resources that can better support older adults in the community.

Encouraging and Sustaining Best Practices

To encourage and sustain the development of best practices around the care of older adults within its hospitals, the ministry and its LHINs should look to using Hospital Sector Accountability Agreements (H-SAAs) and Quality Improvement Plans (QIPs) to prioritize work in this area and articulate performance targets in relation to the care of older patients that will drive meaningful health system improvement. This includes requirements for hospitals to develop, monitor, and report Senior Friendly Hospital Action Plans that also prioritize supporting continuity and transitions within and beyond the hospital with primary and community care providers should be pursued.

Accreditation Canada is also committed to delivering the highest quality of patient care and safety through the entrenchment of national health care standards, and is responsible for accrediting all Ontario Hospitals. Therefore, considering advocating that the incorporation of Senior Friendly Hospital principles as hospital accreditation standards should establish a standard benchmark that will undoubtedly help improve patient safety and the quality of care that hospitalized older adults receive in Ontario.

209 Ibid.
Recommendations:

63. The Ministry of Health and Long-Term Care should encourage the expansion and development of evidence-informed Geriatric Emergency Management (GEM) Nursing Programs and High-Risk Screening Protocols in EDs across Ontario to promote the early detection of geriatric issues that require attention to promote safer discharges back to the community or, when necessary, facilitate admissions to hospital that minimize risk.

64. The Ministry of Health and Long-Term Care, in partnership with the LHINs, should continue to promote the adoption of Senior Friendly Hospital principles through its accountability agreements with hospitals to aid them in the development of more enhanced care environments for hospitalized older adults that deliver better patient provider and system outcomes.

65. The Ministry of Health and Long-Term Care should advocate with Accreditation Canada that Senior Friendly Hospital principles be considered an accreditation standard.

66. The Ministry of Health and Long-Term Care and its LHINs should support hospitals across the province to adopt, implement, and strengthen models and processes of care that deliver better patient and system outcomes for older adults through the implementation of a collaborative coaching program model in partnership with leading hospitals, based on peer support and knowledge transfer and exchange.

Enhancing Transitions in Care

As older adults tend to experience a greater incidence of complex and often inter-related health and social care issues as they age, this often necessitates more contacts with various health, social and community care providers in a variety of settings. More providers and settings often necessitate more transitions and the potential for care to become increasingly fragmented and for adverse events to occur.

In one recent survey conducted by the Change Foundation, too many older Ontarians reported being confused or uncertain about the next steps in their care journeys. For example, 55 per cent indicated that they had experienced problems navigating a transition in the health care system, while less than 16 per cent said they had not experienced any such problems. This appears to be the result of the system being hard for them to navigate without clear guidance, and poor communication between providers and patients, particularly at the point of discharge from hospitals.210 Indeed, studies have shown that due to poor transitions, 49 per cent of patients experience at least one adverse event, including medication errors, and readmissions to hospital partly because of receiving poor follow-up instructions and care.211,212,213

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Hospital readmissions often occur due to gaps in care and communications that all too commonly occur as patients transition from hospitals to their next care settings and reflect the complexities of the transitions in a health care system in which care is delivered by multiple health, social and community care providers with different accountabilities.\textsuperscript{214}

Ensuring that transitions between providers and health care settings are respectful, coordinated, and efficient can be best achieved by ensuring patients, their families, and their caregivers are seen as integral parts of the care team who can collaborate with their care providers in making decisions in relation to their care. Furthermore, ensuring patients have a primary care provider and that they are engaged as well in managing care transitions appropriately is also essential.

During our consultations, however, too many primary care providers told us that they were often not informed in a timely way that their patients were admitted to a hospital or seen in an ED, and of important changes to the health status of their patients and their overall care plans as a result. Unfortunately, this also remains a common occurrence across Ontario as hospital readmissions within 30 days continue to rise.

In the Avoidable Hospitalization Advisory Panel’s report, \textit{Enhancing the Continuum of Care}, hospital readmission rates within 30 days for Ontario at the time were reported to be 15.92 per cent. This is high in comparison to some leading health systems and also costly, accounting for what they estimated to account for $705 million alone in hospital costs in 2008-2009, even though many of these readmissions were felt to have also been avoidable.\textsuperscript{215} Further analyses also demonstrate that readmissions are most common amongst older adults with complex conditions, and that there are some specific conditions or diagnoses like Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) that are associated currently with the highest readmission rates of 19.42 per cent and 22.47 per cent respectively in 2011. The fact that overall readmission rates varied significantly from 13.3 per cent to 18.68 per cent in 2011 across the 14 LHINs suggests that there also is room for improvement in Ontario.

What is further concerning is that only 63.8 per cent of Ontarians are seen in follow-up by their primary care provider within seven days of being discharged from hospital. This is concerning as lower rates of follow-up appear to be more highly correlated with higher readmissions rates. As an example, in the LHIN with the highest overall readmission rate in 2011-2012, the follow-up rate with a patient’s primary care provider within seven days stood at only 51.3 per cent, the lowest follow-up rate in the province.

In his landmark report, \textit{Caring For Our Aging Population and Addressing Alternate Level Of Care},\textsuperscript{216} Dr. David Walker stressed the immediate need to promote the development and adoption of best practices across all LHINs relating to the care, discharge, and flow of ALC patients and those patients at risk of becoming ALC. It was stressed, however, that there is also a need to standardize patient assessments, referrals, admission, and discharge processes and practices across all sectors in support of this aim as well.

\textsuperscript{215} Ibid.
In November 2011, the Avoidable Hospitalization Advisory Panel chaired by Dr. Ross Baker, issued their report *Enhancing the Continuum of Care*, recognizing that reducing avoidable readmissions of patients discharged from hospital is an important area for improving the quality and safety of health care and making more effective use of health care resources in Ontario. Achieving this also requires the entire health care team, with co-operation from community-based care providers, to work together to ensure effective communication and coordination to support safe, effective transitions across all sectors of the care continuum. The panel recognized that the evidence indicates that effective interventions used to improve care transitions and reduce avoidable readmissions feature several common elements, including:

- Early screening to identify patients at high risk for readmissions
- The use of standard assessment tools
- Defined clinical pathways that support early planning for discharge
- Seamless transitions and the effective utilization of technology
- Improved communication mechanisms for sharing assessments
- Discharge plans
- Medication lists and other information with patients and all of their care providers
- Medication reconciliation and management when the patient returns home
- Patient and caregiver education
- Timely primary care follow-up in the community

To support the successful implementation of best practices around transitions of care, they also highlighted the need to clearly define the roles and responsibilities for providers including identifying the lead at each stage and using common metrics to monitor performance through which all providers and sectors would be held collectively accountable. They further suggested that this data should be made easily accessible and available promptly to health, social and community care professionals to facilitate rapid-cycle quality improvement efforts.

**Recommendation:**

67. The Ministry of Health and Long-Term Care should continue to work with HQO to expedite the implementation of the care transitions standards and processes and their associated outcome and process indicators as recommended in the Avoidable Hospitalization Advisory Panel’s report *Enhancing the Continuum of Care*. See Appendix B for a list of proposed indicators that could also be publicly reported that can help to assess the quality of and outcomes related to transitions in care that older adults experience.

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218 Ibid.
Nursing-Led Initiatives to Enhance Transitions in Care

Over the past few years, the ministry has made significant investments to strengthen human resources in home and community care in order to support the goal of improving transitions in care. In particular, significant investments in a number of nursing-led initiatives in various community care settings that play a critical role in discharge planning, managing effective transitions and managing health issues proactively to reduce the likelihood of admissions and readmissions to acute care settings have been a focus. These have included:

- **Rapid Response Nurses** – To support the transition from hospital to home of older adults and others at high risk of readmission by ensuring that discharge plans are well documented, shared and understood, that follow-up with a primary care provider is in place and that linkages to other useful home and community supports are established.

- **Telehomecare Nurses** – To support patients with chronic diseases and their primary care providers using in-home monitoring equipment to help proactively manage issues that may arise. The program has a particular focus on empowering patients to better self-manage their chronic illnesses with a goal of reducing avoidable hospitalizations and ED visits.

- **Nurse-Led Outreach Teams (NLOT)** – To provide a team of advance practice nurses to better support the residents of long-term care facilities and their care providers. These teams focus on supporting residents who may develop an acute care issue that can be managed in the long-term care home, or through a focused and facilitated visit to a local hospital. The program has a particular focus on building the capacity of long-term care nurses and other front-line staff to successfully manage appropriate acute issues in the long-term care home and thereby reducing avoidable hospitalizations and ED visits.

- **Community Palliative Care Nurses** – To support the provision of in-home palliative care services as part of community-based interprofessional teams. In serving as an added resource for patients and families to help manage end-of-life care in the home, these nurses are trying to empower more patients who want to receive their palliative care at home.

- **Geriatric Emergency Management (GEM) Nurses** – To support high-risk frail older adults who present to EDs with targeted geriatric assessments that allow the development of care plans that help to facilitate effective transitions back home whenever possible. The program has a particular focus on building the capacity of ED staff to better recognize and manage issues unique to frail older adults in EDs.

Despite the recent interest and investments being made to better enhance transitions in care, several issues still remain. Our overall system of care remains fragmented with most sectors still working with patients in isolation, with no shared accountabilities and metrics that speak to broader system performance. Patients, with their families, and caregivers largely have to coordinate their own care without a full understanding of their care options available; no standard communication processes are currently in place to facilitate the sharing of assessments and information amongst providers and their patients. This creates a challenge for many of the newly created nursing roles, which are just beginning to establish common standards of practice and performance monitoring. Nevertheless, establishing common standards of practice and performance monitoring will allow us to identify areas of success and areas of development to ensure that these roles can continue to be refined so that they can contribute in a meaningful way to drive overall system performance.
**Recommendation:**

68. The Ministry of Health and Long-Term Care should ensure that LHINs facilitate the full integration and monitoring with clear metrics of the new and existing community nursing models it has introduced (e.g., ED GEM nurses, LTC Nurse-Led Outreach Teams, Community Rapid Response and Telehomecare Nurses) to support “warm hand-offs” through transitions from hospital to home (including long-term care homes) and especially between all providers and primary care providers. Funding for programs that are not able to demonstrate benefits should be repurposed to more effective initiatives within a given LHIN.

**The Home First Approach**

Moving forward it will be essential that LHINs, in collaboration with their hospitals, home care, and community support services providers, implement best practices that will ensure the delivery of patient-centred care that matches the established needs of the patients and supports whenever possible to create a seamless transition from hospitals to the community.

As an example, Home First was initiated in 2008 by the Mississauga Halton LHIN and quickly spread across the province to all other LHINs. In being seen as a “philosophy” rather than a specific program or project, Home First has been adopted differently in different LHINs based on local needs and circumstances. Many of the Home First initiatives, funded through the Aging at Home Strategy, have helped to significantly address the ALC challenge. Representing a partnership between Hospitals, CCACs, and CSS agencies, Home First has come to represent a significant shift in health care thinking that now seeks to ensure that every effort will be made to ensure adequate home and community care resources will be leveraged whenever possible to enable persons who are admitted to a hospital to return home. Home First initiatives have focused on a) helping those frail older patients felt to be at a high risk of losing their independence and requiring a long-term care admission and b) reducing the demand and wait lists for long-term care by properly assessing their needs after their acute episode and ensuring that only those who truly need long-term care are applying for it. Early adopter LHINs have demonstrated the most significant impacts to date. However, all LHINs are now seeing substantial benefits as a result of Home First.

Since the program started, 12 of the 14 LHINs reported that they have helped to transition 28,000 clients home from hospital as a result of their initiatives and maintain the majority of them in the community. Early adopter LHINs have reported seeing the ALC rates drop by as much of as 50 per cent as they have helped to reduce the numbers of patients waiting in hospital or at home for long-term care. The last three years have seen the overall numbers of patients waiting for long-term care in Ontario hospitals drop 32 per cent from 3,145 to 2,141.\(^{219}\) Indeed, as will be discussed in the following chapter, the reductions in the demand for long-term care across the province are likely due in part to the investments and approach that Home First has supported in delivering better patient and system

outcomes. The challenge now is that the ALC rates have remained stagnant over the past year, including those waiting for long-term care. Therefore, this may be a sign that building on previous gains will now likely require greater investments in home and community care as well as more upstream preventative and proactive approaches and investments to try and get ahead of the issue.

In addition to funding more home care and community support services to allow more older adults with complex needs to remain in the community, additional best practice initiatives that complement the Home First philosophy, and could be strengthened and standardized across the province, include the Home at Last Program administered by many of the LHINs’ CSS agencies and the Waiting at Home for Long-Term Care Program administered by many of the LHINs’ CCACs.

**Home at Last**

Home at Last has become a best practice initiative funded by a number of LHINs through the Aging at Home Strategy. The program assists older adults, who may not have the support of a caregiver, in removing barriers to discharge and ensuring a safe return to their home environment after a visit to an ED or an admission to hospital. This transition service from hospital to home may include: providing the patient a personal support worker to drive and/or accompany the patient home, picking up medication and/or groceries; providing some personal care and/or homemaking services upon returning home; following up with phone calls and/or visits to check on the patient’s well-being, and: making referrals to other home care or community support services that they may benefit from. Many LHINs have reported this program being one that has assisted them in reducing hospital or ED readmissions by ensuring the transition back home remains a smooth one for these vulnerable patients.

**Waiting at Home**

Waiting at Home is another best practice initiative funded by a number of LHINs through the Aging at Home Strategy, and administered by their CCACs. This program has been designed to support patients needing long-term care after an acute care stay, but who can be supported in their homes during the interim waiting period for up to 90 days with enhanced home and community care services. Many LHINs and their hospitals have reported this program being one that has particularly assisted them in significantly reducing their ALC.

The one main issue with these programs is that their criteria for enrolment, and the services offered through them, are not consistent from LHIN to LHIN. This creates confusion for care providers or patients, their families, and their caregivers who may not understand the geographical boundaries and the implications this has for the care they receive. While this has been called a “postal code lottery” when it comes to care, this has led to a perception of inequitable care being provided with varying service standards and levels of care. Therefore, once again the opportunity to standardize the enrolment criteria and services levels and standards should be pursued across the LHINs and their CCACs.
Recommendation:

69. The Ministry of Health and Long-Term Care in partnership with the LHINs should promote early discharge planning practices with the support of CCAC and CSS care coordinators. CCACs, CSS agencies, and Hospitals must work together to further standardize and strengthen the adoption of Home First best practices that can ensure proactive identification of appropriate discharge destinations (interim and permanent) using system level, consistent admission criteria, facilitated by automated systems such as Resource Matching and Referral. This approach can successfully transition patients home who might have otherwise been given an ALC designation for a care environment they do not actually need.

Adopting Standard Measures of Quality and Performance

To support and monitor the ability of hospitals to deliver better patient and system outcomes as it relates to older adults in particular, a core set of mandatory performance indicators should be included in all future hospital Quality Improvement Plans (QIPs) as well. These indicators could help bring a greater level of focus on the degree of effectiveness with which hospitals and their local primary and community care providers work collaboratively to ensure high quality acute care and effective transitions of care are being supported between providers upon discharge with a focus on aging in place.

Recommendation

70. The Ministry of Health and Long-Term Care and its LHINs should require that core performance indicators be added to all future hospital QIPs that can help to assess the quality of hospital care that an older adult receives, with a particular emphasis on patient and systems outcomes, integration of and transitions in care. See Appendix B for a list of proposed indicators that could also be publicly reported.
Special Considerations

Care Coordination for Specialized Populations

In alignment with a more ideal community care coordination model discussed in Chapter 5, seamless care coordination will necessitate integrated care planning by providers across the continuum of care, whether they be CCACs, CSS agencies, Community Mental Health Agencies (CMHA), primary care providers, or hospitals. It is clear that while CCACs, CMHAs, and CSS agencies will be best suited to lead the coordination of home and community care in partnership with primary care providers, in some cases it may make sense for hospitals to be supported in developing targeted care coordination structures and home and community care delivery models to address the needs of select populations that require enhanced care coordination or a specialized and time-limited set of home and community care services. With the success of such bundled-care models for specialized populations being demonstrated with the St. Joseph’s Health Care System in Hamilton, the opportunity to expand the delivery of care in this way should be strongly considered in other areas of the province and for populations where this would make the most sense.

Recommendation:

71. The Ministry of Health and Long-Term Care should encourage the further expansion and testing of hospital-led care coordination and home care models for select populations. These models need to complement existing community-based care coordination structures and patients’ primary care providers.

Northern and Rural Hospitals

In many northern and rural communities across Ontario, small hospitals may sometimes be the only organization with the capacity to provide care for frail, older patients in their localities. In some of these communities there may not even be a local home care service provider available to support older adults in their own homes. As a result, for many of these hospitals, significant bed capacity is occupied by older patients with ALC designations as there may be few or no local alternate care settings for these patients. Smaller hospitals could significantly advance the care of older adults in these communities and support more older adults to age at home as well if greater flexibility is introduced in terms of how they are funded and encouraged to support the needs of their local populations.
Recommendation:

72. The Ministry of Health and Long-Term Care should acknowledge that small and rural hospitals may be the only institutional care providers in a region. They should thus be valued as being integral to the care of the frail elderly and be funded differently through more flexible funding mechanisms that help classify the care that is being provided and funding that care accordingly, and with enhanced remits to take their care beyond the hospital into a patient's home if it can support a patient's return home and their desire to age in place.
Chapter 6: Enhancing Ontario’s Long-Term Care Home Environments
Transforming Long-Term Care Services to Meet Our Evolving Needs

The long-term care home sector in Ontario is currently at a crossroads. Traditionally, long-term care homes were built, organized, and resourced to exclusively provide long-term residential care environments for those Ontarians needing continuous care and support; those who could no longer rely on family members, home care and community care services to meet their needs in their own homes. However, as the needs and care preferences of Ontarians continues to evolve, the sector has also spent a considerable amount of time trying to understand and define what its future role can and should be as part of the broader evolving continuum of care. This evolution may result in the need to redefine our terminology when we describe long-term care (LTC) homes in the future. The Long-Term Care Innovation Expert Panel's report Why Not Now? supports the need to consider rebranding the sector, in recognition that LTC homes currently, and should in future, offer much more than just long-term residential care.220

Ontario's 634 long-term care homes, with nearly 78,000 beds, provide specialized care, accommodation, and services to over 112,000 individuals each year who come to rely upon them to better meet their care needs due to advanced disease, injury or social circumstances. With a 99 per cent overall occupancy rate at any given time, and 19,700 Ontarians currently on waiting lists for a long-term care placement, the straightforward solution at hand may appear to simply require the building of more LTC homes. Indeed, assuming the continued growth of our aging population, and its concomitant care needs, nearly 238,000 adults may be in need of the levels of care currently being provided in long-term care homes by 2035.221 This will only create a growing gap between the supply and demand for long-term care if alternate and often more cost-effective supportive housing and care options for older Ontarians are not made available.

Despite the continued aging of our population, the past two years has actually seen the demand for long-term care decline 6.9 per cent from 115 to 107.1 per 1,000 Ontarians 75 years and older.222 At the same time, the overall supply of long-term care accommodation has declined 2.7 per cent from 88.1 to 85.7 beds per 1,000 Ontarians 75 years and better, while the placement rate into long-term care has declined 26 per cent from 5.8 to 4.3 per 1,000 Ontarians 75 years and better.223 At the same time, the median wait times for long-term care placement have continued to improve, especially in the community; they now stand at 146 days from home and 64 days from hospital. This may reflect the significant past investments made in the home and community care sector over the past few years through Ontario’s Aging at Home Strategy and its Home First initiatives that are now helping more individuals age in place. While the last three years have seen overall numbers of patients waiting for long-term care in Ontario hospitals drop 32 per cent from 3,145 to 2,141, our current challenge is that our Alternate Level of Care (ALC) rates have remained stagnant over the past year, including those waiting for long-term care.

223 Ibid.
There also exists evidence to suggest that we are not making the best use of our existing long-term care beds to ensure older Ontarians are always getting the right care, in the right place, at the right time. In 2011, one study noted that as many as 37 per cent of the ALC patients waiting for a long-term care placement had care needs no more urgent or complex than those of people being cared for at home.224

“Long-term care requires specialized leaders and skilled staff to care for some of the most vulnerable people in our society.”
– Long-Term Care Task Force on Resident Care and Safety

While some proponents have suggested that simply building more long-term care beds will alleviate the ALC crisis, in his report on ALC, Dr. Walker noted that the challenges of appropriately supporting an aging population neither can nor should be solely reliant on simply expanding current long-term care capacity. As he noted, in the past these policies have been ineffective and, in many instances, counter-productive.225 He cites how the significant investment in approximately 15,000 new long-term care beds between 2002 and 2004 saw many individuals enter LTC homes who did not meet benchmarks of need, while a sustained impact on ALC rates was never realized.226

What is also interesting is the variable demand for long-term care that exists across each of the Local Health Integration Networks (LHINs). While one would assume that the lowest demand for long-term care would exist in those LHINs with the highest supply of beds, almost the opposite was found to be the case in a number of settings. As illustrated in Figure 6.1, the most compelling example was that of the Mississauga Halton LHIN, a LHIN which not only has the lowest per capita supply of long-term care beds, but also the lowest per capita demand for long-term care as well. Within each LHIN, it became clear that the supply of supportive housing and assisted living spaces, as well as the availability of more intensive home and community care supports were just as integral to influencing the demand for long-term care as was the overall supply of beds.

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How Many and What Types of Beds Then?

No one disagrees that we eventually will have to build more LTC homes in Ontario. However, many agree that there also exists significant potential to divert demand for long-term care to other care settings, settings that would likely be more cost-effective and more aligned with patient preference. This was especially the case when the ministry invested $3.7 billion into long-term care and only $3.1 billion into the home and community care sector last year. Furthermore, older Ontarians overwhelmingly indicated, through our consultations, that they would prefer to remain in their own homes or in the community for as long as possible, rather than receive premature or unnecessary institutional care. Nevertheless, every Ontarian wants to be assured that a strong and robust long-term care sector will exist to meet their need for this care, should it arise.

In line with this thinking, the Long-Term Care Innovation Expert Panel established by the Ontario Long-Term Care Association (OLTCA) and the Ontario Association of Non-Profit Home and Services for Seniors (OANHSS) in their recently released report outlining their new long-term care innovation strategy entitled Why Not Now?, predicted that Ontario could avoid the need to build additional...
long-term care beds over the next five years.227 Their strategy, which considered the evolving needs and preferences for care of Ontarians, noted that in order to meet this goal, it would require that a greater shift towards ensuring a full range of home and community care supports was in place across the province. This would need to be coupled with a rebalancing of the existing LTC home bed mix to provide more short-stay, respite, and convalescent care services, while reserving long-stay beds for those with the heaviest care needs.

Other jurisdictions like Denmark have also been highlighted as exemplars for their innovative approaches towards meeting the evolving care needs of its aging population, while enabling its long-term care sector to remain an active partner in the transformation of its health care system. In making new investments strategically in home and community care, and promoting the ability of older people to continue living in their own home as an explicit policy priority, Denmark avoided building any new long-term care beds over 20 years.228 Given that the taxpayer cost to build a new long-term care bed sits at around $150,000 and the annual average cost to provide the care to a single resident is $47,940 or $131.34 per day, the cost implications of the associated changing demands for long-term care will be significant.

Over the past few years, increasing numbers of long-term care homes are also becoming providers of more specialized and transitional care services. As part of the ministry’s Aging at Home Strategy, many LHINs have funded the creation of transitional or short-term convalescent, respite or interim care beds in their long-term care homes. For example, the ministry’s Convalescent Care Program is targeted to high needs patients, often after a hospitalization, who are at risk of losing their independence in the community and who require care with a strong rehabilitative focus in a residential care setting for up to 90 days. The current program is relatively small, with 485 beds in 34 homes across 13 LHINs, but last year it served 2,295 patients and returned 85 per cent of them home. With regard to respite and behavioural support services, there are currently 404 funded respite and 58 beds designated for behavioural support across Ontario, although varying levels of access and utilization have been seen with them across the LHINs.

While three per cent of our current long-term care beds have now been converted to short-stay respite, convalescent or interim care beds, 97 per cent remain long-stay beds, serving as a final destination for many older Ontarians. While providing long-term care for those with complex needs and limited options to remain at home in the community will always remain the predominant focus of this sector, increasing the capability of the sector to provide a variety of short-stay care services could better support the transitional care needs and preferences of older patients and further support more of them eventually returning or remaining independent at home longer. Indeed, there now exists a foundation upon which to build this shift to providing more transitional care in this sector, and a genuine interest amongst sector providers to take more of a lead role in the provision of this sort of care. This transition also needs to encompass the provision of enhanced palliative care services and the development of the necessary expertise to deliver it, in long-term care homes, to enable more residents to die in these homes rather than in a hospital setting.

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228 German Institute for Economic Research. Schulz, E. 2010. The Long-Term Care System in Denmark. Berlin, Germany.
To determine what the future configurations of long- and short-stay programs may need to be, the ministry will also need to better understand how demand for these types of care will change at both a system and local level over time and in relation to changes that will occur in other sectors through broader health system transformation efforts. Indeed, the establishment of a robust and evidence-informed capacity planning framework that can allow the ministry, the LHINs, and the sector to make planning decisions related to service organization and delivery that are equitable, while addressing local needs, will be a critical first step in these efforts; one that needs to start immediately. The process should also support decision-making around the development of new or expanded service delivery models that address system gaps and the location of more specialized long-term care services, like behavioural support units, to promote quality and efficiency in local service delivery. Ultimately, effective capacity planning will help this sector remain focused on achieving high quality, efficient and innovative care delivery through system reconfiguration, and expansion where appropriate, while ensuring existing resources and capacity are fully utilized.

Finally, in 2007, the ministry announced its plans to redevelop approximately 35,000 B, C and upgraded D long-term care beds to ensure that they could offer quality accommodation to residents and could be fully utilized to meet the evolving needs. However, enrolment in Phase 1 of the redevelopment program was lower than expected. In response, the sector has advised that improvements to the program and its related policies will be required to increase uptake. Thus, to further enable redevelopment, the ministry should consider its available options to support improved business conditions and strengthen incentives for bed redevelopment.

**Recommendations:**

73. The Ministry of Health and Long-Term Care should undertake the development of an evidence-informed capacity planning process to meet the needs of current and future eligible LTC populations and others who could be better supported in supportive housing or assisted living residential environments or in their own home with home care.

74. The Ministry of Health and Long-Term Care should develop new long-term care home-based service models to maximize capacity, increase programs to support older adults living in the community longer, and enhance programs to meet the needs of short- and long-stay residents. This could be more specifically accomplished by:
   a) Increasing short-stay respite and convalescent care program capacity in LTC homes.
   b) Enabling LTC homes to provide higher levels of care to individuals with complex care needs.
   c) Exploring the ability of LTC homes to serve as community-care hubs that could provide community-oriented services, including home care that may further assist local residents to age in place.

75. The long-term care sector should consider rebranding their facilities as “Care Homes” instead of “Long-Term Care Homes,” as has occurred in other jurisdictions, to better reflect the growing diversity of residential care services they provide.
76. The Ministry of Health and Long-Term Care should improve the quality of long-term care accommodation by improving the conditions for redevelopment of the approximately 35,000 remaining B, C and upgraded D beds.

The Evolving Care Needs of Long-Term Care Residents

Allowing the CCACs to standardize and centralize the coordination of admissions to long-term care homes has improved the overall transparency and efficiency of the process and ensured that increasingly, only the most appropriate candidates for long-term care are prioritized for admission. Through the implementation of its Home First Philosophy, after being assessed with a standard interRAI Home Care Assessment to determine their appropriateness for admission, CCAC Care Coordinators have been able to support an overall reduction in the demand for long-term care by leveraging available support from family caregivers, home and community care services, and supportive housing services.

Over the last three years, the care needs of those being admitted to long-term care have risen substantially, so that long-term care homes are now increasingly meeting the needs of very frail older adults who cannot be cared for elsewhere. Using the interRAI Method for Assigning Priority Levels (MAPLe) Index, we know that currently 85 per cent of the new admissions coming from the community and 78 per cent of the admissions coming from hospitals are in the High (Level 4) or Very High (Level 5) MAPLe clinical needs categories, while less that one per cent of overall admissions are now in the Low (Level 1) or Mild (Level 2) MAPLe clinical needs categories. The sector predicts that virtually all those admitted to long-term care homes in the future will soon be from these two highest needs categories.229

According to CIHI, currently in Ontario, three quarters of its long-term care residents are either totally dependent or require extensive assistance with their activities of daily living; just over three quarters are cognitively impaired, while one third have responsive behaviours, and over one half show signs of health instability.230 As the needs of long-term care residents continue to become increasingly complex, we will need to ensure that our long-term care homes are equipped with the appropriate resources and that its 40,000 direct care staff are properly trained to care for these residents. This is especially important given that acute and post-acute care hospitals remain challenged by ALC patients whose clinical needs cannot be suitably met in the community and in traditional long-term care settings. These ALC sub-populations with heavy care needs, dementia and responsive behaviours, ventilator-dependency and dialysis requirements, often remain in hospital for excessively long periods of time – sometimes years – as no other care setting is available.231 Enabling long-term care homes to provide higher levels of care should be explored, especially as there exists interest and a growing capacity in the sector to do so.

229 Ontario Long-Term Care Association (OLTCA). 2012. Building on Strength: Long-Term Care's Contribution to Specialized Seniors Care in Ontario. Submission to Dr. Sinha.
Providing and enabling choice in making decisions around where a future resident will receive their long-term care will remain an important public policy goal. Currently, the flow of future long-stay patients from hospitals and the community can be restricted if their choices of potential homes remain limited as well. Increased choice can often be accommodated by: a) ensuring prospective residents, their families, and caregivers understand the process of choosing a home; b) ensuring a consistent level of care and quality across all homes – a process already under way through the Residents First initiative and the redesigned LTC Inspection System; and c) diversifying the pool of beds that may more closely meet the needs and preferences of those requiring care – a process being supported through the planned renewal of the 35,000 beds in Ontario that require redevelopment.

However, for short-stay care residents and those with specialized needs, “choice” of a long-term care program may need to be limited to some extent if the program is part of an agreed upon care pathway following a hospital stay, or if only a few homes offer it to support residents from other homes or those wishing to remain in the community. Furthermore, as the provision of short-stay programs increases, improvements should also be made to occupancy provisions and to admission and discharge processes to facilitate access to and flow through these specialized care environments.

Finally, the ministry should also consider enabling the charter protections provided to any resident requiring confinement for their care and safety. These provisions are identified but not proclaimed in the 2007 Long-Term Care Homes Act. As the proportion of residents suffering from responsive behaviours due to dementia and/or other neurological disorders continues to rise, it will be critical to ensure that procedural protections are available for these vulnerable residents.

**Recommendations:**

77. The Ministry of Health and Long-Term Care should improve flow to and from LTC homes, for both long-stay and short-stay services, by reviewing the existing application and transfer processes and policies to consider increasing the number and type of homes selected and to better support potential residents (and, when necessary, their substitute decision-makers and care coordinators) in the selection process. This could be more specifically accomplished by:

a) Implementing a referral-based model for short-stay care programs such as respite, behavioural, palliative, and convalescent care that should not require an onerous capacity assessment process to determine a person’s eligibility for this care.

b) Encouraging LTC homes that are part of broader continuums of care to be more proactive in identifying potential persons who should be encouraged to apply for a LTC bed in anticipation of their expected need for this level of care, understanding the usual wait that this choice may entail as well.
Enhancing Resident Safety and Quality of Life

A continued focus on quality will be integral to the evolution of the long-term care sector. Ontarians expect the long-term care sector to provide high quality accommodation and a safe living environment to each of its residents. The recently released report of the Long-Term Care Task Force on Resident Care and Safety, entitled *An Action Plan to Address Abuse and Neglect in Long-Term Care Homes*, details numerous recommendations to make long-term care homes a place where residents feel safe, respected, and cared for in a way that can better address and reduce issues of abuse and neglect. This report also identified the need to strengthen long-term care staff training in the prevention of elder abuse and to enhance staff confidence and skills in the management of challenging residents. Helping to ensure that residents and their families are aware of their rights and responsibilities can promote resident safety and satisfaction. Currently, there is a requirement under the legal framework for an annual resident and family satisfaction survey. The results of the survey and actions taken by the licensees in response to the survey results are provided to residents, families, Residents’ Councils, and Family Councils.

The ministry has already invested in numerous quality improvement-focused initiatives that are now under way in long-term care homes; examples of these initiatives include its Residents First and Behavioural Supports Ontario (BSO) Initiatives. In 2011, the ministry committed to invest approximately $40 million annually to hire health human resources with specialized skills to enhance services and to support residents with challenging and complex behaviours in long-term care homes or other community settings. The program aims to achieve reductions in: resident transfers between long-term care homes and hospitals, hospitalizations of people with these behaviours, and lengths of stay in hospital, as appropriate supports become available in other settings. While the initial feedback around this initiative has been positive, the ministry should continue to monitor these investments to ensure they are being implemented successfully and are achieving their objective of increasing the confidence and skills of staff in providing the highest quality care that meets the increasingly complex clinical needs of long-term care residents.

The ministry should also ensure that the capacity built through its Residents First initiative is sustained within the sector. The quality improvement program focuses on finding workplace efficiencies using LEAN training to transfer staff from administrative to care duties. Currently, the program offers change packages around: ED Utilization, Reducing Pressure Ulcers, Preventing Falls, Promoting Continence, Improving Consistency of PSW Assignment, Responsive Behaviours, Pain Management, and Medication Safety. It has already helped a number of homes across the province identify and act on opportunities to make process improvements that have significantly improved the overall quality of the care being delivered.

The ministry should also look to leverage its newly established Centres for Learning, Research, and Innovation (CLRI) to support and advance quality improvement and staff education and training efforts that further advance the overall sector.

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232 Long-Term Care Task Force on Resident Care and Safety. 2012. *An Action Plan to Address Abuse and Neglect in Long-Term Care Homes*. Toronto, Ontario.

233 Ibid.
In addition to new service models and maximizing the use of current resources, the long-term care sector will need to build its capacity to meet the needs of future residents by optimizing its health human resources. This will require enhancing the sector's ability to recruit and retain staff, advance the knowledge and skills of its direct care staff, increase the efficiency of long-term care business processes, and leverage existing investments in health human resources.

As long-term care home staffing and training resources are scarce, consideration should be given to how to enable long-term care homes to better focus on increasing the knowledge and skills of their dedicated staff. The ministry has a role to play in supporting long-term care homes to recruit, train, and retain qualified staff by working collaboratively with education providers such as colleges and universities to develop and deliver priority training to staff to increase their knowledge and skills.

**Recommendations:**

78. The Ministry of Health and Long-Term Care should support the following initiatives to further understand and promote resident satisfaction:
   a) Support the Ontario Association of Residents’ Councils with updating and distributing to each resident and/or their substitute decision-maker a manual that explains their rights and responsibilities.
   b) Work with the sector to implement a resident and family satisfaction tool, the results of which should be made publicly available.

79. The Ministry of Health and Long-Term Care should ensure resident safety and enhance the quality of life in long-term care homes through quality and process improvement initiatives through programs such as Residents First, the BSO Initiative, and the new Centres for Learning Research and Innovation in Long-Term Care.

80. The Ministry of Health and Long-Term Care should support mechanisms to maximize the knowledge and skills of long-term care home staff with additional training opportunities and support them in releasing their time to care through quality and process improvement initiatives in programs such as Residents First, the BSO Initiative, the Long-Term Care Best Practice Guideline Coordinator Initiative, and the new Centres for Learning Research and Innovation in Long-Term Care.

**Upgrading Assessment and Care Planning Instruments and Protocols**

As the evolving profiles of long-term care residents continue to become increasingly complex, it will be important to have more accurate assessment and planning instruments in use by both CCAC and long-term care home staff to allow for better care planning and coordination. The interRAI assessment and care planning instrument, the RAI MDS 2.0, while now outdated, remains a good assessment instrument that can record, accurately and appropriately, the clinical needs of residents. However, currently it triggers too many clinical care recommendations that sometimes create extra work for staff.
The next version of the instrument, known as the interRAI Long-Term Care Form (LTCF), triggers more appropriately and therefore may be more supportive in helping front-line staff address and manage the care needs of their residents. Overall, it is also critical that the data recorded through an interRAI assessment is accurate and always reflects appropriately the clinical needs of residents in the home, especially as this data is linked to the funding that long-term care homes receive and will be important for future quality of care and capacity planning initiatives. Therefore, the ministry should use its legislative options, including appropriate financial sanctions, to ensure the integrity and quality of the interRAI data collected.

**Recommendations:**

81. The Ministry of Health and Long-Term Care should support Long-Term Care Homes to upgrade their resident assessment and planning instrument – the Resident Assessment Instrument Minimum Data Set (RAI MDS) 2.0 to the interRAI LTCF to allow its full compatibility and interoperability with the existing community-based interRAI instruments and to take advantage of the enhanced care planning protocols associated with this latest version of the assessment.

82. The Ministry of Health and Long-Term Care should review existing legislative and policy options for addressing LTC homes that are found to code inaccurately within the RAI MDS 2.0. This should include the option of applying financial sanctions, per the existing legislation, where the evidence would support such an action.

83. The Ministry of Health and Long-Term Care should utilize existing legislative and other options to ensure lower performing homes acquire coaching and peer support, knowledge transfer and education to improve their performance.

**Enhancing the Roles and Impact of Long-Term Care Nurse-Led Outreach Teams**

The increasing medical complexity that characterizes long-term care residents has meant that significant changes in their conditions can occur with relatively short notice. This requires timely assessments and the initiation of appropriate interventions to reduce negative health outcomes. At times, changes in a resident’s condition that are not proactively identified and managed can lead to avoidable transfers to hospital. This in turn may cause residents anxiety, result in long waits in an ED, which can create added health risks, increase the potential for admission, and lead to inefficient use of EMS resources. Therefore, reducing potentially avoidable hospitalizations presents a significant opportunity to improve care and reduce the overall health care costs for long-term care residents. The quality of overall care can also be enhanced through enhancing the capacity of long-term care staff with enhanced knowledge and interprofessional communication and through the provision of urgent phone or on-site assessments in LTC homes that can avert ED transfers or facilitate focused transfers to acute care settings when required.

In 2008, the ministry established Long-Term Care Nurse-Led Outreach Teams (NLOTs) in each LHIN as one of several projects implemented under its Emergency Room and Alternate Level of Care (ER/ALC) Strategy. NLOTs bring together a dedicated team of nursing professionals to provide long-term care
residents and their care providers access to timely, high quality urgent care support within the comfort of their own homes. The NLOT model emphasizes three essential components:

1. **Prevention:** NLOT nurses visit their affiliated long-term care homes to build front-line provider capacity to detect and respond to acute changes in a resident’s condition.

2. **Avoidance:** Long-term care providers contact the NLOT nurses to allow them to provide telephone mediated assessment and coaching and/or an on-site visit to assist in assessing urgent issues and determining the need for hospital care and to provide interventions such as intravenous therapies, antibiotic management, oxygen administration, and palliative support that can allow a resident to receive the care they need at home and, thereby, prevent an unnecessary transfer to an acute care setting.

3. **Flow:** NLOT nurses work in partnership with local ED and hospital care providers to enable rapid transfer, intervention, and discharge for care that requires an acute care setting.

The NLOT model is intended to minimize avoidable transfers to EDs and hospital admissions, to reduce hospital lengths-of-stay for residents who can be discharged home earlier with appropriate supports and follow-up, and to build the clinical capacity of long-term care providers with knowledge around the management of urgent and palliative issues.

While this model appears to be having an overall positive impact, a lack of standardization in the ways that the LHINs implemented their NLOT models, as well as the way data is being collected to evaluate overall program impact, have made meaningful comparisons of these programs difficult. With a recent announcement to enhance overall program funding, data sources and collection methodologies have now been standardized to provide greater opportunities to evaluate, refine, and further evolve and link this model to other long-term care initiatives.

In the United States, the Centres for Medicare and Medicaid sponsored the development of the INTERventions to avoid Acute Care Transfers (INTERACT) II initiative. The program was implemented to build front-line clinical capacity to improve the quality of care of long-term care residents through the implementation of an evidenced-based system of assessment tools, protocols, and care pathways. In its evaluations, this model has shown its ability to encourage interprofessional collaboration in the creation of resident care plans, avoid unnecessary ED transfers and facilitate appropriate ones.\(^{(234,235)}\) There likely exists an opportunity to complement the work of the NLOTs in Ontario with the implementation of this program. Therefore, the ministry should strongly consider using its NLOTs to support the implementation of INTERACT II across its long-term care homes as well.


Recommendation:

84. The Ministry of Health and Long-Term Care should enhance the utilization of Nurse-Led Outreach Teams in Long-Term Care Homes to expand their capability to effectively meet the care of patients with more complex conditions and proactively identify emerging acute or sub-acute health issues that could subsequently lead to an unscheduled transfer to an ED and subsequent hospital admission. Specific actions that can enhance this model of care should include:

a) Promoting the standardization and more rigorous adherence to the core model principles and outcomes measurements that can determine the overall effectiveness of the model in responding to a region's needs.

b) Monitoring the performance of involved homes around outcomes that should include actual unscheduled transfer rates to EDs, hospitalization days, and patient, resident, and provider satisfaction.

c) Linking the evolution of the NLOT models to the deployment of the INTERACT II program in long-term care homes to support the proactive management of common medical illnesses that could further reduce the overall number of acute care transfers that residents might otherwise experience.

Adopting Standard Measures of Quality and Performance

Finally, enhancing sector transparency and accountability through better patient systems and outcomes reporting can be key drivers in supporting quality improvement. With the renewal of the Long-Term Care Sector Accountability Agreements (L-SAA) set to occur for April 1, 2013, there now exists an opportunity to re-evaluate and revise current indicators and to establish new indicators. The establishment of indicators that will support sector improvements and align with overall system transformation efforts of particular meaning to residents and their families will be essential. It would also allow policy-makers and care providers to more accurately identify and address resident safety and quality of care issues, improving the overall resident experience.

Recommendation:

85. The Ministry of Health and Long-Term Care should require core indicators be added to all long-term care home L-SAAs and QIPs that reflect and can help to assess the quality of long-term care that an older adult receives, with a particular emphasis on patient and systems outcomes, integration of and transitions in care. See Appendix B for a list of proposed indicators that could also be publicly reported.
Chapter 7: Addressing the Specialized Care Needs of Older Ontarians
Increasing numbers of older adults are continually entering their later years in better health. However, as we age our overall care needs will likely increase, but could become even more complex depending on the unique factors we may find ourselves faced with that may impact our overall health and well-being. Understanding that the older population is a heterogenous group helps us understand why pursuing a more holistic approach to their care should be the preferred method so that we may give special consideration to the various issues they may be faced with. This chapter focuses on providing further special consideration to some of the specialized care needs that can impact the life of older adults, their families and caregivers. Giving consideration to the development of programs and specialized geriatric services that assist in addressing these needs will be essential to support healthy aging.

The Provision of Specialized Geriatric Services

In recognizing the evolving and growing needs of our aging population, the Local Health Integration Networks (LHINs) have made their own significant investments in the development of specialized geriatric assessment and treatment programs in hospital, clinic and community settings. While local needs have influenced the development of these programs, the availability of funding and more importantly the right mix of professionals to staff them have largely influenced the services that are available across the province.

Despite older Ontarians being such large consumers of health care services in Ontario, there is a critical deficiency of geriatricians and physicians with expertise in caring for these older adults. As of October, 2012, there were 122 active Ontario physicians holding specialist certification in geriatrics for a population of 1,878,325 individuals 65 years and better; this represents a ratio of 0.65 geriatricians per 10,000 older Ontarians. By contrast, as of October 2012, there were 1,538 active Ontario physicians with specialist certification in pediatrics for a population of 2,180,775 individuals aged 0-14 years; this represents a ratio of 7.05 pediatricians per 10,000 children.

Given that the numbers of trained geriatricians and care of the elderly family physicians in Ontario is so low, it is impressive to see the level of engagement with and the commitment to service delivery that these physicians have provided across the province. With geriatrics being a speciality that has pioneered team-based care, the ability to leverage the support of other health, social, and community care professionals in the development of interprofessional and team-based models of care has allowed tens of thousands of frail older adults to benefit from the collective geriatrics expertise of all of these professionals working together.

The establishment of Regional Geriatric Programs (RGPs) in the 1980s was the province’s first attempt to develop a network of specialized geriatrics services across Ontario, anchored in its five original academic health sciences networks. Over time, this has led to the development of some excellent services. However, a lack of evolution in historical funding envelopes and an ability to deliver a common service delivery structure has limited the full scope of these bodies to develop clinical services

236 Wong, R. October 24, 2011. Who is Going to Look After our Aging Canadians? The Province.
models in less than half of the existing LHINs. The inequity in the historical funding allocations for the five RGP areas further created challenges for these bodies to fully respond to the local needs of their regions. During our consultations, it was noted that LHINs without access to this historical funding were left to fund their own services out of Aging at Home Strategy funds and at times at the expense of other priorities. Through our consultations, it was also noted that in jurisdictions with or without RGP funding in place, the stability of their programs that tended to rely on non-dedicated funding and goodwill were constantly being seen as at risk should other funding pressures take precedence.

Overall, the lack of a provincial plan with dedicated funding for the delivery of specialized geriatrics services has further contributed to the inequity in the provision of these services across the province. Insufficient resources have also made it challenging to be able to monitor and understand the effectiveness of local practices and the types of investments in local service provision that can derive the best outcomes and value.

Currently, the provision of geriatric services varies across and even within LHINs. While this year finally saw the actual presence of a full-time geriatrician in each LHIN, the actual distribution of the 122 currently practicing geriatricians varies considerably with the majority being located near the five original academic health sciences centres in Ontario. Geriatricians throughout the province are providing inpatient and outpatient consultations and some community outreach services. The degree to which these services are integrated with local primary care providers varies as well.

**Building on Strengths**

Dr. Walker identified the need to develop a provincial Geriatric Assessment Clinic model that takes into consideration the existing primary care models, to allow geriatricians and other health and social care professionals to work with and support primary and community care providers.

He reasoned that in overseeing the completion of comprehensive assessments of the care needs of older adults while they are in the community, this could prove to be the most vital step in helping older adults stay healthy, stay out of hospitals and stay at home longer.239 Most geriatricians would agree with this, although previous fee-for-service payment mechanisms made the ability to do outpatient work financially unfeasible. This resulted in the speciality becoming one that would largely be working in hospitals, where access to interprofessional team supports would more likely be available to them. With recent payment reforms, geriatricians are now rewarded in a way that makes their work in outpatient settings far more viable; however, the importance of having the support of community-based resources will be integral to advancing the vision Dr. Walker suggested.

The Geriatric Assessor Model roles established in the Champlain and North East LHINs represent one innovative way in which local geriatricians have been able to extend their reach within primary and community care settings. In this model, nurses or other allied health professionals in primary or community care settings have been trained to perform comprehensive assessments on patients prior to being seen by the geriatrician. This allows the assessor and the geriatrician to review a number of

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patients in one session, when a lot of the more routine but necessary work has been done in advance by the assessor.

More geriatricians have also been embedding themselves in Family Health Teams (FHT), and in other primary care team models across the province, to offer more collaborative consultative models which support capacity building in primary care and the development of stronger collaborative working relationships. In the Toronto Central LHIN, the geriatricians at Mount Sinai Hospital, for example, have embedded themselves into a home-based primary care team for frail older adults as well as the hospital’s FHT where they have established a Geriatrics in Primary Care Clinic to provide collaborative consultations with the older patient’s primary care provider.

**In focus:**

**Primary Care Memory Clinics, WW LHIN and beyond**

A geriatrician and a primary care physician who share an interest in dementia, based in the Waterloo Wellington LHIN, have helped to establish 31 interdisciplinary Primary Care Memory Clinics servicing approximately 450 primary care practices across 6 LHINs.\(^{240}\) Using an accredited standardized training program developed in collaboration with the Ontario College of Family Physicians, this model has allowed primary care physicians to develop greater skills and confidence in screening, diagnosing and managing routine cases of dementia and mild cognitive impairment. This has resulted in much more efficient use of limited available geriatrician resources, enabling the area geriatricians to respond in a much more timely way to help the primary care physicians with their more challenging cases.

Along with more primary and community-based models of practice, geriatricians along with other specialist geriatric nursing and other allied health professionals have shown their ability to improve patient and system outcomes in emergency departments, as well as in inpatient acute and post-acute rehabilitative care settings. Therefore, it is clear that geriatric expertise and its team-based approach to care can add value across the continuum of care.

The ability, however, to develop a more coordinated system of geriatric care across the province will require more stable and dedicated funding across each LHIN to support the development of team-based geriatric care models in a variety of settings. The finalization and implementation of the Geriatrician and Care of the Elderly Alternate Funding Plan (AFP) remuneration models will also allow a more predictable remuneration system to become an enabler to geriatricians who might not have otherwise chosen community-based practice models. As fee-for-service models previously favoured working in hospitals rather than the community, the new AFPs will hopefully continue to help reverse these previous practice trends. Furthermore, removing the cap on the number of geriatricians who could work under this model will help to attract more postgraduate medical graduates into geriatric medicine training programs and may also attract more geriatricians to move to Ontario from other jurisdictions as well.

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\(^{240}\) Lee, L et al. 2010. Enhancing Dementia Care: A Primary Care Based Memory Clinic. *Journal of the American Geriatric Society.* 58(11):2197-204.
With the presence of geriatricians in each LHIN now and improvements realized in previous remuneration structures for geriatricians and care of the elderly family physicians, the next step needed is to work with the province’s geriatricians, care of the elderly family physicians and specialist nurses, allied health professionals and others to help establish a common vision for a regional approach to geriatric care that could be adopted across each LHIN. The goal is to develop a scalable model that allows these specialist practitioners working within their LHINs to establish a service delivery model that grows in its depth and variety of services in line with the local availability of human resources and the necessary funds to support them. This planning would certainly complement other health transformation initiatives like the current and future planning around the development of Health Links in each LHIN. This work may lend further emphasis to the idea of establishing a network of Geriatric Assessment Clinics that can specifically work with and support primary care providers and complement existing primary care models.

Overall, a more standardized approach to the delivery of specialized geriatric services across the province will help to ensure that older patients have access to the expertise of these specialists in the ways that would be of greatest benefit in meeting the overall needs of our aging population.

**Recommendations:**

86. The Ministry of Health and Long-Term Care and its LHINs should establish a provincial working group of geriatricians, care of the elderly family physicians and specialist nurses, allied health professionals and others to help develop a common provincial vision for the delivery of geriatric services and a prioritization plan to guide the local staffing and funding of models as resources become available.

87. The Ministry of Health and Long-Term Care, in line with the recommendations of the proposed provincial working group, should encourage the adoption of and prioritize funding for standard evidence-based models that prioritize proactive community-based clinic and home-based consultation services, ED-based GEM nursing models, inpatient-based consultation teams, and specialized care units.

88. LHINs, in line with the recommendations of the proposed provincial working group, should take on a greater role in helping to plan local specialized geriatric medicine and psychiatry services based on local needs and available expertise, i.e., geriatricians and geriatric psychiatrists. This work should be integrated into future planning around the development of Health Links.
Evolving the Role of the Regional Geriatric Programs (RGPs)

RGPs were established to leverage the expertise of geriatricians in academic health sciences centres to help improve the quality of geriatric services provided by acute and chronic hospitals and to enhance local geriatric education and capacity-building initiatives.

The provincial guidance, under which they were established, set out a goal for them to develop comprehensive, coordinated systems of health services for the elderly within a region, with the objective of assisting them to live independently in their own communities, thereby preventing unnecessary and inappropriate institutionalization. In total, five were created beginning in the mid-eighties and were affiliated with the original academic health science centres in Ottawa, Kingston, Hamilton, London and Toronto.

Working from the same guidelines, the five academic health sciences centres used different structures and strategies to develop different kinds of programs to meet their regional needs. To varying degrees, each program provides a mixture of inpatient assessment units and consultation teams, outpatient clinics, day hospitals, and community outreach teams. RGPs also work to support knowledge exchange and capacity-building among community providers and clinicians related to the needs of frail older adults.

When the LHINs were created, the RGPs lost their autonomy over their clinical resources when these funds were rolled into the base funding of the hospitals where programs had historically been based out of. Therefore, the flexibility to repurpose funds between hospitals and other providers has as a result been largely lost. This becomes especially problematic in cases where a hospital’s overall priorities change and prioritize the provision of these services less, or it loses key geriatrics personnel whose presence would be integral to running a particular model of care. Increasing concerns have also been raised that without more oversight of their clinical service delivery budgets, there exists the potential that in times of funding pressures, these funds could be repurposed in less than preferred ways. Furthermore, the loss of an arm’s-length control of these funds has also greatly diminished the ability of RGPs to leverage these funds to attract more resources from service provider organizations like hospitals.

Some LHINs have also raised concerns that the historical funding allocations have inadvertently created service delivery inequities which have made it difficult for them attract, retain and support geriatricians and therefore provide specialized geriatric services without a dedicated funding model.

To review the above concerns and to explore opportunities to strengthen the provision of more streamlined geriatric services across the province, the ministry and the LHINs recently established a working group to evaluate the alignment of the programs and services of the RGPs to provincial and local initiatives. A standard provincwide approach is being used for the review, which will include a current state analysis and a review of adherence to service delivery guidelines. The focus will be on determining how the strengths of the RGPs could be capitalized upon to advance current and future ministry and LHIN priorities such as the Seniors Strategy, the Behavioural Support Ontario, Senior-Friendly Hospitals, and Aging at Home initiatives.
Recommendations:

89. The Ministry of Health and Long-Term Care and its LHINs should expedite their review of the provincial Regional Geriatric Programs to determine if they are being utilized to their greatest strengths and how well they align with current government priorities. They should then develop recommendations on a future model for Regional Geriatric Programs in Ontario.

90. The Ministry of Health and Long-Term Care should review the current funding mechanism for geriatric programs in select hospitals to ensure resources being provided are achieving value and are being deployed equitably to promote capacity building and support for the development of a larger range of community and hospital-based geriatric services to meet their region’s evolving needs.

Mental Health and Addictions Issues and the Provision of Geriatric Mental Health Services

“Mental health and illness is a very relevant and growing issue for seniors.”
– Seniors Strategy Survey Respondent

The prevalence of most mental health disorders is considered to be the same amongst older Ontarians as it is among other age groups, except for age-related psychiatric disorders such as dementia and delirium.241 The most common mental illnesses amongst older adults are mood and anxiety disorders, cognitive and mental disorders due to a medical condition (including dementia and delirium) and psychotic disorders. Older Ontarians are also particularly at risk of developing a serious mental illness during critical transitions, including disablement, loss of spouse, caring for a spouse with dementia, or moving to a long-term care home.242 Those from immigrant groups may be at particular risk, with the risk of depression significantly increasing the longer one has been here.243 In many cases, experiencing housing, income, and transportation challenges along with other social determinants of health can affect the ability to cope with mental illness or addictions, while the stigma associated with these issues also acts as a deterrent to early identification and treatment.

Many of the common chronic illnesses in later life have known correlations with mental illness. The presence of comorbidities further makes the accurate diagnosis of mental illnesses much more challenging: differentiating symptoms of physical illnesses from mental illnesses such as depression can be difficult and, without proper training and attention, treatable illnesses can, and do, go unnoticed by health care providers. Research suggests that older adults with mental health and addictions are often left untreated, one of the key reasons being the inability of primary care providers to identify persons at risk.244

243 McKenzie K et al. 2009. Improving Mental Health Services for Older Adults from Racialized Groups. Centre for Addiction and Mental Health (CAMH), Across Boundaries Research
244 Mackenzie K et al. 1999. Do Family Physicians Treat Older Patients with Mental Disorders Differently than Younger Patients? Canadian Family Physician. 45:1219-1224.
**Depression and Anxiety**

Depression is the most common mental health problem for older adults\(^\text{245}\) and substantial depressive symptoms affect an estimated 15 per cent of those living in the community.\(^\text{246}\) Rates of depression are higher in long-term care homes with up to 44 per cent of residents having an established diagnosis of depression or significant depressive symptoms.\(^\text{247}\) Overall, in older adults, the prevalence of depression is greatest in those 80 and better and in women regardless of age.

Depression in older adults may manifest differently than in younger people and may overlap with the symptoms of other conditions, or may be seen as a normal part of aging, resulting in the depression being overlooked.\(^\text{248}\) Unrecognized or under-treated depression is also associated with greater morbidity, functional decline, poor self-care, diminished quality of life, increased use of health care services, and death.\(^\text{249}\)

Anxiety disorders tend to persist in later life and new anxiety symptoms are often part of later onset mood and cognitive disorders. Older adults also represent the group with the highest rate of hospitalizations for anxiety disorders.\(^\text{250}\)

**Dementia**

Dementias, of which Alzheimer’s is the most common, are progressively debilitating diseases that erode cognitive and functional abilities. There are currently nearly 200,000 older adults with dementia in Ontario and this number is expected to increase 30 per cent by the year 2020.\(^\text{251}\) Older adults with dementia are intensive users of health care resources. They are twice as likely to be hospitalized, visit emergency departments for preventable conditions, and have ALC days as compared to those without the disease.\(^\text{252,253,254}\) Older adults with dementia living in the community are also more likely to receive physician services and have a greater number of prescriptions than their counterparts without dementias.\(^\text{255}\)

When the cognitive and functional impairments of dementia advance, institutional care is often required where 65 per cent of care recipients carry a diagnosis of dementia.\(^\text{256}\) As the prevalence of dementia increases, so does the demand for long-term care. As increasing numbers of older adults with dementia choose to remain living in the community, this will require a large investment in community

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\(^{246}\) Ibid.

\(^{247}\) Canadian Institute for Health Information. 2010. *Depression Among Seniors in Residential Care.* Ottawa, Canada.


\(^{252}\) Ibid.


services, including mental health services, day and respite programs, and home care. These services will need to be tailored to meet the needs of older adults in all stages of the disease process. In the more advanced stages of dementia, some individuals may revert back to their mother tongue. This is particularly important when only 58 per cent of Canadians have reported English to be their original spoken language. Services will need to account for the linguistic needs of Ontario’s older adults.

The behavioural and psychological symptoms of dementia affect up to 90 per cent of persons with dementia over the course of their illness and are typically the most challenging ones experienced by those with dementia and their caregivers. As a result, geriatric mental health services need to be available particularly to assist primary and community care providers in the management of behavioural and psychological symptoms, which include psychosis, depression, aggression, agitation, and disinhibition. An equally important role for geriatric mental health services is to support primary care providers in differentiating between the diagnoses of mild cognitive impairment and early dementia, and between dementia and depression.

The impact on the mental health of caregivers can also be significant. Family members or friends who act as caregivers for older adults living with depression or cognitive impairments have been shown to have high rates of distress, while approximately one third of family caregivers of people with Alzheimer’s and other dementias report symptoms of depression. Therefore, offering respite, counselling, and other support services will be essential to allow caregivers to continue caring for the person in the home and to avoid a premature admission to long-term care.

Delirium

Delirium is a common mental health disorder involving disturbances in consciousness, perception, thought, and memory that primarily affects older adults with dementia. It is increasingly being recognized as a serious disorder with a significant potential to negatively impact upon the quality of life of older adults, while increasing their lengths of stay and risk of institutionalization and death, especially in more severe cases. Older adults who develop delirium also become at higher risk for developing a dementia.

Unlike dementia or depression, the symptoms of delirium fluctuate over short periods of time (hours or days), alternating with periods of clarity, and can last in some cases for up to six months. It can occur in response to stressors such as surgery, systemic infections, alcohol use and withdrawal, interactions of drugs, and malnutrition. The challenge is that, because delirium can be mistaken for, or exist alongside other mental disorders, assessment can be somewhat difficult.
Approximately 10 per cent to 15 per cent of older adults admitted to hospital have symptoms of delirium, while an additional 15 per cent to 25 per cent develop the disorder following an admission. Despite the high incidence and its clinical significance, delirium often goes unrecognized or is misdiagnosed in at least 30 per cent to 60 per cent of cases. The evidence indicates that up to 40 per cent of hospital-acquired cases of delirium are preventable, and given its association with negative consequences, its prevention and more effective management using established and evidence-based guidelines needs to become a priority, especially in our hospitals.

**Alcoholism**

Alcohol is the most common substance use problem among older adults, with six to ten per cent reporting having problems with alcohol. Approximately one-third of older adults with drinking problems begin misusing alcohol after they reach old age. However, given physical changes associated with aging, older adults are much more vulnerable to the negative effects of alcohol on cognition, emotions, and physical health in general. Substance misuse often results in acute and longer-term cognitive impairment, depression or anxiety, and contributes significantly to falls, accidents and fractures.

**Suicide**

Suicide is five times more likely amongst older adults than in younger age groups, with mortality rates due to suicide being the highest among men in their eighties and over. Risk factors include depression, anxiety, and physical illness, history of stroke, and being widowed and living alone. Uncertainty and fear about the ability to influence one’s own dying and a “weariness of life” may also be risk factors. While older people are less likely than younger people to indicate their suicidal intentions, 50 per cent of suicide attempts by older adults are successful, compared to just over 10 per cent in younger individuals. This is said to be the case as older adults with suicidal intents tend to be much more committed to acting on their intentions.

**The Provision of Geriatric Mental Health and Addictions Services**

One of the major challenges with provision of mental health and addictions services is the lack of coordination across the sector. The 2011 Select Committee on Mental Health and Addictions report commented, “one of the main problems in Ontario’s mental health and addictions system is that there is, in fact, no coherent system.” The Select Committee commented that it was also “struck by the
observation that no one person or organization is responsible for connecting these various parts,” or “breaking down the silos” and ensuring that services and supports are delivered consistently and comprehensively across Ontario.\textsuperscript{271} \textit{Open Minds Healthy Minds}, Ontario's Comprehensive Mental Health and Addictions Strategy, also notes that for the strategy to succeed “we need strong leadership – provincially and locally.”\textsuperscript{272}

This observation applies to mental health and addictions treatment, supports, and services for older adults. Service delivery occurs in multiple settings, including primary care settings, community mental health and addictions agencies, hospitals, and long-term care homes. Throughout our consultations, we kept hearing how despite there being many services available, too many older adults, their caregivers, or their care providers still found it challenging to understand what community geriatric mental health and addictions services were available and how to access them. There clearly is a need for an improved system of governance around the management of mental health and addictions issues across these settings to ensure older adults receive the right care, at the right time, and in the right place.

Ensuring that our current and future health, social, and community care providers have specific training to support the identification and management of these issues will be necessary. With the adoption of the new Ontario Common Assessment of Need (OCAN) in the provision of mental health services, demonstrating that it is not an effective assessment tool for clients with dementia, we will need to ensure a more geriatric-oriented mental health assessment tool is adopted. In parts of the province, innovative assessment, treatment, and outreach models have been developed, including ones for those from ethnocultural communities.\textsuperscript{273} Therefore, as work is undertaken to develop a more integrated mental health system for older adults, these models should be examined closely as well.

As part of the province’s Behavioural Support Ontario (BSO) Strategy, some of the LHINs have developed best practice tools to help their primary care providers better facilitate early identification and intervention among those older adults at risk for dementia and other cognitive impairments. The increased provision of community-based specialized geriatric mental health services has been encouraging, in conjunction with Community Support Services (CSS) agencies such as local Alzheimer Societies, who play a key role in supporting community education, awareness, and support through this initiative. These collaborations are also helping to develop a more rationalized, proactive and systematic approach to the management of patients with important behavioural issues in our communities. These initiatives are also helping to raise awareness about how behavioural and mental health issues can often be complicated by other social determinants and how a better system needs to be developed to identify and manage these issues as well. Early success of the BSO initiative should serve as a guide for the future development of community-based geriatric mental health services.

\textsuperscript{271} Ibid.
\textsuperscript{273} Lee, L et al. 2010. Enhancing Dementia Care: A Primary Care Based Memory Clinic. \textit{Journal of the American Geriatric Society}. 58(11):2197-204.
**Recommendations:**

91. The Ministry of Health and Long-Term Care should support their LHINs to leverage their Behavioural Supports Ontario (BSO) Program’s partnerships, momentum, and successes to help define what core community geriatric mental health and addictions services need to be funded and delivered. Additionally, a standard approach to assessment, referral, and service delivery models needs to be developed and implemented within and across LHINs.

92. The Ministry of Health and Long-Term Care should consider supporting the LHINs in developing lead agency and lead coordination models that can standardize service provision, reduce service fragmentation, facilitate better care transitions, and achieve greater efficiency in administrative functions that support the delivery of these services across regions. This work should be aligned with the government’s Mental Health and Addictions Strategy that is seeking to define an overarching governance model for its entire mental health and addictions system.

93. The Ministry of Health and Long-Term Care should explore the adoption of a standardized geriatric-oriented assessment tool like the interRAI Mental Health, rather than the OCAN tool, in programs that specifically provide geriatric mental health services. Adopting the interRAI Mental Health instrument will allow assessment and care planning information to be more easily shared with and from other interRAI assessments to avoid and reduce the duplication of assessment efforts. Additionally, a standard approach to assessment and referral needs to be developed and implemented.

**Palliative and End of Life Care Issues and Services**

Longitudinal health economics analyses demonstrate that the time approaching death, rather than age in itself, is the main demographic driver of health care costs. However, high quality palliative care delivered earlier in an illness trajectory makes it less costly and more aligned with individual preferences. While most Canadians would like to have access to palliative care, approximately 70 per cent do not, and where individuals do have access, it is often not equitable across diagnoses. Currently, 50 per cent of all Ontario deaths occur in hospitals, which is contrary to the preferences of most Ontarians who wish to die in other settings of choice, such as their own homes, long-term care homes, residential hospices, or other community-based settings.

Within our current system, the care people receive close to the end of their lives is often reactive, episodic, more costly, and less appropriate to their needs and preferences. Most individuals who receive palliative care are also referred to it closer to the end of life, or when death is imminent and they usually receive it in the most expensive care settings. The experience, however, of other jurisdictions provides evidence that more proactive palliative care delivery can translate into system-wide fiscal benefits through the more appropriate use of therapies, treatments, investigations, and reduced emergency costs.

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department visits and hospital admissions. In Ontario, earlier admission to high-quality home-based palliative care was also demonstrated to reduce acute care hospitalizations and their subsequent costs at the end of life by as much as 35 to 50 per cent. Therefore, there is ample evidence to suggest an effective end-of-life care strategy that includes access to palliative care and formalizes the process of advance care planning will have the ability to reduce health system costs and support the long-term viability of our health care system.

In April 2011, the Minister of Health and Long-Term Care publicly committed to undertaking a provincial review of palliative care services in Ontario and announced increased funding for the provision of residential hospice palliative care services. Subsequently the ministry, its LHINs, and the Quality Hospice Palliative Care Coalition launched a stakeholder engagement strategy to advance high-quality, high-value palliative care delivery in Ontario. This led to the creation of their Declaration of Partnership and Commitment to Action, which includes a shared vision and goals for the system, key measures of success to guide system transformation, and action plans for the LHINs and each sector to help achieve and monitor improvements on an annual basis in the delivery of palliative care across the province. With the establishment of more robust community-based palliative care programs, a number of LHINs have started to demonstrate that savings can be realized principally through cost avoidance through reduced use of acute care services.

**Heath Care Consent and Advance Care Planning**

Hospice Palliative Care Ontario, the Canadian Hospice Palliative Care Association, and the Advocacy Centre for the Elderly, amongst others, have collectively advocated for the need to increase awareness around as well as the importance of health care consent and advance care planning.

Health care consent is not simply confirmation of an agreement to a particular treatment or care option. It should include care planning, to assist individuals to make decisions about care and treatment in the context of their present health condition. Advance care planning, a related activity, is a process of reflection and communication, whereby an individual confirms or chooses who would be their future substitute decision-maker (SDM) and lets others know of their values and beliefs, as well as their health and personal care preferences about future care, in the event that they become incapable of consenting to or refusing treatment or care. Those preferences are referred to as “wishes” in the Health Care Consent Act.

In allowing family, friends, caregivers and health care providers to know one’s overall goals of care and end-of-life care preferences, this can support a more proactive palliative care approach that can relieve suffering and improve the quality of life amongst those who are living with or dying from a life-

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limiting illness. The presence of good health care consent practices and advance care plans has also been demonstrated to support the more appropriate use of therapies, treatments, and investigations and the greater likelihood that a person will die in the setting of their choice.

The challenge with advance care plans is that care preferences or wishes can change, particularly as health conditions change, or options for treatments change with time. Furthermore, if vague language is used to express one’s wishes, this could lead to misinterpretations and the wrong care being delivered. Advance care plans, therefore, must always be viewed as a previous expression of wishes or preferences, and therefore, the only way a provider should proceed with a treatment decision on behalf of a patient is to pursue obtaining consent from the patient, when capable, or from their designated substitute decision-maker (SDM) when the patient is not capable of making treatment decisions.

We heard during our consultations that within our health care system, institutions and health care providers do not always pursue getting informed consent before providing a treatment of any kind. Furthermore, some organizations are misusing advance care plans or “level-of-care” forms as consents regarding current or future care decisions, and not pursuing getting current consent from a patient or their SDM. Therefore, any future efforts that are made to encourage the use of advance care plans or any care planning tools, such as level-of-care forms, should be coupled with education for patients, SDMs, and care providers around health care consent and the appropriate use of advance care plans.

Encouraging primary care providers to engage their patients in discussions around health care consent and the development of advance care plans can help establish a clear understanding around both of these areas before a health care crisis occurs. It is also important that health care providers initiate discussions regarding documentation of power of attorney for personal care for same-sex couples, as their unions may not be fully acknowledged in all situations unless they are married – despite the fact that the health care consent law does include common-law, same-sex, and opposite-sex relationships in the definition of “spouse.” Ensuring that discussions around health care consent and advance care plans occur soon after an admission to an acute care or long-term care home will also allow for proper care decision processes to be followed in line with a person’s care choices and preferences.

Recommendations:

94. The Ministry of Health and Long-Term Care should forge ongoing partnerships with its LHINs, the Quality Hospice Palliative Care Coalition, and other partners to implement the Vision and Action Plan identified within the Declaration of Partnership and Commitment to Action, as part of the LHINs’ efforts to implement their Palliative Care/End-of-Life Three-Year Plans at the local level.

95. The Ministry of Health and Long-Term Care should continue to support its LHINs in broadening the range of palliative care settings available in their regions, including within a patient’s home, hospice, and institutional care settings as well.
96. The Ministry of Health and Long-Term Care should support the standardization and adoption of health care consent and advance care planning processes that help Ontarians understand their role in decision-making around their care decisions, while providing them with an opportunity to express their care preferences and wishes in advance care plans. Educating SDMs around health care consent should be a part of these processes to ensure they understand their roles and responsibilities on behalf of the care recipient they may have to advocate for.

97. The Ministry of Health and Long-Term Care should work with the LHINs and Quality Hospice Palliative Care Coalition to develop a strategy to promote Health Care Consent and Advance Care Planning as a standard activity for all care providers working with older adults.

Additional Issues for Special Considerations with Older Adults

Continence

While urinary and fecal incontinence are not diseases of older age per se, the likelihood of having these conditions significantly increases with age, especially in older adults. Urinary and fecal incontinence impacts all parts of a person’s, and by extension, their caregiver’s life, including social interactions, personal intimacy, and participation in community life. Many older adults who live in the community find that either or both of these conditions significantly restrict their ability to exercise and stay socially engaged with others, and can lead to isolation, physical deconditioning and depression. Left untreated, incontinence can worsen over time, leading to other conditions that will require further treatment such as depression, falls, fractures, and skin lesions.

The prevalence of any degree of urinary incontinence in older adults is reported to be as high as 5.4 per cent for men and 29 per cent for women,\textsuperscript{281} while the overall prevalence of fecal incontinence is 15.3 per cent.\textsuperscript{282} Despite the high prevalence of these issues, older adults often do not seek treatment due to embarrassment and social stigma, or because they assume this is a normal aspect of aging. Indeed, it is estimated that only 26 per cent of those with urinary issues seek professional help.\textsuperscript{283} Adding to this problem, health, social, and community care professionals are often unaware of incontinence symptoms,\textsuperscript{284} partly because of the reluctance of their care recipient to raise the issue, but also because care professionals usually do not enquire about it themselves – or when they do enquire, they may ask a confusing question, using unfamiliar terms, rather than a question that will help to break down stigma and lead to meaningful discussions.\textsuperscript{285}

There also exists a general lack of interest amongst health, social, and community care professionals to engage with older patients around the issue of incontinence and its management. Nevertheless,

educating both the public and professionals on how to engage more around this issue will allow more persons with these issues to be identified and for help to be provided. Ensuring that routine health assessments of older adults raise this issue will also help to prioritize this issue.

**Oral Health**

Maintaining good oral health is essential to the overall health and well-being of older adults. Having a healthy, pain-free mouth, free of chewing difficulties, contributes to the enjoyment of a variety of nutritious foods, as well as talking clearly, sleeping well, and having a positive self-image, satisfying social interactions, and higher quality of life overall.

Current studies have shown links between poor oral health and medical conditions such as pneumonia, diabetes, cardiovascular disease, osteoporosis, and rheumatoid arthritis. Whether poor oral health is a contributor, or an indicator of these serious and sometime life-threatening conditions, it underlines the need for older adults to receive regular assessments, maintenance, and treatment by dental professionals.

The costs of most services provided by dental professionals – including check-ups, cleanings, denture fittings, and acute services such as fillings and extractions – are not publicly funded for most Ontarians. Thirty-two per cent of Canadians have no dental insurance, and many of these persons are older adults who lose coverage when they retire or can't afford professional dental care. Currently, most government initiatives that provide dental care to low-income Ontarians are aimed at children and youth through Healthy Smiles Ontario. Additionally, for adults who qualify, Ontario Works and the Ontario Disability Support Program provide funding for basic care and emergency services. Therefore, for low-income older Ontarians with limited finances and no dental insurance, the cost of preventative dental care is a barrier. As a response, some municipalities have leveraged the infrastructure of their Healthy Smiles dental clinics to fund and develop programs such as Peel Public Health’s Seniors’ Dental Program that covers the costs of basic care (cleanings, fillings, dentures) for low-income seniors who would otherwise have no access to any form of dental care. The fact that this program currently has a one-year waiting list speaks to the need for more programs like these across the province.

There also exists a general lack of interest amongst health, social, and community care professionals to engage with older patients around their oral health. Nevertheless, educating professionals around assessing the oral health needs of their patients can help make oral health care a part of routine health care in the community and in institutional settings, especially when the proactive management of oral health issues can prevent more serious health issues from arising. Ensuring that routine health assessments of older adults raise this issue will also help to prioritize this issue.

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Nutrition

Adequate nutrition is an important part of healthy aging in helping to maintain one’s health and delay the onset of disease and disability. Most older adults could benefit from nutrition education that promotes quality of life and health maintenance. As well, the increased prevalence of chronic diseases that come with age and the need for modified diets to delay the progression of disease, make information on good nutrition vital for older adults.

Many factors influence cooking and shopping habits and are seen as risk factors for poor nutrition, including income, nutrition knowledge, cooking skills, physical health and disabilities, and access to transportation. In a recent survey on eating and nutrition, 69 per cent of the older adults questioned were identified as being “nutritionally at risk” where common risk factors can include weight change, restricting food, low fruit and vegetable intake, difficulty with chewing, cooking or shopping, and poor appetite. While some research has noted that 57 per cent of older Ontarians are overweight or obese, 34 per cent were considered to be at a high nutritional risk. While poor nutrition can lead to obesity, it can also be associated with unintentional weight loss that can affect as many as 27 per cent of frail older community-dwelling adults. As a result, unless older adults are routinely screened for weight loss and nutrition risks and made aware of the available community resources, they will be at risk for systemic malnourishment.

“Providing reliable evidence-based information on healthy eating to seniors and caregivers is important, but consideration must also be given to issues of food security, access, and acceptability”
– Submission from the Dietitians of Canada

Some older adults seek out supports to ensure better nutrition, but many are not aware of the resources and sources of support that are available to them. Due to the current shortage of dietitians, the ministry helped to establish EatRight Ontario to provide free access to nutrition and healthy eating advice from registered dieticians, in multiple languages, through a website or dedicated phone line. While this can serve as a useful resource for those with access to food, those who are food insecure should be made aware of other options as well. In 2011-2012, 45,042 older Ontarians received 2,763,285 meals, through a Meals on Wheels program. A number of CSS agencies and older adult centres have developed programming specifically aimed to support healthy eating for older adults such as group shopping, community gardens and kitchens, and communal meals.

**Falls**

As identified in Chapter 2, falls are a leading cause of hospital admissions and can often lead to a loss of independence for older adults. Falls are most often caused by a combination of factors including: muscle weakness, imbalance due to sensory issues, vision and hearing impairment, sudden blood pressure drops when standing, dementia, medication side effects, and an inappropriate physical environment.

The most effective interventions require a multifactorial approach to risk modification, including strength and balance training, the use of assistive devices, medication review, treatment of contributing medical issues and environmental modifications. The best approaches usually require a multidisciplinary team of practitioners to provide assessments and treatments. Furthermore, because falls are often an indicator of other issues, their occurrence and frequency should routinely be monitored by anyone caring for an older patient.

**Sexual Health**

Sexuality is an integral aspect of human life regardless of age and encompasses many dimensions, including relationships, sex, desires, orientation, practices and behaviours. Sexual health has been defined as a state of physical, emotional, mental and social well-being; not merely the absence of disease, dysfunction or infirmity. While aging brings about natural changes, both physically and emotionally, it may also affect how people experience and express their sexuality. For older adults, personal relationships take on an increased importance as the focus on raising children and building careers subsides. The need for intimacy is ageless and universal. Regardless of marital status, sexual orientation, or gender, people never outgrow their need for affection, emotional closeness, and intimate love. While the physiological changes that come with aging may reduce the frequency or ability to perform sexually, intimacy and sex is still important to the majority of older men and women.

Older adults are often afraid or embarrassed to talk to their doctors about sex or sexual problems and many health care professionals simply do not bring up the subject of sexual activity with their older patients. This is problematic, however, as the lack of education amongst older adults regarding the need for safe sex practices, coupled with the pharmaceutical development of erectile dysfunction aids, has led to an increase in sexually transmitted infections in older adults. For example, the rates for infectious syphilis, chlamydia and gonorrhea amongst older adults has remained steady or slightly increased over the past five years in Ontario, while the national incidence of HIV in older adults has seen a 4.7 per cent increase over the past decade. Furthermore, the most reported cause of sexually transmitted infections amongst older adults is due to not using a condom. Educating both older adults and professionals around the importance of promoting safer sex practices will help to reduce the spread of sexually transmitted infections.

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Addressing the Needs of Lesbian, Gay, Bisexual, Transgender and Queer Older Adults

Sexual orientation is much more than sexual behaviour and includes concepts of attraction, and/or self-identification. Gender also has a strong cultural definition, in addition to precise biological, and extensive psychosocial components. Many of today’s Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) older adults lived their youth and young adult lives, to varying degrees, in hostile environments, prior to the more inclusive modern-day standards. This has resulted for some in feelings of great stigma and shame that continue to shape their lives, often requiring them to keep their sexual orientation hidden as a strategy for survival. Furthermore, current or past negative experiences with health care professionals may have caused barriers to receiving appropriate health care, leaving older adults who are LGBTQ with specific health care needs that are largely unrecognized by health care professionals.

LGBTQ older adults can have the same geriatric syndromes as their heterosexual counterparts, and need much of the same health promotion and maintenance advice and support. However, there are certain medical issues that require particular attention in LGBTQ older adults such as: regular screening for HIV and other sexually transmitted infections amongst gay and bisexual men, greater risks of cardiovascular disease due to higher rates of obesity and metabolic syndrome, smoking, and alcohol use for lesbian and bisexual women, and a higher prevalence of psychological disorders and distress overall. This latter issue is particularly important as managing social stressors such as prejudice, stigmatization, violence, and internalized homophobia over long periods of time can result in higher risks of depression, suicide, risky behaviour, and substance abuse for LGBTQ older adults.

“We need to ensure that lesbian, gay, bisexual and transgendered older adults are accommodated with positive acceptance and not just tolerance.”

– Seniors Strategy Survey Respondent

Past negative experiences with health, social, and community care professionals may also lead to hesitation on the part of older LGBTQ adults to seek supportive services. Older LGBTQ adults may also have fewer caregiver options as they are less likely to have children or grandchildren, or they may be isolated from their families of origin. While they may need to access home care and community support services to remain independent, we heard from LGBTQ elders who told us of their reluctance to request services, out of a fear of being discriminated against in their own homes, which can negatively affect their overall quality of life. For LGBTQ older adults who enter residential or long-term care environments or require acute care services, similar concerns were noted as well, resulting in some LGBTQ older adults and their partners reporting that they felt forced to hide their identity in these environments out of a fear of discrimination.


Therefore, just as health, social and community care providers are being educated to better understand and address the ethnocultural needs of patients, we must ensure that the care processes we design and provide are done in a safe, inclusive, and responsive way for LGBTQ older adults as well. This can ensure their health, social and community care needs can be addressed appropriately as well.

**Recommendations:**

98. The Ministry of Health and Long-Term Care should encourage the inclusion of questions regarding continence, sexual, oral, and nutritional health, and the frequency of falls in all informal and formal tools used to assess the health of older adults.

99. The Ministry of Health and Long-Term Care should promote the development of cultural competency training for all health, social, and community services providers to ensure LGBTQ and other “non-visible” minority groups are delivered safe, competent care in an inclusive environment.
Chapter 8: Medications and Older Ontarians
Identifying and Addressing the Medication Management Needs of Older Ontarians

As people age, their use of medication tends to rise. About 80 per cent of older adults have at least one chronic condition that requires the use of medication. Furthermore, the Canadian Institute for Health Information (CIHI) recently noted that almost two thirds of community-dwelling older Canadians are using five or more classes of prescription medication, with slightly more than one in five of these older adults using 10 or more types of prescription medication, while just over 1 in 20 are using 15 or more different classes of medication.

Although medication enable many older people to function at a higher capacity and live longer than they might if they did not have access to these pharmaceutical therapies, they also expose them to potential additional health risks like adverse medication events.

“We need to encourage regular medication reviews to ensure medications are still relevant and not contraindicated.”

– Seniors Strategy Survey Submission

As we age, our body’s natural ability to handle medication changes, sometimes making us more sensitive to the same dose of a medication that we may have been taking for years. This becomes more of an issue especially if we develop problems with our livers or kidneys, which both play an important role in the way our bodies handle medications. In fact, we know that older adults are more than twice as susceptible to the side effects related to taking medication as compared to younger persons, and these side effects are often severe enough to require a visit to a doctor or to the hospital. In 2011-12, approximately 16,000 older Ontarians were hospitalized due to an adverse medication event.

Given the higher likelihood of “polypharmacy” – being prescribed many medications at the same time – older adults are also at an even greater risk of suffering from medication interactions than younger individuals. What complicates things further is that older adults are more likely to be improperly prescribed medication at a dose that is too potent or not potent enough, or even maintained on medication that no longer provides any therapeutic value. The problem with these scenarios is that all three can lead to the prescribing of further medication to manage ongoing disease symptoms or even the side effects of other medication. This situation, often called a “prescribing cascade,” will usually lead to further side effects and adverse events.

The management of medication use for older Ontarians needs to be focused always on finding the right balance of positive outcomes that these therapies can deliver, including an enhanced quality of life.
through better symptom and pain management, and an enhanced life expectancy through a growing array of life-saving therapies, while addressing and mitigating, where possible, the increased risk of suffering from side effects and/or adverse events.

**Ministry Programs to Promote Safer Medication Practices and Use**

The Ministry of Health and Long-Term Care has taken various steps to address the risks associated with drug use and has worked with the Institute for Safer Medication Practices (ISMP) to implement their Medication Safety Support Service (MSSS) Program, which delivers a variety of provincial initiatives to assist pharmacists and other professionals working in hospitals, long-term care homes, and community pharmacies throughout Ontario to implement strategies and safeguards for the prevention of patient injury from medication use. The ministry supports the work of the ISMP and relies on them to ensure that medication safety continues to be a top priority and that appropriate initiatives are being developed and implemented, including:

- medication reconciliation programs in the community, and standards around medication reconciliation before, during, and after an acute hospitalization (in collaboration with health care providers),
- the Safer Medication Use in Older Persons Campaign,
- the development of Medication Safety Indicators, and
- the Medication Safety Self-Assessment (MSSA) Program.

While the ministry’s current initiatives are helpful in improving prescribing practices, it is becoming widely recognized that formal teaching around the basic prescribing principles, and medication management services for older patients remains rudimentary, or even absent, from current training curriculums for health, social, and community care professionals in Ontario (including pharmacists). Given that well over two-thirds of older Ontarians have at least one chronic condition that requires medication, it will be paramount that appropriate training curriculums and public education efforts be instituted, so that older patients, their families, and their caregivers, in partnership with their designated health, social, and community care professionals, are able to institute the best approaches to the management of their medication. Furthermore, encouraging that resources are available to support the continuing education needs of both the public and professionals in this area will also be important to help better support the needs of older Ontarians for whom medication therapies are being considered or prescribed.
Recommendations:

100. The Ministry of Health and Long-Term Care should consider ways to share the content of the existing ODB claims information of ODB recipients with other health and social care providers within the circle of care to support their ability to better understand a patient’s previous medication history, especially when admitted to an ED or hospital for care. Currently the range of access is limited as access is via Ontario Drug Benefit (ODB) – Drug Profile Viewer.

101. The Ministry of Health and Long-Term Care should identify trends regarding inappropriate combinations of drugs and develop best practice guidelines and knowledge transfer mechanisms to improve prescribing practices and reduce the harmful effects of medication interactions in older adults.

102. The Ministry of Health and Long-Term Care should encourage pharmacist training in geriatrics including certification programs where available and/or programs incorporated in pharmacy curriculums.

Enhancing the Role for Pharmacists in the Care of Older Ontarians

It is clear that Ontario’s pharmacists will play an integral role in the implementation of the Seniors Strategy. They are already uniquely positioned to work in all care settings with all other health, social, and community care professionals to identify and support approaches for ensuring the appropriate prescription and use of medication for and by older adults.

In recognizing the unique position pharmacists could fulfill in supporting the prescription and medication management needs of older Ontarians, the ministry, in collaboration with the Ontario Pharmacists’ Association (OPA), and others have supported pharmacists to expand their scope of practice to better address and meet these needs. It is widely recognized that older adults who are taking multiple medications should have their medication regularly reviewed to verify they are taking what they have been prescribed properly, that they understand what they are taking and why, that they know how to take their medication, and that they have a system in place to manage taking their medications more easily. Participating in regular reviews can help them ensure that they are getting the most from their medication and allow their regimens to be altered if needed to improve response and compliance and can ensure that adverse events are prevented whenever possible.\(^\text{308}\)

The ministry and the OPA, with advice from Ontario’s Pharmacy Council, implemented the MedsCheck program in 2007, which supports in-person medication reviews between community pharmacists and patients who are taking a minimum of three prescription medications to manage chronic conditions. MedsCheck is designed to help patients better understand their medication therapies and ensure that medication is taken as prescribed. Any potential medication-related concerns identified during the review are further investigated by the pharmacist. The final result of a MedsCheck review is that

patients will receive a signed and dated medication list that they can carry with them and share with others as is needed. The ministry further implemented two variations of the MedsCheck program in 2010 to specifically target older adults residing in Long-Term Care Homes (MedsCheck for Long-Term Care) and frail homebound older adults who are unable to attend their community pharmacy in person (MedsCheck at Home).

Pharmacists may provide support to older adults, especially those with cognitive impairments, in the administration of their prescriptions through methods that aid their compliance in taking them – such as blister packs or dosettes. Overall, the participation of pharmacists providing these services continues to grow; however, some pharmacists feel hindered due to time constraints and what some see as inadequate remuneration associated with delivering these services.

The traditional roles of pharmacists in Ontario continue to evolve towards a professional services focus and, most recently, they were granted additional opportunities to expand their scope of practice with patients. These opportunities allow them now to renew certain prescriptions, prescribe certain medication, provide formal education around the use of certain medication, and even administer flu shots. In the context of understanding how these new opportunities will place additional demands on the time of pharmacists, along with other factors that influence the uptake of these additional roles and responsibilities into common practice, it will be important for the ministry, the OPA, the Pharmacy Council, the Ontario College of Pharmacists, and others to monitor these issues over the coming years.

Already, the ministry and the OPA have agreed that a formal evaluation of the MedsCheck Program should be conducted now that it has been in place for a few years. This will help to determine its overall effectiveness and impact and also identify areas for further improvement and implementation. For example, just as the regulations around providing prescription renewal services require a pharmacist to communicate with their patient’s primary care provider when performing this service, the same requirement does not exist when conducting a MedsCheck review and consultation. In exploring this issue further, it is clear that primary care providers want to know what other health, social, and community care professionals are recommending to their patients, and would welcome being informed as a part of this service to ensure communication occurs around managing an older patient’s medication. In addition, it is critical that, as Ontario moves towards integrated electronic health records, there is an expectation that MedsCheck medication management records will be used to make and inform decisions by other health providers. Finally, consideration of an expansion of an enhanced program to hospital and primary care team pharmacists has already been identified as a potential opportunity for further implementation of this program.
Recommendations:

103. The Ministry of Health and Long-Term Care should conduct a full review of its MedsCheck Program to understand how effective it has been and how this service can be improved to better support patients managing with multiple medication and provide more added value, including:

a) Strengthening collaborations between the pharmacist and the physician in medication therapy management.

b) Setting clear best practices benchmarks or protocols for implementing systems that ensure pharmacists are providing the best possible medication history. This includes informing physicians in a meaningful way of recommended changes to therapy with appropriately summarized follow-up and action plans.

c) Engaging the public in better managing their medication; getting the public involved and more aware of the MedsCheck program.

Financing the Future Medication Needs of Older Ontarians

Another area the Government of Ontario has moved forward with is starting to examine and revise how medication are publicly funded in this province. The current ODB Program covers all Ontarians 65 years and older, and other specified populations, for over 3,800 prescription drugs listed in the provincial formulary and for an additional 850 through the province’s Exceptional Access Program. In 2011-2012, the ODB Program provided drug coverage to over 3.6 million Ontarians at an overall cost of $4.4 billion, of which $3 billion was spent on older Ontarians.

In Ontario, like in most other parts of Canada, a one-size-fits-all policy was introduced years ago with a guarantee that the full costs of people’s medication would be covered once they reached age 65, except for a small deductible co-payment. However, our current and future fiscal and demographic imperatives are now coupled with the fact that medication costs currently represent the fastest growing part of our health care budget. This is creating concern that our current coverage policies may not be sustainable unless we agree to raise taxes or cut funding from other areas of the health care system.

Like other Canadians, Ontarians have come to value the communitarian approach we have developed to deliver health care, based on one’s need and not one’s ability to pay. In Ontario, the Trillium Drug Program provides ODB coverage to people who are not otherwise eligible for the ODB program and who have high drug costs in relation to their income. Ontario was one of the first provinces to implement this type of program in 1995; this is a type of safety net that requires an annual application by the household. In line with this philosophy, British Columbia went a step further in revising their provincial drug benefit program this past decade to cover all low-income citizens, regardless of their age, as it was recognized that some older citizens do have the ability to pay for their medication without the need for a public subsidy. In taking this approach, the program expanded its overall coverage while maintaining a guarantee that one’s inability to pay, regardless of age, would not be a barrier to
affording the costs of taking necessary medication. A subsequent 2006 study showed that the revised BC program resulted in a 16.9 per cent reduction in public spending without affecting access.309

The Government of Ontario has already started to examine and implement fairer coverage models to support the overall sustainability of its system. Ontario’s 2012 Budget introduced the first significant changes to the ODB program so that, beginning in August 2014, Ontario’s highest-income older adults will no longer pay the standard deductible when paying for their medication, but rather a new income-based deductible, which increases gradually with their overall net income. While these changes will help to ensure that the ODB program can continue to provide benefits to older Ontarians, it also ensures that the greatest help can be provided to those in greatest need. In a poll conducted by the Canadian Association of Retired Persons (CARP) in response to this, 62 per cent of its members agreed with this shift towards means-testing for drug benefits rather than the current approach.310 Indeed, it appears that Ontarians are ready to discuss further changes that will support the future sustainability and equitability of the program. Furthermore, it is clear to us that this conversation should happen as soon as possible.

Additionally, as private insurers and employer groups who provide private drug coverage are now starting to recognize the need to better manage the future sustainability of their coverage programs, the opportunity to work more closely with the ministry around common issues that affect prescription medication funding should be pursued, especially around the development of their formularies, product listing agreements with manufacturers, and a more seamless way to address transition issues of prescription medication coverage when individuals move from private insurance coverage to public program coverage.

Finally, for over a decade, Ontario and the other provinces have recognized the potential value that a national pharmacare strategy and program could have around applying the best evidence to understand the benefit of covering new medication, establishing lower prices and, therefore, reducing overall costs in a similar way that many other nations have already done.311 The provincial premiers recently agreed to advance this agenda312 and this should be fully pursued in supporting the development of a Seniors Strategy.

**Recommendations:**

104. The Ministry of Health and Long-Term Care should continue to use the best possible evidence to understand the benefit of covering new medication.

105. The Ministry of Health and Long-Term Care, in collaboration with Private Insurers/Employer Groups, should discuss common issues related to prescription medication funding. Issues may include:
   a) Ensuring funding decisions by private insurers are evidence based.
   b) Examining the transition issues of prescription medication coverage when patients move from private insurance coverage to public program coverage.
   c) Examining product listing agreements with manufacturers.

106. The Ministry of Health and Long-Term Care should continue its work of reforming the Ontario Drug Benefit (ODB) Program to more directly link benefits to income rather than age, and thereby consider expanding this coverage for all Ontarians.

107. The Ministry of Health and Long-Term Care should continue its efforts towards working with its Federal, Provincial and Territorial counterparts to develop a national pharmacare strategy and program that would facilitate the purchasing of common pharmaceuticals at lower overall costs.
Chapter 9: Caring for Caregivers
Understanding the Contributions and Challenges of Caregivers

For a number of older Ontarians, unpaid caregivers often come to represent the most important members of their care teams. These caregivers provide support not only to family members but often to friends and neighbours as well, assisting them with activities that allow them to maintain their independence in the community. The invaluable support unpaid caregivers provide on a daily basis across the province has come to represent, for many older adults wishing to age in place, the difference between remaining independent in their communities or having to turn to alternative and more institutional residential care settings.

According to the latest Healthy Aging Survey, 29 per cent of the people who provided unpaid home care to older Ontarians were their children, 29 per cent were spouses or common-law partners, and 14 per cent were friends or neighbours. Overall, 62 per cent of all unpaid caregivers were females. The types of care commonly provided by unpaid caregivers can vary enormously depending on the situation, but often include providing assistance with housework, groceries and meal preparation, transportation, personal and medical needs, and in many cases, helping the care recipient navigate the health care system and advocating on their behalf. As Figure 9.1 illustrates, with the exception of medical care, older Ontarians are also more likely to receive all other types of care from unpaid caregivers.

**Figure 9.1 Types of Care Provided to Older Ontarians by Paid and Unpaid Caregivers**

![Bar chart showing types of care provided to older Ontarians by paid and unpaid caregivers.](image)

Data source: Healthy Aging Survey, Statistics Canada, 2008/09

Despite the fact that almost one quarter of older Ontarians receive some type of home care (paid, unpaid, or both), according to the most recent Healthy Aging Survey, 4 per cent, or approximately 175,000 of older Ontarians still reported having unmet home care needs. Through a deeper analysis of what characterized these older Ontarians, it was determined that those who lived alone, lived in the lowest income categories, those with high levels of functional impairment or disability, those with poor self-reported health, and those only receiving unpaid home care support were the most likely
to report unmet home care needs. In fact, the latter factor was the strongest predictor of someone reporting unmet home care needs.313

“Caregiving is a 24 hour 7 day a week job.”
– Seniors Strategy Survey Respondent

The health policy literature has debated for years the notion that the more home care support a government provides its citizens, the less likely that families, friends, and neighbours would continue to serve as unpaid caregivers. However, this is not the case at all, especially in Ontario. While a number of older Ontarians do receive the help of paid caregiver support through a variety of home care providers, even in these circumstances, 98 per cent of them are also likely getting help from an unpaid caregiver.314 Clearly, the financial benefit to Ontario’s health, social, and community care systems through the economic value of the care that unpaid caregivers provide is significant. In fact, across Canada, it is estimated that unpaid caregivers who work specifically with older adults save our health, social, and community care systems $24 billion to $31 billion annually.315

The Challenges Caregivers Face

Caregiving in Ontario is a common occurrence, with approximately one in five Ontarians serving as a caregiver to a family member, and contributing to more than 70 per cent of their family member’s total caregiving needs.316 While many unpaid caregivers are retired older adults themselves, a significant number are working as well. The 2012 National Study on Balancing Work and Caregiving in Canada demonstrated that half of its working respondents spend time each week providing child care and 23 per cent spend an average of 6.9 hours per week providing care or activities for older dependents.317 Furthermore, as the number of older Ontarians continues to rise, the demands on unpaid caregivers is only expected to increase. In particular, this will be due to the fact that the vast majority of older Ontarians, those who depend on care as well as those who provide care, are continually expressing their increasing preference for aging at home and for receiving home and community care over institutional care.318

Although caregiving can be a very fulfilling and rewarding experience for many, unpaid caregivers can find it challenging, stressful and expensive as well. The Healthy Aging Survey found that over half of the caregivers it surveyed indicated that they did not experience any difficulties, and many reported that the most rewarding experience for them was the personal satisfaction they derived from caregiving.319

In a number of cases, however, the burden of caregiving can also take an enormous toll on a person's health and well-being due to the substantial economic, social, physical, and psychological costs that caregivers often bear. Caregivers are likely to incur out-of-pocket expenses, significant lifetime income losses, and career limitations from taking time off work, and they commonly experience stress, social isolation, and guilt. The 2012 National Study on Balancing Work and Caregiving in Canada demonstrated that one in five of its working respondents reported high levels of caregiver strain, with much of it stemming from the physical challenges of caring for an adult, from feeling overwhelmed by the experience of being a caregiver, and from the financial strain of caregiving. The Healthy Aging Survey also found that, for the caregivers who reported difficulties, 36 per cent felt that being a caregiver was emotionally demanding and 23 per cent felt that it created stress. Caregivers were also more likely to report experiencing distress when the person they cared for exhibited physically or verbally abusive behaviour, had moderate to severe cognitive impairment, or had high or very high interRAI MAPLe scores.

In late 2011, The Change Foundation conducted an extensive series of provincewide consultations with older adults with chronic health issues and their unpaid caregivers to understand their views and experiences navigating the health care system. What was too often communicated was how disconnected the system was, especially with their primary care providers, how poor communication and a lack of follow-up occurred too often, how some providers demonstrated an inability to include them and their families or caregivers in care planning decisions that affected their lives, and that, too often, people facing barriers to care, fall behind.

What the Ontario Caregivers Survey Told Us

In recognizing the importance of unpaid caregivers to the development of a Seniors Strategy, the Ministry of Health and Long-Term Care wanted to hear directly from caregivers across Ontario to better understand their realities and needs, as well as to learn of existing obstacles and barriers that they face when they provide care and support to older adults. As such, in April 2012, the ministry conducted 800 in-depth interviews with caregivers of older Ontarians. Overall, the survey revealed that 25 per cent of the caregivers surveyed were older adults themselves, while 40 per cent will soon become older Ontarians. Nevertheless, over half of the respondents reported being employed outside the home, with one-third working full-time. Of those who worked full-time, 27 per cent reported providing care daily with at least 57 per cent providing care weekly.

A significant proportion of the caregivers surveyed reported that stress associated with caregiving was having a negative impact on their career, and reported a need for more flexibility in their work schedule so they could better manage their caregiving responsibilities. This is understandable as 40 per cent of the caregivers surveyed reported bearing the brunt of the caregiving responsibilities themselves, with

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many wishing they could share the load with others or take the occasional break. This made sense as, according to the respondents, caregiving often required a significant time investment and could often require their support on a daily basis in 39 per cent of those supporting an older adult with complex care needs. The caregivers also reported that 24 per cent of them were serving as the coordinators of someone’s care, while only 21 per cent reported that it was being coordinated by the primary care or other formal care providers, while, in 54 per cent of cases, no one was helping to coordinate the recipient’s care. What was even more concerning was as the health of the care recipients became more complex, the primary care provider appeared to play less of a coordinating role, while their caregivers tended to assume more of this responsibility.

The burden of caregiving also manifested itself in showing that the caregivers were less inclined than their care recipients to want them to stay at home as the care needs became increasingly complex. Amongst the most complex and highest need care recipients, while 89 per cent expressed a clear desire to stay at home, only 58 per cent of their caregivers were inclined to agree, compared to 81 per cent of caregivers working with the lowest care needs recipients. Overall, without prompting, finances followed by work were reported to be the main sources of stress of the caregivers we surveyed. Finances were also the area they told us where they needed support the most; especially when caregivers reported spending up to around $4,200 annually in supporting the care costs for an older adult with complex care needs.325

Table 9.2 further delineates the several areas where the caregivers reported needing more support according to four broad classifications introduced in Chapter 1 that were developed to characterize the heterogeneity of our older population. As expected, it was clear overall that as a care recipient’s health and care needs became increasingly complex, the overall need for support amongst their caregivers often increased as well.

Table 9.2 Areas in Which Caregivers Reported Needing More Support as per the Health and Care Needs of their Care Recipients

<table>
<thead>
<tr>
<th>Areas in Which Caregivers and Care Recipients Reported Needing More Support</th>
<th>Healthy Older Adult with Minimal or No Health Issues and Needs (n=161)</th>
<th>Older Adult with Chronic but Stable Health Issues and Needs (n=365)</th>
<th>Older Adult with Chronic but Unstable Health Issues and Needs (n=158)</th>
<th>Older Adult with Complex Care Issues and Needs (n=116)</th>
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<tr>
<td><strong>Caregiver Literacy and Navigation Assistance</strong></td>
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<tr>
<td>A single-point person to discuss care</td>
<td>22%</td>
<td>31%</td>
<td>32%</td>
<td>39%</td>
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<tr>
<td>Information on government, social and community services</td>
<td>23%</td>
<td>26%</td>
<td>22%</td>
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<tr>
<td>Practical information on navigating the health care system</td>
<td>20%</td>
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<td><strong>Practical Assistance to Support Aging at Home</strong></td>
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<tr>
<td>Finding trained and reliable home care services</td>
<td>9%</td>
<td>13%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>Easy access to transportation to health appointments</td>
<td>16%</td>
<td>21%</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td>Help with maintenance and upkeep of their home</td>
<td>26%</td>
<td>23%</td>
<td>35%</td>
<td>27%</td>
</tr>
<tr>
<td>Help with shopping and cooking</td>
<td>19%</td>
<td>17%</td>
<td>28%</td>
<td>26%</td>
</tr>
<tr>
<td>Help with personal care (e.g., dressing, bathing)</td>
<td>4%</td>
<td>14%</td>
<td>22%</td>
<td>54%</td>
</tr>
<tr>
<td>Assistive devices to aid mobility at home</td>
<td>11%</td>
<td>12%</td>
<td>24%</td>
<td>38%</td>
</tr>
<tr>
<td>Home modifications that improve accessibility</td>
<td>6%</td>
<td>9%</td>
<td>26%</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Health Care System Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care providers providing more coordinated care</td>
<td>12%</td>
<td>25%</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>Faster access to medical care</td>
<td>19%</td>
<td>20%</td>
<td>29%</td>
<td>26%</td>
</tr>
<tr>
<td>Medical care at home (e.g., medication, therapy)</td>
<td>2%</td>
<td>6%</td>
<td>16%</td>
<td>36%</td>
</tr>
<tr>
<td>House calls from the family doctor</td>
<td>7%</td>
<td>10%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Emotional and Other Support Needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health/Emotional support</td>
<td>8%</td>
<td>19%</td>
<td>27%</td>
<td>40%</td>
</tr>
<tr>
<td>Getting a break from caregiving</td>
<td>13%</td>
<td>16%</td>
<td>16%</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Legislative/Professional Support and Recognition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal (legislative) recognition and support for caregivers</td>
<td>8%</td>
<td>19%</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>Professional support from your employer (flexible hours, job sharing, working from home, etc.)</td>
<td>14%</td>
<td>10%</td>
<td>10%</td>
<td>13%</td>
</tr>
</tbody>
</table>
Living Longer, Living Well: Recommendations to Inform a Seniors Strategy for Ontario

What we learned this summer was that, although there are a variety of tax credits and caregiver support programs currently in place, they sometimes fall short in delivering what a caregiver actually needs, or, even worse, they remain unknown to others altogether. In fact, through the ministry survey, we were astounded to learn that a large number of caregivers were unaware of what existing caregiving-related services were available to them, and were not sure how to access them. Many wanted to have a single point of access for practical advice on how to navigate the health care system and find information on government, social, and community services. It was pointed out that there was no clear information source where caregivers could turn to, perhaps because there is not much out there tailored specifically to their needs.

Indeed, as examples from the ministry’s Ontario Caregivers Survey, we noted 38 per cent of the respondents were unfamiliar with CCAC services, and only 24 per cent were aware of the Health Care Connect Program to help care recipients find a primary care provider if they needed one. Caregivers were also clear that they need their care recipient’s care to be more integrated, coordinated, and proactive in a way that could allow them to access the support they need in a timely way and at home whenever possible. In addition to requesting more support to help with the financial burden of caregiving, and for more flexibility with their work schedules, caregivers also indicated that an increase in the availability of more flexible home and facility-based respite options to support them was of great importance to them.326

Overall, it is clear that unpaid caregivers play an essential role in our health care system as they significantly improve the quality of life of those they care for, decrease the reliance on formally available caregiving supports, and often prevent unnecessary institutionalizations.327 Given our current fiscal and demographic imperatives, there is no doubt that unpaid caregivers will continue to remain an essential component of an older adult’s care team, but we need to do more to support them.

Supporting Caregivers in Ontario

In 2009, the Special Senate Committee on Aging suggested that four key policy supports are needed to help caregivers:

- Direct services to caregivers which would give them information, education, counselling, and respite support,
- Direct payments, where caregivers receive allowances, compensation or reimbursement for expenses,
- Improved labour policies, workplace policies, labour standards, and Employment Insurance policies (e.g., compassionate care benefit), and
- Indirect compensation through tax credits, pension credits, and dropouts from pensions.328

Overall, these key policy directions are ones that still appear to resonate with older adults, their families, and their caregivers, as well as the health, social, and community care providers we spoke to across

327 Ibid.
Ontario. These directions also recognize that, as our province continues to age, its reliance on unpaid caregivers will only grow. Thus, it will be essential to ensure that we have the right infrastructure in place to support those who want or need to become an unpaid caregiver. As such, in order to demonstrate our continued support and appreciation for caregivers, it will be imperative to take the time to understand their unique and evolving challenges and needs in order to appropriately address them.

Critical to the development of any caregiver strategy will be a commitment to understand how caregivers balance their own needs with those of the person they care for. This was raised many times throughout our consultations as a way through which we need to engage caregivers respectfully as “partners,” rather than just resources in care. This approach also recognizes the importance of incorporating their needs into the care plans for older care recipients, and considers how they access supports and services that can address their own identified needs.329

In addition to traditional home care services, caregivers told us about how much the availability of day programs and respite services meant to them. These services were crucial in allowing them to get some time alone so that they could take a break or attend to other needs while knowing the person they were caring for was being well looked after. What was clear from the caregivers we spoke to was the fact that every situation was different and that every person being cared for, along with their caregiver, often had different needs depending on their overall medical condition and living situation.

While most reported not having enough home care, day programs, or respite services available in their areas, they also stressed that what was important was having a variety of support options available to meet their unique and evolving needs. Many also spoke about an interest in being able to take more control in the planning of the home care services that their care recipient was deemed eligible to receive. In some parts of the province, especially in more rural and remote areas, some providers, like those in the North West LHIN, are experimenting with direct payment options that allow caregivers to manage a budget to buy the personal care, respite, and other services that may be needed. Overall, caregivers spoke to a desire to be part of the care planning team and to have a process that recognizes and, if possible, supports their needs as well.

Caregivers also told us how the availability of education, counselling, and support services were crucial to help them cope with what could otherwise be an isolating and often stressful experience. There is also a growing demand for the development of services that are geared to support not only the emotional and psychological needs of caregivers, but also help them understand the condition affecting the person they are caring for, as well as what things to anticipate and how to manage them throughout the illness trajectory. These caregiver support programs may also help prevent burnout and, therefore, delay admission of the care recipient to an institutional care environment.330

What is clear is that, while we as Ontarians have many choices for action, the consequences of inaction will be more severe. Indeed, the alternative will be a less willing and empowered population of unpaid caregivers and an increasing reliance and demand on taxpayer-funded homes, community, and long-term care services.331

**Recommendations:**

108. The Ministry of Health and Long-Term Care should improve the awareness of services and supports available to unpaid caregivers with improved single points of access as discussed earlier (see Recommendation 15). In particular, the ministry should ensure that these single points of access recognize the unique identity and needs of unpaid caregivers that may require information to be presented differently.

109. The Ministry of Health and Long-Term Care should increase access to community, respite care and home support programs and services through existing and new funding and policy frameworks, including those that support direct payment options. Emphasis should be placed on the provision of:

   a) Day/Respite programs that recognize the differential needs of patient/clients and caregivers to support patients/clients and caregivers across an illness trajectory.

   b) Support programs that offer counselling and coaching on how to handle situations that are unique to unpaid caregivers.

   c) Community Care plans that incorporate the needs of unpaid caregivers in addition to the needs of the clients themselves to ensure a more effective caring environment and situation is created.

110. The Ministry of Health and Long-Term Care should identify mechanisms to improve access to supports targeted to unpaid caregivers and reduce barriers preventing or limiting caregivers from accessing these supports. This could be accomplished through:

   a) Exploring the development of Direct Funding models to empower caregivers to manage needed services (see Direct Funding Chapter 4).

   b) Increasing the availability and accessibility of existing Long-Term Care (LTC) home-based respite beds by addressing current occupancy funding regulations that can serve as disincentives for providers to fill them.

   c) Examining the elimination of or the introduction of an income-based means-testing process in regards to the daily co-payment for LTC home-based respite services for low-income Ontarians.

   d) Addressing other barriers identified as appropriate.

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Supporting the Financial Needs of Caregivers

The reality for many unpaid caregivers in Ontario is that they are forced to make a decision between paid employment and being a caregiver. Therefore, addressing some of the financial barriers to unpaid caregiving will allow many caregivers to continue to provide the valuable care that they provide to their family members, neighbours, and friends; and it will encourage and enable other Ontarians to become caregivers as well.

In addition to the need to further review the existing, and to explore the development of new, financial and employee assistance policies and benefits to support unpaid caregivers, we learned through our consultations that many older adults, their families, and their caregivers remain unaware of the wide range of benefit and tax credit programs that have been designed to meet their unique needs and that are currently in place. In order to better support these Ontarians to more easily access information on what is available to support them, the Ontario Benefits Directory was developed as a simple, easy, and convenient point of access to find information about many provincial benefit and tax credit programs, determine one’s eligibility, learn how to apply, get updates about changes to a program, and learn about new programs.

With respect to federal and provincial tax credit and benefit programs available in Ontario that may apply to unpaid caregivers and/or older adults who may be a care recipient, the following are listed in the Ontario Benefits Directory:

1. Family Caregiver Tax Credit
2. Infirm Dependant Tax Credit
3. Eligible Dependant Tax Credit
4. Disability Tax Credit
5. Medical Expenses Tax Credit
6. Medical Expenses Incurred by Caregivers
7. Compassionate Care Benefits / Family Medical Leave
8. Veterans Independence Program
9. First Nations and Inuit Home and Community Care Program
10. Aboriginal Affairs and Northern Development Canada – Assisted Living Program
11. Assistive Devices Program

It is clear that the lack of awareness of all these available benefits means that we must do a better job making this information more accessible to all Ontarians. Additionally, some of the existing tax credits and programs are available only for those caregivers supporting individuals with persistent and ongoing illnesses/disabilities, excluding those who may have an episodic condition or who have been recently hospitalized and need support for a short period to get back on their feet. Therefore, looking at options that support caregivers in these situations would be worthwhile as well, especially if an opportunity to resurrect and augment the recently proposed Family Caregiver Leave Act arises again.
**Recommendations:**

111. The Ministry of Health and Long-Term Care in conjunction with the Ministry of Finance and the Ontario Seniors’ Secretariat should promote the awareness and uptake of various programs (financial benefits and tax credits supporting the financial burdens of unpaid caregiving).

112. The Ministry of Finance should consider episodic conditions/disabilities, when reviewing its existing tax credits or developing any new tax credits, to ensure caregivers in these circumstances can qualify for them as well.

113. The Government of Ontario should support the resurrection of Bill 30, the Family Caregiver Leave Act (Employment Standards Amendment), 2011.

   a) The Government of Ontario should work with the federal government to support extending Employment Insurance benefits to those caregivers who make use of Family Caregiver Leave, in the same way that most Ontarians who take Family Medical Leave are supported by Employment Insurance under the Compassionate Care Benefits program.

114. In collaboration with the Federal Government, the Government of Ontario should also explore the concept of developing a similar provision in the Canada Pension Plan to support those who withdraw from the workforce to provide caregiving support as is done through the Child Rearing Provision.

**Encouraging the Enhancement of Employee Assistance Programs**

While there are things the federal and provincial governments can do to alleviate the financial burden of caregiving, governments should also continue to encourage employers who offer Employee Assistance Programs to consider offering specific support for their employees who are caregivers to an older adult. We learned that some leading Employee Assistance Programs in Ontario specifically support caregivers of older adults by offering access to counselling and care planning support services, emergency in-home eldercare for an employee’s parents or their spouse’s parents, and family responsibility or compassionate care leave policies to allow employees to leave for short durations to tend to family/personal responsibilities in supporting an ill or dependent family member.

**Recommendation:**

115. The Ministry of Health and Long-Term Care in conjunction with the Ministry of Labour should encourage the development of more responsive corporate Employee Assistance Programs to better support Ontario employees that are also serving as unpaid caregivers of an older adult.
Supporting Ontarians with Dementia and their Caregivers

Ontario’s 38 Alzheimer Societies now offer First Link® Services across 12 of Ontario’s 14 LHINs, with $2.4 million in additional annual funding support through Ontario’s Aging at Home Strategy. This service has a goal of bringing primary care providers and other health professionals together to provide services and treatments to persons with dementia, their families, and their caregivers – from diagnosis to end of life. The program, based on the Canadian Consensus Guidelines on Dementia, was specifically designed to give patients with dementia and their families and caregivers a direct connection to information and a network of education and support services available in their community, and specific to their situation that can help them manage this disease and its consequences.

First Link® has helped to decrease the average time between diagnosis and referral to local Alzheimer Societies from 18 to seven months. Because First Link® focuses on service coordination, resources, and planning, families and caregivers become better equipped to create care plans to tackle future legal, financial, and health needs; clients become more confident and involved in their own care, helping to reduce an overall burden on primary care, long-term care, and emergency services.

In recognizing the value that a standardized and commonly available program like First Link® can play in meeting the needs of the expected growth in numbers of older Ontarians with dementia, their families, their caregivers, and their health, social, and community care providers, there clearly exists an opportunity to see this program take a more prominent role in better meeting the needs of patients with dementia and their caregivers.

**Recommendation:**

116. The Ministry of Health and Long-Term Care should encourage the standardization of services and supports offered through the Alzheimer Society’s First Link® program and fully support the implementation of this program in every LHIN across Ontario to ensure this vital support program and service for older adults and unpaid caregivers affected by dementia is available to all.
Chapter 10: Addressing Ageism and Elder Abuse in Ontario
Understanding Ageism and its Implications

Ageism, or age discrimination, refers to the process of systematic stereotyping of and discrimination against individuals or groups because of their age, just as racism and sexism accomplish this with skin color and gender. While ageism can affect any age group, it was coined as a term specifically to describe the casual or systematic discrimination of older persons in our society.

“With regards to elder abuse, many older adults suffer in silence and some do not know how and where to get help.” – Seniors Strategy Survey Respondent

Ageism is multi-faceted and manifests itself in multiple ways, such as prejudicial attitudes towards older people, old age, and the aging process; discriminatory practices against older people; and institutional practices and policies that perpetuate stereotypes about older people. While there has been work undertaken in Canada and internationally to address ageism, it still appears to be very much present in our health care system and is treated less seriously than other forms of discrimination.

Attitudes regarding older Ontarians can have a significant impact on their health, well-being, and involvement within our communities. Indeed, ageism can influence the way we make decisions about others based on age and our biases that come with our perceptions about an older person. We see ageism play out all the time within areas such as health care when we let a person’s age, rather than their overall status, influence our decisions to conduct a test or provide a treatment, or even in the workforce where we may let a person’s age, rather than their experience and abilities, influence a hiring decision. Mandatory retirement was only ended in Canada in December 2006 when the federal government officially repealed the section of the Canadian Human Rights Act that permitted mandatory retirement. Nevertheless, according to a recent poll, 74 per cent of Canadians still consider age discrimination to be a problem in the workplace. Finally, when we fail to recognize that older persons may have special needs that we need to accommodate differently in the services we offer, it raises concerns that we may not value this population in our society as much as we should.

Within the Government of Ontario, the Ontario Seniors’ Secretariat (OSS) develops a wide variety of programs and services to meet the needs of older Ontarians and help them live safe, active, and healthy lives. It also builds partnerships with organizations that represent older adults across Ontario and guides the development of policies and programs across government, on behalf of them. Further, the OSS champions issues of importance to older adults on the intergovernmental stage and has engaged with other jurisdictions in the development of a Seniors’ Policy Handbook, a guide to developing and evaluating policies and programs for older adults. This lens encourages that the perspectives of older adults and their diversity be considered when developing policies and programs.

Recommendations:

117. The Government of Ontario, through its Seniors’ Secretariat, should adopt a process to ensure that legislation or policies which permit age to influence the access of older Ontarians to any specific service should be identified and reviewed in liaison with older user groups.

118. The Government of Ontario and municipalities should encourage local service providers to establish arrangements which make it clear that older people are a local as well as a provincial priority, and that any forms of ageism are unacceptable.

119. The Ministry of Health and Long-Term Care and the Ministry of Community and Social Services should commit to ensuring that health services will be provided, regardless of age, on the basis of clinical need alone; and social services will not use age in their eligibility criteria or policies to restrict access to available services.

Supporting Informed Decision-Making Amongst Older Ontarians

Everyone has the right to make an informed decision to the best of their abilities. Even though someone may no longer be capable of making certain decisions, we should always assess their ability to participate in a decision-making process or at least have the opportunity to state their needs or preferences whenever possible.

Ensuring consistent processes and practices are established and in place to obtain informed consent from care recipients or those who make decisions about care on their behalf will strengthen opportunities for people to participate meaningfully in their own care. Ensuring that care providers are educated around these principles and in how to engage care recipients or their delegates in decision-making processes will support the provision of high quality care. In some settings, the development of guides for clients and care recipients or their delegates can ensure that consent is raised at specific points where decisions are required, and that clients, care recipients, and their delegates understand their rights.

Recommendation:

120. The Ministry of Health and Long-Term Care should support the development of consistent processes and practices to obtain informed consent from clients and care recipients, or those who make decisions about care on their behalf. Continued education of providers to reduce knowledge gaps in this area should be required and supported as well.
Addressing Elder Abuse in Ontario

The World Health Organization defines the abuse of older adults as “a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or distress to an older person.” Elder abuse can destroy an older person’s quality of life, and significantly increase their overall risk of death. Elder abuse can take several forms, including physical abuse, psychological or emotional abuse, financial abuse, sexual abuse, and neglect. While older adults are the least likely demographic to suffer violent crime, they are the population most at risk of suffering violence at the hand of a family member, and police-reported violence against older adults appears to be on the rise.

The Ontario Human Rights Commission (OHRC) heard that approximately 4 per cent, or 75,000 of Ontario’s 1.9 million older adults, are living with elder abuse. However, many older persons are not willing to report elder abuse because of the social stigma attached to it or because of their concern regarding the consequences of reporting a loved one or caregiver. For instance, reporting abuse could mean the withdrawal of care or the loss of their caregiver, making their decision to report that much more difficult. As a result, this percentage may be underestimated. It is therefore estimated that as many as 10 per cent of older Canadians experience some form of neglect or abuse. Table 10.1 provides a description of the different forms of elder abuse.

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Table 10.1 Understanding the Several Forms of Elder Abuse

<table>
<thead>
<tr>
<th>Form of Elder Abuse</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Abuse</td>
<td>The most common form of elder abuse, financial abuse, often refers to the theft or misuse of money or property like household goods, clothes or jewellery. It can also include withholding funds and/or fraud.</td>
</tr>
<tr>
<td>Psychological (Emotional) Abuse</td>
<td>The wilful infliction of mental anguish or the provocation of fear of violence or isolation is known as psychological or emotional abuse. This kind of abuse diminishes the identity, dignity and self-worth of the senior. Forms of psychological abuse include a number of behaviours, for example: name-calling, yelling, ignoring the person, scolding, shouting, insults, threats, provoking fear, intimidation or humiliation, infantilization, emotional deprivation, isolation or the removal of decision-making power.</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>Any physical pain or injury that is wilfully inflicted upon a person or unreasonable confinement or punishment, resulting in physical harm, is abuse. Physical abuse includes: hitting, slapping, pinching, pushing, burning, pulling hair, shaking, physical restraint, physical coercion, forced feeding or withholding physical necessities.</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Sexual abuse is understood as contact resulting from threats or force or the inability of a person to give consent. It includes, but is not limited to: assault, rape, sexual harassment, intercourse without consent, fondling a confused older adult, intimately touching an older adult during bathing, exposing oneself to others, inappropriate sexual comments or any sexual activity that occurs when one or both parties cannot, or do not, consent.</td>
</tr>
<tr>
<td>Neglect</td>
<td>Neglect can be intentional (active) or unintentional (passive) and occurs when a person who has care or custody of a dependent senior fails to meet his/her needs. Forms of neglect include: withholding or inadequate provision of physical requirements, such as food, housing, medicine, clothing or physical aids; inadequate hygiene; inadequate supervision/safety precautions; withholding medical services, including medication; overmedicating; allowing a senior to live in unsanitary or poorly heated conditions; denying access to necessary services (e.g., homemaking, nursing, social work, etc.) or denial of a older adult’s basic rights. For a variety of reasons, older adults themselves may fail to provide adequate care for their own needs and this form of abuse is called self-neglect.</td>
</tr>
<tr>
<td>Systemic Abuse</td>
<td>Our society, and the systems that develop within it, can generate, permit or perpetuate elder abuse. Most prevalent is discrimination against older adults, due to their age and often combined with any of these additional factors: gender, race, colour, language, ethnic background, religion, sexual orientation, ability, economic status or geographic location.</td>
</tr>
</tbody>
</table>

Reports to the OHRC indicated that financial abuse of older adults tends to be the most common form of abuse reported (62.5 per cent), followed by verbal (35 per cent) and physical abuse (12.5 per cent), along with neglect (10 per cent). \(^{341}\) Submissions to the OHRC have also indicated that primary caregiver stress significantly contributes to the incidence of elder abuse, highlighting the need to provide unpaid caregivers with increased supports.


The stress associated with elder abuse and neglect can lead to long-term physical and psychological problems including: heart attack, stroke, anxiety, angina, depression, high blood pressure, panic attacks, poverty, isolation, over- and under-medicating, and, in some cases, death. Some abused older adults may misuse medication, drink more alcohol, and eat or sleep more or less frequently than usual. Signs of abuse can also go undetected by care providers, when mistaken for memory loss or dementia. There is also difficulty in detecting signs of elder abuse as very few published, validated instruments or screening tools exist.

Elder abuse is also more complicated than child abuse, as older adults tend to be capable of addressing issues themselves. However, the power imbalances that can occur in relationships between older adults and their families or caregivers, especially if the former is dependent on the latter for having one’s living or care needs met, further complicate these situations. The increasing prevalence of older Ontarians living with dementia, functional impairments, or poverty due to the recent economic downturn, is placing more older adults in vulnerable positions that could allow them to become victims of abuse or neglect. Furthermore, determining when health, social and community care, and public safety professionals have a duty to report elder abuse and neglect (as we do with child abuse and neglect) is another aspect that will need to be considered. Older adults may neglect to take care of their personal health and well-being, often due to declining mental awareness or capability. Some older adults may also choose to deny themselves health or safety benefits, which may not be self-neglect, but a reflection of their personal choice. While difficult, caregivers and other responsible parties must honour an older person’s choice to live at risk, especially if the older adult is capable of making such a choice. There is a need to keep in mind our own biases that often abuse a person’s right to make decisions, particularly when those decisions do not comply with conventional recommendations.

As Ontario’s population ages, the potential exists that elder abuse will increase unless it is more comprehensively recognized and addressed. At a minimum, we will need to do better as a province at raising awareness among older adults and members of the public about elder abuse and neglect so they can better understand when and how they should provide help.

**Ontario’s Strategy to Combat Elder Abuse**

In 2003, in response to this issue, the Government of Ontario became the first government in Canada to introduce a strategy to combat elder abuse. Ontario’s Strategy to Combat Elder Abuse focuses on three areas: coordination of community services, training for front-line staff, and public education to raise awareness. Since 2003, Ontario has invested over $6 million in elder abuse prevention and awareness initiatives, including providing operating funding to support the Ontario Network for the Prevention of Elder Abuse (ONPEA) in implementing the strategy. ONPEA’s network of Elder Abuse Regional Consultants across the province help to promote and support efforts in addressing and preventing elder abuse by serving as a key resource to justice and community service providers and local elder abuse networks.

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ONPEA also administers its Seniors’ Safety Line, which offers support to victims of elder abuse 24 hours per day, seven days a week in over 150 languages. Since its inception in April 2009, it has received 17,703 calls with continuously increasing volumes, although its current capacity to handle more calls is limited. However, our consultations also found that too many professionals and members of the public remained unaware of this service or how to access it. As was mentioned earlier in Chapter 2, the opportunity this service is now pursuing to link itself with Ontario 211 will likely allow an increased number of older adults and others calling on their behalf to be connected to the Seniors’ Safety Line.

**Recommendation:**

121. The Government of Ontario should continue its current commitments to its Strategy to Combat Elder Abuse through the supporting partnership of the Ontario Seniors’ Secretariat, Ontario Victim Services Secretariat, Ministry of the Attorney General, and the Ontario Network for the Prevention of Elder Abuse (ONPEA) to support work that seeks to raise public awareness about the abuse and neglect of older adults, provides training for front-line staff and coordinates community services to better assist victims of elder abuse in communities across the province.

**Protecting Vulnerable Older Immigrants**

Similar to the findings of the Special Senate Committee on Aging, our consultations also identified older immigrants arriving in Canada and Ontario under the family class category as a particularly vulnerable group. In being subjected to a ten-year sponsorship period, sponsored parents or grandparents are not entitled to any form of social assistance even if they become citizens during this time. This means that these older adults will remain ineligible for the Old Age Security (OAS), Guaranteed Income Supplement (GIS) and the Guaranteed Annual Income System (GAINS) benefits that other income-taxpaying older Ontarians would receive. In addition, many vulnerable older immigrants would not have had any employment history in Canada, thus making them ineligible for the Canada Pension Plan (CPP). This also leads to sponsored older adults having limited or no access to more economic forms of home and community care, or even long-term care, until after being resident for ten years. We heard as a result that in a number of circumstances, this has led to these older adults being stuck in hospitals without the ability to move to an alternate level of care due to their ineligibility for most post-acute care services. With many of these older adults having no independent sources of income, as a result they live in a vulnerable state due to their limited options. In being largely dependent on their families, this sometimes places them at increased risk of abuse, exploitation or neglect.

In 1997, the Government of Canada made the decision to reduce the period of sponsorship for spouses and partners from ten to three years in recognition of the potential for abuse in sponsorship...
arrangements,\textsuperscript{346} and in line with the time it takes to become a Canadian citizen. Therefore, a similar reduction of the immigration sponsorship period for parents and grandparents could significantly improve the settlement of sponsored older adults in Ontario and alleviate the distress they may experience in the process of integration.

\textbf{Recommendation:}

122. The Government of Ontario should advocate with its federal, provincial and territorial partners that the immigration sponsorship period for older relatives be reduced from ten to three years, and the residency requirement for entitlement to a monthly pension under the Old Age Security Act be reduced from ten to three years as well.

\textbf{Supporting Advocacy Efforts for Older Ontarians}

Ontario’s Advocacy Centre for the Elderly (ACE) is a specialty community-based legal clinic funded through Legal Aid Ontario and is the first legal clinic in Canada to specialize in the legal problems of older adults. ACE provides a broad range of legal services to low-income older Ontarians and focuses on elder law issues that include health care consent, substitute decision-making, long-term care, community care and elder abuse.

ACE’s public legal education services provide older adults with information needed for them to advocate for themselves or to identify issues that require resolution, while educating the broader community regarding older adults’ rights. ACE also engages in law reform activities, producing briefs, analyzing legislation and regulations, conducting research, and advocating for changes in policy or legislation where they are counter to the interests of older Ontarians. Services like ACE need to be maintained and strengthened given the ever growing needs of our aging population, and the expected increase in vulnerable older adults who will need the support of services like this.

\textbf{Recommendation:}

123. The Government of Ontario through its Ministry of the Attorney General should continue to support its provincial legal aid program that is focused on providing legal services to low-income older adults, public legal education, and support in law reform activities through its Advocacy Centre for the Elderly.

In October of 2007, the Government of Ontario established its Office of the Provincial Advocate for Children and Youth. This office reports directly to the Legislature and was created to provide an independent voice for children and youth, including children with special needs and Aboriginal children.

Advocates in the office receive and respond to concerns from children, youth and families who are seeking or receiving government services. Finally, the Provincial Advocate has the responsibility to identify systemic problems involving children, to conduct reviews, and to provide education and advice on the issue of advocacy and the rights of children. While we have seen the benefit of having such an office to support the needs of younger Ontarians, the same opportunity should be extended to support older Ontarians as well.

It is becoming increasingly clear that older Ontarians would benefit from a provincially supported and recognized independent voice for older adults that is accessible, transparent, and accountable. Numerous jurisdictions, including British Columbia, are currently looking to create similar offices to collaborate with existing organizations currently serving older adults, in order to help them to access, understand, and navigate the care system, as well as strengthen protections for vulnerable older adults. While a jurisdictional scan indicated that most advocate models have tended to focus on older adults residing in residential care facilities, models that serve a broader range of older adults support promotion, consultation, advocacy, and education efforts. Indeed, a broader mandate should cover not just health, but transportation, housing, home and community care, and other issues that affect older Ontarians, although any new body that is created should take into account whether there are existing systems that could fulfill any of these potential functions.

**Recommendation:**

124. The Ministry of Health and Long-Term Care, Ontario Seniors’ Secretariat and other relevant ministries should support the creation of an Office of the Provincial Advocate for Older Adults that would report directly to the legislature and provide an independent voice for older Ontarians, receiving and responding to concerns from older adults and caregivers of older adults who are seeking or receiving provincially governed services.
Chapter 11: Addressing the Unique Needs of Older Aboriginal Peoples in Ontario
Understanding the Unique Needs of Older Aboriginal People in Ontario

While older Ontarians from ethnocultural communities share common concerns and issues, older Aboriginal people are deserving of specific recognition given their particularly unique set of experiences, challenges and needs.

The word “Aboriginal” has come to represent a name for the original peoples of North America and other continents and their descendants. The Canadian constitution recognizes three groups of Aboriginal peoples: Indians (now commonly referred to as First Nations), Métis and Inuit. Indeed, these are three distinct peoples with unique histories, languages, cultural practices, and spiritual beliefs that have richly contributed to the growth and development of our province.

“We need to recognize the specific cultural needs in Aboriginal populations.”
– Seniors Strategy Survey Respondent

Currently, there are approximately 270,000 Aboriginal people in Ontario. While there are 133 First Nations communities in Ontario, about 80 per cent of Aboriginal people in Ontario are living off-reserve.\(^\text{347}\) Regardless of where they live, however, Aboriginal people still experience the lowest health status of any identifiable population in Ontario.\(^\text{348}\) As the prevalence rates for having three or more chronic conditions are higher for the Aboriginal population as compared to the non-Aboriginal population,\(^\text{349}\) it is understandable why Aboriginal people rely disproportionately on the need for emergency care,\(^\text{350}\) and are more likely to self-report having “poor” or “fair” health.\(^\text{351}\)

For Aboriginal peoples in Ontario and elsewhere, their continued lower socioeconomic status, as compared to the non-Aboriginal population, and the persisting effects of colonialism, remain two of the key drivers of health disparities amongst them. The average income of Aboriginal people is substantially lower than the non-Aboriginal population, with median incomes being over $9,000 less.\(^\text{352}\) A low socioeconomic status is also more likely to be associated with developing or having a wide range of chronic conditions, including diabetes, cardiovascular and respiratory disorders, and mental health issues, leading to other problems and an increased use of use of health, social, and community care services. As a result, Aboriginal people have a lower life expectancy than non-Aboriginal people.

With a growing burden of chronic diseases amongst Ontario’s Aboriginal peoples, many also suffer from functional limitations at an earlier age than the non-Aboriginal population. Aboriginal community members also noted that the more complicated and often inter-related health, social, and functional issues that affect older non-Aboriginal people, tends to occur at a much earlier age in Aboriginal people. Thus, when considering the needs of older Aboriginal people, it was mentioned that the traditional age cut-off of 65 years of age and older is less relevant when considering their unique needs. Finally, while Aboriginal people have lower life expectancies than the non-Aboriginal population, higher birth rates

\(^\text{348}\) Lakehead University. Centre for Rural and Northern Health Research. Katt, M et al. 2006. Assessing the Quality of Primary Care Services Available to Ontario’s Aboriginal Residents. Thunder Bay, Ontario.
create a younger overall age structure. This often focuses our attention away from the fact that the gap in life expectancy is shrinking and more Aboriginal people are living into old age than ever before. In fact, it has been noted that the percentage of older Aboriginal people is expected to triple over the next two decades, compared to a doubling of this cohort for the overall population during the same time period.\textsuperscript{353} Indeed, shifting demographics, coupled with the more vulnerable health of older Aboriginal people, will demand that these needs are responded to with interventions that are thoughtful and culturally appropriate.

### The Growing Need for Culturally Appropriate Care

We learnt through our consultations around the province that older Aboriginal people have rich traditional cultural values and needs that should be more fully understood and integrated into the health, social, and community care services and options that we provide in Ontario. Indeed, the importance of providing culturally appropriate health, social, and community care services was consistently emphasized by the Aboriginal representatives we met with.

Too often during our consultations, however, we heard that many health, social and community care providers remain unaware of the cultural needs, health, and social conditions and services that may or may not be available locally to support older Aboriginal people. Furthermore, the inability to integrate their cultural needs into the services we provide only further worsens the experiences of providers and the Aboriginal peoples we are working with.

Aboriginal organizations have reported that their patients respond better to culturally appropriate health care.\textsuperscript{354} Improving access to traditional medicines, foods, cultural practices, and translation services in traditional languages and dialects, are some of the ways through which more culturally appropriate care could be delivered. In settings where these initiatives have become a focus, better patient, provider, and system outcomes have been noted. The language issue is particularly important to older Aboriginal people as some are only able to communicate comfortably in an Aboriginal language, which can present a significant barrier to accessing health, social, and community services when culturally appropriate care is not available.\textsuperscript{355}

Understanding the past and even more recent history of Aboriginal peoples in Ontario also speaks to the need to ensure that culturally competent and safe care for older Aboriginal people is prioritized as well. In providing this sort of care, providers will need to be trained to understand the potential trauma an Aboriginal person may be struggling with as a result of attending a residential school or other experiences that may make it hard for them to engage with our largely non-Aboriginal oriented health, social, and community care systems. It should be noted that learning the skills needed to provide culturally appropriate and safe care can equally benefit health, social, and community care providers. It can lead to increased confidence on the job by giving providers an enhanced ability to address


\textsuperscript{354} National Aboriginal Health Organization. 2009. \textit{Cultural Competency and Safety in First Nations, Inuit, and Métis Health Care Fact Sheet}. Ottawa, Ontario.

the needs of various groups in society. The resulting increase in job satisfaction may further help to improve recruitment and retention rates in rural and remote communities,\textsuperscript{356} including those that have large Aboriginal populations.

The way in which health, social, and community care services are provided to Aboriginal peoples in Ontario is dependent on both historical and geographical factors. Currently, Health Canada provides eligible status First Nations and Inuit peoples with a specified range of medically necessary health-related goods and services when they are not covered through private insurance plans or provincial/territorial health and social programs. Items that are covered include prescription drugs, over-the-counter medication, medical supplies and equipment, short-term crisis counselling, dental and vision care, and medical transportation. However, many First Nations and Inuit peoples have experienced issues accessing these benefits. At the same time, the provision of primary, acute, public health, and community care for Aboriginal peoples in Ontario has primarily become a provincial responsibility. Nevertheless, it was clear during our consultations that issues remain around the appropriate provision of services, when it is not clear who should be responsible for their provision.

As one way to better address some of the jurisdictional issues impacting health in First Nations communities, the \textit{Trilateral First Nations Health Senior Officials Committee} (TFNHSOC), was established in September 2011. This senior-level committee includes representation from Ontario First Nations as well as provincial and federal government Assistant Deputy Ministers of Health and is co-chaired by Grand Chief Stan Beardy. The main objective is to work collaboratively in identifying and implementing practical measures on specific priority areas such as diabetes prevention and management, mental health and addictions, public health and data collection/analysis. This type of forum may prove to be an effective model through which other issues of importance to Aboriginal people, both on- and off-reserve, could be addressed.

\section*{The Aboriginal Healing and Wellness Strategy}

The \textit{Aboriginal Healing and Wellness Strategy} was established in 1994 as a policy and service initiative. It brings together Aboriginal Organizations and the Government of Ontario in a unique partnership to promote health and healing amongst Aboriginal people, in an effort to address poor health status and family violence in Aboriginal communities. The strategy has helped bring awareness to the fact that Aboriginal health care needs to be holistic and include the physical, mental, emotional, spiritual, and cultural aspects of life. Through this understanding, a vision of healing and wellness which balances the body, mind, emotions, and spirit, has been promoted throughout the healing continuum.

The strategy has also led to the development of a range of programs such as health and friendship centres, healing lodges, and women's and family shelters to foster improvements in the health and well-being of Aboriginal peoples in Ontario, their families, and their communities. Aboriginal Health Access Centres (AHACs), for example, offer culturally appropriate and safe comprehensive primary care to Aboriginal families throughout the province. There are currently 10 AHACs in Ontario, providing services to both on- and off-reserve Aboriginal people in urban, rural, and northern locations.

Additional programs and services they offer may include pre- and post-natal care, nutrition, health education, disease prevention, counselling, and traditional healing.

In 2010, the Government of Ontario worked with its Aboriginal partners to develop a renewed Aboriginal Healing and Wellness Strategy (AHWS). The renewal included some important changes to allow greater Aboriginal oversight and control of AHWS programs and services, and strengthen health services for Aboriginal communities. In September 2010, the government wrote to its Aboriginal partners setting out the components of the renewed strategy. The Ministry of Health and Long-Term Care launched consultations with internal ministry stakeholders, the Association of Ontario Health Centres, and its existing AHACs to discuss amendments for new funding agreements for the 2012-2013 fiscal year and beyond that would allow them to continue and expand their work. As a result of these consultations, the AHACs recently received significant base-funding increases aligned with increases realized across the rest of the community sector, and will now receive a dedicated and defined funding envelope specifically for the provision of physician services which aligns with physician funding provided to Community Health Centres. AHACs will now also gain access to the ministry’s capital funding consideration/approval process as well.

Additional Initiatives

To increase the capacity to deliver more culturally relevant services for Aboriginal people, in 2005 the federal government committed $100 million over five years towards the creation of the Aboriginal Health Human Resources Initiative (AHHRI) to:

- Increase the number of Aboriginal people working in health careers
- Retain health care workers in Aboriginal communities
- Change educational curricula to develop health care providers that are culturally competent in providing health care services to Aboriginal people

To further promote the development of cultural competency training for all health, social, and community services providers working with Aboriginal populations, the Local Health Integration Networks (LHINs) have also recently embarked on a project that will aim to have Friendship Centres work with local health, social, and community care providers to deepen their understanding of what is needed to provide culturally appropriate and safe care to Aboriginal people. Similar training would also be beneficial for all future health, social, and community care providers to acquire these competencies during their core training programs.

While it is clear that progress has been made and that health outcomes are generally improving for Aboriginal peoples in Ontario, much remains to be done. As they age, increasing numbers of Aboriginal people will engage with parts of the health, social, and community care systems that were not specifically developed with their needs in mind. This only emphasizes the need to ensure that we move forward in creating a system that can provide more culturally appropriate and safe care for Aboriginal people and all Ontarians.
**Recommendations:**

125. The Ministry of Health and Long-Term Care, in partnership with Ontario’s Seniors Secretariat and the Ministry of Aboriginal Affairs, should commit to a process to meaningfully engage on and off-reserve Aboriginal people and their organizations across Ontario in the development of an Aboriginal Seniors Strategy.

126. The Ministry of Health and Long-Term Care, in partnership with the Ministry of Aboriginal Affairs, should promote the development of cultural competency training for all health, social, and community services providers working with older Aboriginal people.

127. The Ministry of Health and Long-Term Care, in partnership with the Ministry of Aboriginal Affairs, should increase its capacity to deliver culturally relevant services for older Aboriginal people.

128. The Ministry of Health and Long-Term Care, in partnership with the Ministry of Aboriginal Affairs and the Ministry of Training, Colleges and Universities, should continue to support the Ontario Aboriginal Health Human Resources initiative.

129. The Ministry of Health and Long-Term Care should continue to support its Aboriginal Health Access Centres (AHACs) consistent with community sector funding levels, including providing access to the capital funding considerations and approvals process.
To facilitate the implementation and long-term sustainability of the recommendations contained in this report, broader system enablers will need to be put in place. These enablers will specifically help to support the strategic objectives of the recommendations by:

- ensuring that the province has adequately trained and supported health human resources,
- increasing its efforts to understand and manage issues related to aging and its impacts through investments in research and technology,
- improving its assessment and referral instruments and processes, information, and referral standards through the use of technology, strengthen health system integration and performance through the adoption of shared accountabilities and performance metrics across sectors, and
- establishing a governance and implementation model that will successfully deliver the recommendations within this report.

Strengthening our Health Human Resources for an Aging Ontario

Our ability to develop a highly skilled health, social, and community care workforce will be integral towards delivering the high quality care and services that growing numbers of older Ontarians will require. However, we are currently challenged by the fact that our current core and postgraduate training curriculums for our health and social care professionals in Ontario provide limited exposure towards understanding the specific issues that are related to caring for an aging population.

Let’s take look at physicians as an example. Although older Ontarians represent a large portion of health care consumers, there is a critical deficiency of geriatricians and physicians with expertise in caring for these older adults.\(^{357}\) As of December 2012, there were 122 active Ontario physicians holding specialist certification in geriatrics for a population of 1,878,325 individuals who are 65 years and better; this represents a ratio of 0.65 geriatricians per 10,000 older Ontarians.\(^{358,359}\) By contrast, as of December 2012, there were 1,538 active Ontario physicians with specialist certification in pediatrics for a population of 2,180,775 individuals aged 0 to 14 years; this represents a ratio of 7.05 pediatricians per 10,000 children.\(^{18}\)

Why does there exist a critical shortage of geriatricians in Ontario? While geriatricians have traditionally remained some of the lowest paid specialists until recently, the alarmingly anemic focus on geriatric medicine in medical school curriculums as well as residency training programs is more likely to blame. No Ontario medical school, for example, currently offers core training in geriatrics, but every school offers core training in pediatrics. It is ironic that while the vast majority of graduates will enter fields predominantly serving older and not younger patients, pediatrics and not geriatrics remains a core part of current curriculums.\(^{360}\) Indeed, a lack of exposure to the care of older adults has likely contributed to the low number of medical graduates considering and thus entering formal geriatric medicine training programs in Ontario. Given the increasingly recognized unique needs of older adults seeking medical care, this should be a major concern when most graduating physicians receive little or no exposure to geriatrics, and far fewer choose to practice this specialty.

\(^{357}\) Wong, R. October 24, 2011. Who is Going to Look After our Aging Canadians? The Province.
“It is important to have primary care providers who have training in the special needs of older adults, and who are willing to take the time to LISTEN to their concerns.” – Seniors Strategy Survey Respondent

During our consultations, all of the provincial professional associations we met with also commented that, in addition to health and social care trainees being provided with limited exposure to this field, they are also likely to receive limited exposure to care settings like long-term care or rehabilitation settings, where older adults are the main recipients of care. This has been raised as a prime reason why few graduates in any profession pursue careers related to the care of older adults, especially in settings that also require interprofessional collaborative working practices.

National accreditation standards, those that influence the curriculums delivered in our province’s schools for health and social care professionals, apparently do not adequately emphasize training in the care of older adults. Many of our publicly funded schools have indicated that this has been the fundamental reason why they have not prioritized this training in their curriculums. Nevertheless, developing an adequately trained workforce that will have the knowledge and skills needed to care for an aging population needs to become a provincial priority. Encouraging and supporting the development of continuing educational opportunities for professionals that focus on developing further knowledge and skills in this area needs to occur as well. Indeed, improving the knowledge, skills, and confidence of our health and social care workforce to care for our aging population will further ensure that our aim of providing the right care, at the right time, in the right place will be achieved.

As our population ages, the growing number of people who will require care will also require adequate numbers of health and social care professionals to provide that care. Our health care sector, however, is the one with the largest number of occupations facing human resource shortages. Therefore, in conjunction with curricula changes, sufficient numbers of professionals will be required – in particular geriatricians, geriatric psychiatrists, family physicians, nurse practitioners, nurses, physician assistants, social workers, pharmacists, therapists and personal support workers. Continuing to support the development of team-based care environments will also be integral to promoting the interprofessional care that frail older adults particularly benefit from. With an aging workforce as well, ensuring that barriers to training and adequately compensating specialists specifically trained in the care of the elderly will be just as important as ensuring that our nurses and personal support workers, upon who much of the care for this population will depend, are valued and supported.

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Recommendations:

Supporting Core and Continuing Health Care Workforce Training Needs

130. The Ministry of Health and Long-Term Care, in collaboration with the Ministry of Training, Colleges and Universities, should support the preparedness of all future health and social care providers to meet the evolving care needs of older Ontarians by requiring that core training programs in Ontario for physicians, nurses, occupational therapists, physiotherapists, social workers, pharmacists, physician assistants, paramedics, personal support workers, and other relevant health and social care providers, include relevant content and clinical training opportunities in geriatrics.

131. The Ministry of Health and Long-Term Care, in collaboration with the Ministry of Training, Colleges and Universities, should lead Canada in establishing an educational accreditation standard for training in geriatrics and/or gerontology for all Ontario schools training health and social care professionals that will likely work with older adults.

132. The Ministry of Health and Long-Term Care, in collaboration with the Ministry of Training, Colleges and Universities and the Ministry of Community and Social Services, should encourage the development of a list of core competencies in the care of older adults for all Ontario postgraduate training programs for health and social care professionals.

133. The Ministry of Health and Long-Term Care, in collaboration with the Ministry of Training, Colleges and Universities and the Ministry of Community and Social Services, should support the preparedness of all current health and social care providers by encouraging the development of continuing professional educational activities and certification programs focused on care of the older adult, and encouraging that a proportion of continuing education for health and social care providers be focused around the care of older adults.

134. The Ministry of Health and Long-Term Care should support the collaborative working of the Ontario Telemedicine Network (OTN) with knowledge transfer partners to create and manage an online repository of educational presentations that help health, social, and community care providers acquire additional knowledge and skills in the care of older adults.

135. The Ministry of Health and Long-Term Care and the Ministry of Community and Social Services should continue to support and promote interprofessional education and collaboration between physicians, nurses, and allied health and social care professionals focused around the care of older adults.

Supporting the Development and Availability of Specialist Expertise

136. The Ministry of Health and Long-Term Care in collaboration with the Ministry of Training, Colleges and Universities should ensure adequate funding is in place to provide sufficient residency training positions for those who wish to pursue postgraduate training in geriatric medicine and geriatric psychiatry. This funding policy should also be extended to training positions for primary care physicians in care of the elderly if curriculum and accreditation standards can be developed for this field of specialization by the relevant accreditation bodies.
137. The Ministry of Health and Long-Term Care should finalize the development of its recently introduced Alternate Funding Plan (AFP) to support geriatricians in Ontario in a way that does not restrict the number of geriatricians wanting to practice in Ontario, and provides disincentives to practice geriatrics. The upcoming review of the RGP services should also be examined as a way to support geriatricians working in interprofessional teams, which is a requirement of this AFP.

138. The Ministry of Health and Long-Term Care should align the sessional fees for geriatricians working in FHTs with the sessional fees provided to general internists.

Nurses

139. The Ministry of Health and Long-Term Care should prioritize and implement specific programming to better meet the needs of older adults, e.g., wellness programming and house calls in the Nurse Practitioner-Led Clinics.

140. The Ministry of Health and Long-Term Care's Nursing Secretariat should engage with the College of Nurses of Ontario (CNO), the Council of Ontario University Programs in Nursing (COUPN), Colleges of Applied Arts and Technology (CAATS), and the Canadian Association of Schools of Nursing (CASN) to ensure the integration of:

a) Geriatric and gerontological learning objectives and course content related to the care of older adults in nursing education programs in Ontario, including: practical nursing programs, undergraduate degree programs for RNs, nurse practitioner programs and master's programs for all nurses.

b) Geriatric and gerontological educational requirements related to the care of older adults in undergraduate nursing program accreditation standards for the province.

c) Geriatric and gerontological content related to the care of older adults becomes a mandatory requirement in the CNO's quality assurance program for nurses in 2014.

Personal Support Workers (PSWs)

141. The Ministry of Health and Long-Term Care should provide more support to its PSW workforce by strengthening its new PSW Registry by requiring mandatory registration, requiring a common educational standard for all future registrants and developing a complaints process that can protect the public and the profession.

142. The Ministry of Health and Long-Term Care, in partnership with Ministry of Training, Colleges and Universities, should work towards defining a common PSW education standard that includes training in the care of older adults for new and existing workers.

143. The Ministry of Health and Long-Term Care should look at innovative policies and ways to develop programs and initiatives to stabilize the existing PSW workforce and enhance existing skill sets in a way that promotes quality improvement.
Creating Positive Work Environments

144. The Ministry of Health and Long-Term Care should consider allocating ongoing funding to the Healthy Work Environments program to support the development of sustainable, scalable, institutional, and community-based projects that enhance the ability of health and social care professionals in caring for older adults.

145. The Ministry of Health and Long-Term Care should consider establishing an annual awards and recognition program that highlights the work of health, social, and community care professionals that care for older adults.

Advancing Research and Technology to Supporting Aging in Place

Our increasingly diverse and heterogeneous population of older Ontarians will continue to grow and evolve over the coming decades. As a result, our bodies of knowledge related to understanding older adults and their needs must evolve as well. Further research into understanding the complexities of aging and its impact on health and disease processes, as well as evolving attitudes and care preferences, will support the development of further innovations in evidenced-based care, services, and programs to meet the evolving needs of this population.

Advances in technology have and will continue to serve as enablers in meeting the evolving needs of an aging population. Technological innovations are already enabling better communication standards, but are also allowing more individuals to live at home independently by supporting them to complete functional tasks more easily or to provide better engagement with care providers on an as needed basis with telemonitoring supports.

From a societal perspective, communication technologies have enhanced the ability of older adults to stay informed, aware, and connected with others. As we look to use technological platforms to better communicate information with older Ontarians, their families, and their caregivers, we will need to give careful consideration to how these constituencies prefer to communicate and use technology to ensure that whatever we develop is appropriate and accessible. A user’s language and literacy skills and functional abilities to use some technologies, for example, may significantly impact how they choose to engage with an information source. Therefore, thorough consideration will need to be given around these issues to ensure the technologies and services we develop will allow older adults, their families, and their caregivers to use them in a meaningful and positive way.

Advances in information technologies will also be useful to support the development of infrastructures to support access to and the flow of information across the health care system. As growing numbers of health records become digitized, the development of a universal health record that improves communication within and between sectors and their providers should remain our ultimate goal, especially in order to provide integrated care for frail older patients. Additionally, the development of information systems that could further support the identification, common assessment, and follow-up of needs, the implementation of best practices, and the automation of complex functions will further support our desire to develop a high-performing health care system.
The coming decade will also see significant advances in telemedicine technologies and the development of telehomecare programs that can enable the monitoring of patients remotely through the use of communication technologies. The impact of these technologies on the delivery of health services and the abilities of health care providers and their patients to exchange information will be profound. The early lessons acquired into the successes and failures of using telehomecare technologies in the care of older adults should also remind us of how important the necessary involvement of a primary care provider will be, for example, when implementing the use of this technology to support the management of a chronic disease at home. Although not widely used at the moment in the care of older patients, the potential of these technologies to improve access to care among older adults, particularly in rural and remote areas, should be significant.

**Recommendations:**

146. The Government of Ontario and its related ministries should prioritize research on aging and the needs of older Ontarians in its planning processes and in the granting competitions it administers.

147. The Government of Ontario and its related ministries should recognize during the current and future development of information services the heterogeneity of older adults and caregivers and their readiness, abilities, and preferences around using technology to access information.

148. The Ministry of Health and Long-Term Care should prioritize future investments in eHealth with clear targets linked to efforts that particularly support integrated and coordinated care for older adults, such as integrated assessment, information and referral systems, etc.

149. The Ministry of Health and Long-Term Care should prioritize the development of OTN Telemedicine and Telehomecare Services that support the provision of geriatric services throughout the province and especially in more isolated northern and rural areas where there are particularly acute shortages of specialists in the care of the elderly.

150. The Ministry of Health and Long-Term Care should ensure that the development of new Telemedicine and Telehomecare Services be done in a way that further engages and enhances the role of the patient’s primary care provider.

**Standardizing Integrated Assessment and Referral Processes that Promote Independence**

To facilitate the delivery of high quality care for older adults, particularly those with complex needs, having access to current and meaningful information to support decision-making and care planning is essential. An integrated information system would ensure that, as older adults are seen in different parts of the health care system by different providers, information from these encounters would be

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363 Takahashi, PY et al. A Randomized Controlled Trial of Telemonitoring in Older Adults With Multiple Health Issues to Prevent Hospitalizations and Emergency Department Visits. *Archives of Internal Medicine*, 172(10):773-779.

captured and shared, thereby reducing misinformation and subsequent errors, while driving more informed decision-making and care planning that can better achieve a quality care experience. A more integrated information system can further facilitate the sending of referrals and more rapid decision-making around requests for services. Finally, it can also support the ability of the ministry and its LHINs to use data to understand the evolving needs of older adults and to drive decision-making that focuses on addressing system capacity issues and improving patient and system outcomes.

What is encouraging is to see how far along the ministry and its LHINs have come in developing information systems that have the capability to provide both value to patients and the health care system. Examples include:

- **Electronic Health Records** (EHRs) are being implemented through eHealth Ontario. Almost two thirds of Ontarians now have EHRs that are being connected increasingly to others so that information can be shared across a growing number of health care providers within the requirements of applicable legislation.

- **The Integrated Assessment Record** (IAR) is a provincial assessment record “viewer” that is currently being implemented across the province. This system allows interRAI Home Care and Community Health Assessment information collected by CCAC and CSS Agency care co-ordinators to move with the client amongst home and community care providers across hundreds of organizations. The ministry is currently exploring integrating the IAR with other platforms to further enhance integration and ensure more timely, secure, and accurate sharing of information.

- **ALC Resource Matching and Referral** (RM&R) is a provision system being developed to support the identification and referral of patients to health, social and community services in other care settings. ALC RM&R processes are already helping to support a more seamless method of referring patients, but it can also be used by system planners to derive invaluable information on the relationship between the supply and demand for services and how their wait for care differs according to their needs. The ministry and its LHINs are now developing an updated version of the system that will use fields that are compatible with interRAI data elements to further support the ability of this system to become more integrated with IAR and others.

In the absence of a single approach to delivering specific common systems, be they assessment, referral, or information sharing tools, there exists a good chance of a patient’s care becoming fragmented. Therefore, continuing to promote the development of eHealth information systems that further integrate the work of health, social, and community care providers within and across sectors will be equally important towards developing a high performing health care system.

Within the province, the wide adoption of interRAI assessment and care planning instruments across a variety of settings has improved overall standards of care, has provided an opportunity to share assessment and care planning information between sectors, and has thus reduced duplicative or unnecessary assessments from taking place that waste the time of care providers and recipients. Supporting the province’s sectors to upgrade their outdated assessment instruments, in the case of CCACs and long-term care providers, will allow these sectors to benefit from the updated and evidence-based care planning protocols, but will also allow the assessment information collected to be more easily shared across sectors in future as well.
Along with supporting front-line providers, the ministry, its LHINs, and its sector providers should also further work to reduce duplicative or unnecessary data collection, reporting, and support efforts that enable more efficient information management and improved data availability and access. Furthermore, it should be recognized that the use of standardized, evidence-informed and -based tools can significantly improve the identification and assessment of need when working with patients from a given population. Throughout this report, reference has been made to these tools and to others that have not been validated as used in this province. Therefore, work to encourage the implementation of best practice assessment and care planning tools and the abandoning of non-validated and less effective tools in the care of older adults should be supported.

**Recommendations:**

151. The Ministry of Health and Long-Term Care and its LHINs should require that health, social, and community services providers streamline their assessment and referral processes to avoid duplication and additional burdens for patients and clients, and to promote greater efficiency in the delivery of services. The following more specific recommendations can support this work:

   a) Promote the use of the InterRAI suite of assessment instruments with shared mechanisms for transferring information (e.g., Integrated Assessment Record).
   b) Continue the expansion of the Resource Matching and Referral Business Improvement Initiative across the province.
   c) Mandate that all CCACs and CSS providers need to have their assessment information on the IAR or risk financial penalties or other sanctions for not achieving this goal by April 1, 2013.

152. The Ministry of Health and Long-Term Care should require that health, social and community services providers, whenever possible, implement the use of standardized evidenced-informed and -based assessment and prediction tools or methodologies (i.e., InterRAI assessment instruments, LACE Index, PERIL) and abandon the use of non-validated or less effective assessment and prediction tools or methodologies (i.e., Triage Risk Screening Tool (TRST), RAI Scores, etc.). A voluntary provincial expert panel can be engaged to help assess, reassess, and endorse a common suite of tools that should be considered for use in a variety of health, social, and community care settings.
Promoting System Integration through Shared Performance Metrics and Accountabilities

The 2010 Excellent Care for All Act has led to our health care system becoming increasingly focused on providing high quality, evidenced-based care with increasing accountabilities for doing so. The successful transformational change that is being envisioned and proposed through the development of a Seniors Strategy will necessitate the ability to track, measure, and report the system performance metrics outlined in this report.

To drive improvement within sectors, this report has focused on the development of only a handful of metrics for each health care sector, metrics that can be derived easily, in a timely way, from existing data reporting systems. Furthermore, to better facilitate system integration activities, the metrics recommended for each sector are ones that, whenever possible, can be shared by all sectors to help drive functional integration and monitor overall system performance at the level of each LHIN as it relates to the care of older adults.

The ministry needs to consider carefully the proposed metrics outlined in this report, and then to work with its LHINs to ensure the correct accountability mechanisms for meeting identified targets and objectives can be utilized. The opportunity to further align incentives with desired outcomes, for example, with the proposed development of Health Links, should also be pursued.

Recommendations:

153. The Ministry of Health and Long-Term Care, in partnership with the LHINs, should promote functional integration and the alignment of performance assessment processes within and across sectors, through the establishment of shared core metrics, accountability, and performance agreements and frameworks across sectors.

154. The Ministry of Health and Long-Term Care should require that Health Services Accountability Agreements (H-SAAs) and Quality Improvement Plans (QIPs) embed both mandatory and voluntary performance measures that ensures that a common focus on performance assessment and alignment can occur within and across sectors.

155. The Ministry of Health and Long-Term Care should augment its current Ministry-LHIN Performance Agreement (MLPA) mandatory quarterly performance review process to include a component to address the priorities of the Seniors Strategy and its corresponding performance metrics, to ensure performance around these areas requiring functional integration is being monitored and supported as is required. See Appendix B for a list of proposed indicators that could monitor sector and overall system performance and also be publicly reported.
Funding Considerations

Adequate funding will be a critical enabler to support the successful implementation and to ensure long-term sustainability of the strategic recommendations and goals outlined in this report. At the same time, it was clear during the development of these recommendations that they are being made during a period of enormous fiscal restraint, but with a government that is equally committed to ensuring the sustainability and efficiency of its health care system. To this end, each of the recommendations put forward has been applied against the principal of achieving value for Ontarians, and in some areas cost-savings through targeted investments that achieve process improvements, the reduction in inequities, and ultimately the achievement of better patient and system outcomes. Most importantly, the recommendations being made in this report have all been conceived with the notion that they can be achieved within existing budgets and resources.

Recommendations:

156. The Ministry of Health and Long-Term Care should maintain its support LHINs to provide one million additional PSW hours of care across the province and in the community for this current fiscal year and the next two years.

157. The Ministry of Health and Long-Term Care should at least maintain its commitment to increase home and community sector funding for this current fiscal year and the next two years by four per cent and is encouraged to invest future additional budget increases and savings achieved through future efficiency gains into its home and community care sector.

158. The Ministry of Health and Long-Term Care should ensure that future funding allocations will adhere to HBAM funding criteria to help address the existing base-funding discrepancies that exist across LHINs and their sectors and contribute to differential pressures around service provision and quality in each LHIN.

Governance and Implementation Considerations

To successfully implement and ensure the long-term sustainability of the strategic recommendations and goals outlined in this report, immediate next steps will need to include the development and institution of a governance and implementation framework. The framework should facilitate inter-ministerial collaboration and coordination, stakeholder engagement, the development of a strategic implementation plan, and support routine monitoring and evaluation efforts. This approach will ensure that all parties across the continuum of the health care system and beyond are aligned and working towards common objectives. Only then can our desired improvements be fully realized and achieved.
Recommendations:

159. The Government of Ontario should maintain an external Provincial Expert Lead role to help guide and support the government, its ministries and LHINs to oversee the implementation of its Seniors Strategy. The lead should be required to report to the minister quarterly on the progress, challenges, and opportunities being seen through the implementation of the Strategy and develop an annual report that can be shared with the public.

160. The Ministry of Health and Long-Term Care’s Implementation Branch, in partnership with the Ontario Seniors’ Secretariat, should hold overall responsibility to oversee the implementation of the government’s Seniors Strategy and be required to report to the minister each quarter on the process, challenges and opportunities seen through the implementation of the Strategy and develop an annual report that can be shared with the public.

161. The Government of Ontario should maintain its newly appointed cross-ministerial Assistant Deputy Minister’s Table, where the implementation of the Seniors Strategy can be overseen and facilitated, especially when interministerial co-operation is required.

162. The Ministry of Health and Long-Term Care should require each LHIN to appoint a member of its executive team to oversee the implementation of the Seniors Strategy and establish a steering committee with a broad base of representation from local health, social, and community care providers, including public health and paramedical providers, local municipal officials, patients, and caregivers, to help discuss and plan opportunities to further develop and implement services for older Ontarians in their regions.

163. The Ministry of Health and Long-Term Care should use accountability mechanisms that are readily available to hold LHINs accountable for the objectives, targets, and outcomes established in relation to the implementation of the Seniors Strategy (e.g., through the MLPAs) and publicly report the performance of each LHIN as well.

164. The Ministry of Health and Long-Term Care should support LHINs in holding their providers accountable for the objectives, targets, and outcomes established and embedded in their H-SAAs and QIPs in relation to the implementation of the Seniors Strategy, and ensure corresponding incentives and penalties are aligned and utilized.

165. The Government of Ontario should consider strengthening the role and purpose of Ontario’s Seniors’ Secretariat to facilitate the government’s Seniors Strategy in those issues that go beyond the health, social and community care domains as well.

166. The Government of Ontario should rename the Ministry of Health and Long-Term Care to simply that of the Ministry of Health to focus on its overall commitment to the health and well-being of all Ontarians, and not a specific area of care.
# Appendix A: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE</td>
<td>Acute Care for Elders</td>
</tr>
<tr>
<td>ACE</td>
<td>Advocacy Centre for the Elderly</td>
</tr>
<tr>
<td>ADLs</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>ADO</td>
<td>Accessibility Directorate</td>
</tr>
<tr>
<td>AFP</td>
<td>Alternate Funding Plan</td>
</tr>
<tr>
<td>AHAC</td>
<td>Aboriginal Health Access Centre</td>
</tr>
<tr>
<td>AHHRI</td>
<td>Aboriginal Health Human Resources Initiative</td>
</tr>
<tr>
<td>AHWS</td>
<td>Aboriginal Healing and Wellness Strategy</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ALC</td>
<td>Alternate Level of Care</td>
</tr>
<tr>
<td>AUA</td>
<td>Assessment Urgency Algorithm</td>
</tr>
<tr>
<td>BSO</td>
<td>Behavioural Supports Ontario</td>
</tr>
<tr>
<td>C</td>
<td>Central</td>
</tr>
<tr>
<td>CAATS</td>
<td>Colleges of Applied Arts and Technology</td>
</tr>
<tr>
<td>Candrive</td>
<td>Canadian Driving Research Initiative for Vehicular Safety in the Elderly</td>
</tr>
<tr>
<td>CARP</td>
<td>Canadian Association of Retired Persons</td>
</tr>
<tr>
<td>CASN</td>
<td>Canadian Association of Schools of Nursing</td>
</tr>
<tr>
<td>CCAC</td>
<td>Community Care Access Centre</td>
</tr>
<tr>
<td>CE</td>
<td>Central East</td>
</tr>
<tr>
<td>CHA</td>
<td>Community Health Assessment</td>
</tr>
<tr>
<td>CH</td>
<td>Champlain</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive Heart Failure</td>
</tr>
<tr>
<td>CHPI</td>
<td>Community Homelessness Prevention Initiative</td>
</tr>
<tr>
<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
</tr>
<tr>
<td>CLRI</td>
<td>Centres for Learning, Research, and Innovation</td>
</tr>
<tr>
<td>CMHA</td>
<td>Community Mental Health Association</td>
</tr>
<tr>
<td>CNAP</td>
<td>Community Navigation and Access Program</td>
</tr>
<tr>
<td>CNO</td>
<td>College of Nurses of Ontario</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>COUPN</td>
<td>Council of Ontario University Programs in Nursing</td>
</tr>
<tr>
<td>CPP</td>
<td>Canada Pension Plan</td>
</tr>
<tr>
<td>CREMS</td>
<td>Community Referrals by Emergency Medical Services</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>CSS</td>
<td>Community Support Services</td>
</tr>
<tr>
<td>CW</td>
<td>Central West</td>
</tr>
<tr>
<td>ECHO</td>
<td>Elder Friendly Collaborative for Hospitals in Ontario</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>eHealth</td>
<td>Electronic Health</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
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<td>EPC</td>
<td>Elderly Persons Centre</td>
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<tr>
<td>ER/ALC</td>
<td>Emergency Room/Alternate Level Care</td>
</tr>
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<td>ESC</td>
<td>Erie-St. Clair</td>
</tr>
<tr>
<td>FHT</td>
<td>Family Health Team</td>
</tr>
<tr>
<td>GAINS</td>
<td>Guaranteed Annual Income System</td>
</tr>
<tr>
<td>GEM</td>
<td>Geriatric Emergency Management</td>
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<tr>
<td>GIS</td>
<td>Guaranteed Income Supplement</td>
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<tr>
<td>HBAM</td>
<td>Health-Based Allocation Model</td>
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<tr>
<td>HC</td>
<td>Home Care</td>
</tr>
<tr>
<td>HCC</td>
<td>Health Care Connect</td>
</tr>
<tr>
<td>HCF</td>
<td>Healthy Communities Fund</td>
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<tr>
<td>HELP</td>
<td>Hospital Elder Life Program</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HNHB</td>
<td>Hamilton Niagara Haldimand Brant</td>
</tr>
<tr>
<td>H-SAA</td>
<td>Hospital Sector Accountability Agreement</td>
</tr>
<tr>
<td>HQO</td>
<td>Health Quality Ontario</td>
</tr>
<tr>
<td>IAH</td>
<td>Investment in Affordable Housing</td>
</tr>
<tr>
<td>IAR</td>
<td>Integrated Assessment Record</td>
</tr>
<tr>
<td>ICES</td>
<td>Institute of Clinical Evaluative Sciences</td>
</tr>
<tr>
<td>INTERACT</td>
<td>INTERventions to avoid Acute Care Transfers</td>
</tr>
<tr>
<td>ISAR</td>
<td>Identification of Seniors at Risk</td>
</tr>
<tr>
<td>ISMP</td>
<td>Institute for Safer Medication Practices</td>
</tr>
<tr>
<td>LACE</td>
<td>Length of hospital stay, Acuity on admission, Co-morbidity, ED Visits</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender and Queer</td>
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<tr>
<td>LHIN</td>
<td>Local Health Integration Network</td>
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<td>L-SAA</td>
<td>Long-Term Care Sector Accountability Agreement</td>
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<td>LTC</td>
<td>Long-Term Care</td>
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<td>Acronym</td>
<td>Description</td>
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<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>LTCF</td>
<td>Long-Term Care Form</td>
</tr>
<tr>
<td>MAPLe</td>
<td>Method for Assigning Priority Levels</td>
</tr>
<tr>
<td>MH</td>
<td>Mississauga Halton</td>
</tr>
<tr>
<td>MCSS</td>
<td>Ministry of Community and Social Services</td>
</tr>
<tr>
<td>MH</td>
<td>Mississauga Halton</td>
</tr>
<tr>
<td>MLPA</td>
<td>Ministry LHIN Performance Agreement</td>
</tr>
<tr>
<td>MMAH</td>
<td>Ministry of Municipal Affairs and Housing</td>
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<td>MSSA</td>
<td>Medication Safety Self-Assessment</td>
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<td>MSSS</td>
<td>Medication Safety Support Service</td>
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<tr>
<td>NE</td>
<td>North East</td>
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<td>NICHE</td>
<td>Nurses Improving Care for Health System Elders</td>
</tr>
<tr>
<td>NLOT</td>
<td>Nurse-Led Outreach Team</td>
</tr>
<tr>
<td>NPLC</td>
<td>Nurse Practitioner-Led Clinic</td>
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<tr>
<td>NSM</td>
<td>North Simcoe Muskoka</td>
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<td>NW</td>
<td>North West</td>
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<tr>
<td>OAC</td>
<td>Older Adult Centre</td>
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<tr>
<td>OACAO</td>
<td>Older Adult Centres’ Association of Ontario</td>
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<td>OANHSS</td>
<td>Ontario Association of Non-Profit Home and Services for Seniors</td>
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<tr>
<td>OAS</td>
<td>Old Age Security</td>
</tr>
<tr>
<td>OCAN</td>
<td>Ontario Common Assessment of Need</td>
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<tr>
<td>ODB</td>
<td>Ontario Drug Benefit</td>
</tr>
<tr>
<td>OHRC</td>
<td>Ontario Human Rights Commission</td>
</tr>
<tr>
<td>OLTCA</td>
<td>Ontario Long-Term Care Homes Association</td>
</tr>
<tr>
<td>OMA</td>
<td>Ontario Medical Association</td>
</tr>
<tr>
<td>ONPEA</td>
<td>Ontario Network for the Prevention of Elder Abuse</td>
</tr>
<tr>
<td>OPA</td>
<td>Ontario Pharmacists’ Association</td>
</tr>
<tr>
<td>OSS</td>
<td>Ontario Seniors’ Secretariat</td>
</tr>
<tr>
<td>OTN</td>
<td>Ontario Telemedicine Network</td>
</tr>
<tr>
<td>PERIL</td>
<td>Paramedics assessing Elders at Risk for Independence Loss</td>
</tr>
<tr>
<td>PSW</td>
<td>Personal Support Worker</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality Improvement Plan</td>
</tr>
<tr>
<td>RAI</td>
<td>Resident Assessment Instrument</td>
</tr>
<tr>
<td>RAI HC</td>
<td>Resident Assessment Instrument Home Care</td>
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<td>RAI MDS</td>
<td>Resident Assessment Instrument Minimum Data Set</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>RGP</td>
<td>Regional Geriatric Program</td>
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<tr>
<td>RM&amp;R</td>
<td>Resource Matching and Referral</td>
</tr>
<tr>
<td>SDM</td>
<td>Substitute Decision Maker</td>
</tr>
<tr>
<td>SE</td>
<td>South East</td>
</tr>
<tr>
<td>SW</td>
<td>South West</td>
</tr>
<tr>
<td>TC</td>
<td>Toronto Central</td>
</tr>
<tr>
<td>TFNHSOC</td>
<td>Trilateral First Nations Health Senior Officials Committee</td>
</tr>
<tr>
<td>TRST</td>
<td>Triage Risk Screening Tool</td>
</tr>
<tr>
<td>VON</td>
<td>Victorian Order of Nurses</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WW</td>
<td>Waterloo Wellington</td>
</tr>
</tbody>
</table>
# Appendix B: Recommended Performance Metrics

The goal of these metrics is to ensure older Ontarians stay healthy and independent in their own communities.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2011/2012</th>
<th>Provincial Target</th>
<th>LHINs</th>
<th>Public Health Units</th>
<th>Primary Care Providers</th>
<th>CCACs</th>
<th>CSS</th>
<th>Pharmacies</th>
<th>Long-Term Care Homes</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of older Ontarians receiving an Influenza Vaccination in the previous 12 months</td>
<td>68.6</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
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<tr>
<td>Percentage of older Ontarians who have received a Pneumococcal Vaccination</td>
<td>40</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
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<tr>
<td>Percentage of older Ontarians receiving a Tetanus Vaccination in the previous 10 years</td>
<td>30</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Percentage of older Ontarians who have established health care consent and advance care plans</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
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</tr>
</tbody>
</table>

The goal of these metrics is to support the prevention of falls, and their related injuries, amongst older Ontarians.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2011/2012</th>
<th>Provincial Target</th>
<th>LHINs</th>
<th>Public Health Units</th>
<th>Primary Care Providers</th>
<th>CCACs</th>
<th>CSS</th>
<th>Pharmacies</th>
<th>Long-Term Care Homes</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits due to falls</td>
<td>107,858</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
<td></td>
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<tr>
<td>Hospitalizations due to falls</td>
<td>26,602</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
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<tr>
<td>ED Visitation rates due to falls sustained in the community per 1,000 65+ Ontarians</td>
<td>48.5</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
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<tr>
<td>Hospitalization rates due to falls sustained in the community per 1,000 65+ Ontarians</td>
<td>11.4</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
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<tr>
<td>Percentage of home care clients who report they have fallen in the last 90 days</td>
<td>28%</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
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<tr>
<td>ED Visitation rates due to falls sustained in long-term care homes per 1,000 65+ Ontarians</td>
<td>101.0</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
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<tr>
<td>Hospitalization rates due to falls sustained in long-term care homes per 1,000 65+ Ontarians</td>
<td>28.1</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
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</tbody>
</table>

The goal of these metrics is to support the appropriate use of medications and the prevent of adverse medication events amongst older Ontarians.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2011/2012</th>
<th>Provincial Target</th>
<th>LHINs</th>
<th>Public Health Units</th>
<th>Primary Care Providers</th>
<th>CCACs</th>
<th>CSS</th>
<th>Pharmacies</th>
<th>Long-Term Care Homes</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of older Ontarians who have received a Medication Review (MedsCheck) by pharmacist within the previous 12 months</td>
<td>60</td>
<td>TBD</td>
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<tr>
<td>ED Visitation rates due to adverse medication events per 100,000 65+ Ontarians</td>
<td>629.3</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
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<tr>
<td>Hospitalization rates due to adverse medication events per 100,000 65+ Ontarians</td>
<td>75.7</td>
<td>TBD</td>
<td>•</td>
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<td>•</td>
<td>•</td>
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<tr>
<td>Percentage of hospitals that conduct medication reviews and reconciliations on admission and discharge from hospital</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
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</tr>
<tr>
<td>Percentage of older patients reporting that upon discharge from hospital they were provided with education around their medications, and any changes made to them, and direction around who to contact if they had any concerns or questions</td>
<td>50</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
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</tbody>
</table>
### The goal of these metrics is to ensure older Ontarians have timely access to primary care.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Provincial Performance 2011/2012</th>
<th>Provincial Target 2013/2014</th>
<th>LHINs</th>
<th>Public Health Units</th>
<th>Primary Care Providers</th>
<th>CCACs</th>
<th>CSS</th>
<th>Pharmacies</th>
<th>Long-Term Care Homes</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Primary Care Team Capacity to accept New Patients as per local Roster Sizes</td>
<td>75,000</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Percentage of older Ontarians without a physician that were referred to a primary care provider using Health Care Connect</td>
<td>82.7</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Percentage of older Ontarians designated as being complex and vulnerable without a physician that were referred to a primary care provider using Health Care Connect</td>
<td>88</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Median and 90th percentile Wait Times in days from registration to referral to a primary care provider for older Ontarians using Health Care Connect</td>
<td>43</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Percentage of older Ontarians designated as being complex and vulnerable and referred through Health Care Connect whose primary care was initiated within 14 business days of the receipt of a referral</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Number of older Ontarians receiving Physician House Calls (including Total Number of House Calls delivered)</td>
<td>51,263 (153,789)</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Percentage of older Ontarians reporting being able to receive same day, next day, or after-hours appointments (when needed) with their primary care providers</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>

### The goal of these metrics is to ensure older Ontarians have an adequate supply of and timely access to appropriate and effective home care services.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Provincial Performance 2011/2012</th>
<th>Provincial Target 2013/2014</th>
<th>LHINs</th>
<th>Public Health Units</th>
<th>Primary Care Providers</th>
<th>CCACs</th>
<th>CSS</th>
<th>Pharmacies</th>
<th>Long-Term Care Homes</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care Wait List</td>
<td>6,100</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Median and 90th percentile Wait Times in days from application to initiation of home care services for Community applicants</td>
<td>5 (33)</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Median and 90th percentile Wait Times in days from application to initiation of home care services for Hospital applicants</td>
<td>2 (12)</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Median and 90th percentile Wait Times in days from time of discharge to first CCAC nursing visit for high-risk older adults</td>
<td>2 (8)</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Total number of publicly funded or subsidized hours, in the millions, of home and community personal care and support services</td>
<td>26.7</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Percentage of home care primary caregivers experiencing feelings of distress and/or unable to continue in caring activities</td>
<td>21%</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>
The goal of these metrics is to ensure older Ontarians are receiving timely, appropriate and integrated care across the continuum that prevents avoidable hospital admissions and readmissions.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2011/2012 Provincial Performance</th>
<th>2013/2014 Provincial Target</th>
<th>LHINs</th>
<th>Public Health Units</th>
<th>Health Links</th>
<th>Primary Care Providers</th>
<th>CCACs</th>
<th>CSS</th>
<th>Pharmacies</th>
<th>Long-Term Care Homes</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of community care coordinators that provide their contact information and client’s care/service plan to the primary care provider.</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of primary care providers reporting receiving timely and appropriate communication, including response to their queries, from local community care coordinators working with their patients.</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of community care coordinators reporting receiving timely and appropriate communication, including response to their queries, from local primary care providers working with their clients</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>ED Visitation rates per 1,000 65+ Ontarians</td>
<td>609.4</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Hospitalization rates per 1,000 65+ Ontarians</td>
<td>209.1</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>ED Visitation rates per 1,000 65+ long-term care home residents</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Hospitalization rates per 1,000 65+ long-term care home residents</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of hospitals that notify the identified primary care providers of older patients seen in their EDs or admitted to the hospital</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of hospitals that provide discharge summaries to patients and primary care providers (including full list of meds and follow-up appointments and instructions) at the time of discharge from hospital</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td></td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of patients returning to their pre-admission locations upon hospital discharge from hospital</td>
<td>71</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of primary care providers reporting receiving timely and appropriate discharge summaries from local hospitals working with their patients</td>
<td>TBD</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of older patients discharged from hospital who saw their primary care provider within 7 days of discharge from an acute-care hospital</td>
<td>63.8</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of older Ontarians who are readmitted to a hospital within 30 days of being discharged from a hospital</td>
<td>15.92</td>
<td>TBD</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td></td>
<td></td>
<td>•</td>
<td>TBD</td>
</tr>
</tbody>
</table>
### Provincial Performance

#### Provincial Target

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Provincial Performance 2011/2012</th>
<th>Provincial Target 2013/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of older Ontarians who are readmitted to a hospital within 30 days of...</td>
<td>22.47 TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of older Ontarians who are readmitted to a hospital within 30 days of...</td>
<td>19.42 TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Percentage of older Ontarians reporting they are satisfied with the overall care...</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Additional Days during which older Ontarians have been unable to remain independent in their own homes</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**Healthy Communities that Provide Accessible, Safe, Efficient, Integrated and Coordinated Quality Care for Older Ontarians**

#### The goal of these metrics is to ensure older Ontarians are not waiting too long to receive their next appropriate level of health care services.

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Provincial Performance 2011/2012</th>
<th>Provincial Target 2013/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median and 90th percentile ED Length of Stay in hours for older Ontarians</td>
<td>12.4 TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Median and 90th percentile ED Length of Stay in hours for older Ontarians waiting for an inpatient hospital bed</td>
<td>4.7 (27.6) TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Average Length of Stay in hospital for older patients</td>
<td>9.5 TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Average Monthly Number of older Ontarians with ALC Designations in hospitals</td>
<td>3,343 TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>ALC Days as a percentage of total hospital days for older Ontarians</td>
<td>21.1 TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Average Monthly number of older Ontarians with New ALC to LTC Designations in hospitals</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

#### The goal of these metrics is to ensure older Ontarians have an adequate supply of and timely access to assisted living and supportive housing services.

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Provincial Performance 2011/2012</th>
<th>Provincial Target 2013/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Housing Wait List</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Supportive Housing Wait List Demand per 1,000 75+ Ontarians</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Supportive Housing Wait List Supply per 1,000 75+ Ontarians</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Supportive Housing Wait List Placement Rate per 1,000 75+ Ontarians</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Median and 90th percentile Wait Times in days for Supportive Housing placement from the Community</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Median and 90th percentile Wait Times in days for Supportive Housing placement from Hospitals</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
The goal of these metrics is to ensure older Ontarians have an adequate supply of and timely access to long-term care.

| Healthy Communities that Provide Accessible, Safe, Efficient, Integrated and Coordinated Quality Care for Older Ontarians | Provincial Performance 2011/2012 | Provincial Target 2013/2014 | LHINs | Public Health Units | Health Links | Primary Care Providers | CCACs | CSS | Pharmacies | Long-Term Care Homes | Hospitals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LTC Wait List | 19,500 | TBD | • | • | • | | | | | | |
| LTC Demand per 1,000 75+ Ontarians | 107.1 | TBD | • | • | • | | | | | | |
| LTC Supply per 1,000 75+ Ontarians | 85.7 | TBD | • | • | • | | | | | | |
| LTC Placement Rate per 1,000 75+ Ontarians | 4.3 | TBD | • | • | • | | | | | | |
| Median and 90th percentile Wait Times in days for LTC placement from the Community | 146 | TBD | • | • | • | | | | | | |
| Median and 90th percentile Wait Times in days for LTC placement from Hospitals | 64 | TBD | • | • | • | | | | | | |
| Percentage of persons placed into a LTC home who do not have high or very high needs for LTC services and could be potentially cared for elsewhere | 146 | TBD | • | • | • | | | | | | |
Appendix C: Overview of the interRAI Suite of Assessment Tools

interRAI is an international collaborative of health and social care researchers that are working together to improve the quality of life of vulnerable persons through a seamless comprehensive assessment system that can be used across health care sectors. This group’s work has been particularly relevant to frail older adults, often characterized with chronic illness or disability, who often use a variety of clinical and support services necessitating multiple assessments.

The interRAI collaborative makes its suite of assessment tools available for free as long as the health, social, and community care providers using them share the de-identified data they collect when assessing patients and clients. With this data the interRAI collaborative strives to promote evidence-informed clinical practices and policy decision-making through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings. The Canadian Institute for Health Information serves as the repository for all interRAI data collected in Canada.

The current interRAI suite is comprised of a set of 17 compatible, comprehensive geriatric assessment tools designed to support clinical assessment and care planning across care sectors that include home and community care, long-term care, emergency, acute and post-acute care, palliative care, community mental health, etc. Together the interRAI tools form an integrated health evaluation system. The interRAI suite of tools is also a living system. As more experience is gained in its application across the world, and as further research is conducted, it is continuously upgraded and shared for free.

A fully realized interRAI assessment system allows clinical observations to be translated into identified problems, scales, screeners, clinical assessment protocols and quality indicators (Figure 1).

Figure 1  Measures derived from observations captured in an interRAI tool
The interRAI suite is built on a core set of approximately 70 assessment criteria that comprise the Minimum Data Set (MDS) required to perform a comprehensive assessment. These criteria are deemed to be important across all care settings, and have identical definitions, observation time frames and scoring methods. Examples of criteria include cognitive skills, activities of daily living and health symptoms. Additional items specific to particular populations or care settings are added to the core item set.

The section or identification of certain criteria indicate the presence or absence of problems. Validated scales are then used primarily to provide a sense of the severity of a problem, and may assist to monitor change over time. For example, the pain scale suggests the severity of a pain problem. Some tools have screeners built in to them, such as the delirium screener, which assists in the identification of a problem that is not easily detected with a single observation. Others, such as the institutional risk screener, help to identify the likelihood that an adverse event will occur in the future. The “RAI Score” discussed in Chapter 6 is not a validated interRAI scale or scoring system.

A key aspect of the interRAI assessment systems are the Clinical Assessment Protocols (CAPs), written material designed to assist those responsible for care planning to consider major issues triggered by the initial assessment. The CAPs provide prevention and treatment options, and help the assessor determine whether further evaluation or treatment will be needed according to established guidelines and protocols. This facilitates the development of evidence-based and individualized patient care plans. Finally, quality indicators are designed to identify aspects of care where there might be sub-optimal care or opportunity for improvement. interRAI quality indicators focus on the “outcomes” of care delivery, rather than the “processes.”

interRAI in Ontario

interRAI tools are now used across Canada and around the world in a variety of settings. Ontario has adopted six of the tools into widespread use as is shown in Table 1. The latest suite of instruments are all identified with the name “interRAI” in front of them. The other sector tools listed are older versions of a more current tool that exists.

Table 1. interRAI Tools in Use in Ontario by Health Care Sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>Instrument</th>
<th>New Suite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Access Centres</td>
<td>RAI Home Care (HC)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>interRAI Contact Assessment (CA)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>interRAI Palliative Care (PC)</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Support Services</td>
<td>interRAI Community Health Assessment (CHA)</td>
<td>Yes</td>
</tr>
<tr>
<td>Primary Care Settings</td>
<td>interRAI Community Health Assessment (CHA)</td>
<td>Yes</td>
</tr>
<tr>
<td>Acute Care Settings</td>
<td>RAI Home Care (HC)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>interRAI Contact Assessment (CA)</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Mental Health Units</td>
<td>RAI Mental Health (MH)</td>
<td>No</td>
</tr>
<tr>
<td>Long-Term Care Homes</td>
<td>RAI 2.0</td>
<td>No</td>
</tr>
<tr>
<td>Complex Continuing Care Units</td>
<td>RAI 2.0</td>
<td>No</td>
</tr>
</tbody>
</table>
In the main body of the report, the recommendation to upgrade all tools in use in Ontario to the new suite tools has been made principally because it allows patient data to be more comparable and transferrable between settings. More up-to-date versions also use more advanced and accurate triggering systems to ensure that CAPs are triggered more accurately and when necessary.

**Method for Assigning Priority Levels (MAPLe) Algorithm**

In Chapter 6 – MAPLe was referred to as an algorithm that is being increasingly used to prioritize individuals for access to community and long-term care home services and levels of care that are commensurate with their needs. The MAPLe algorithm is based on 14 indicators collected in tools like the interRAI CHA, interRAI HC as well as the RAI HC. Items such as Activities of Daily Living (ADL) and cognitive functioning, falls, and risk of institutionalization are used to derive and assign a level from 1 (low) to 5 (very high) for each client assessed. The MAPLe Index has been a useful algorithm to help health care providers better understand the types of clients they are serving and the types of care that would best meet their needs and with what priority.
## Appendix D: Stakeholders Engaged

<table>
<thead>
<tr>
<th>Provincial, National and International Stakeholders</th>
<th>Provincial, National and International Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Ontario for People with Neuropathic Pain</td>
<td>Ontario Emergency Department LHIN Leads</td>
</tr>
<tr>
<td>Advocacy Centre for the Elderly (ACE)</td>
<td>Ontario ER/ALC Expert Panel</td>
</tr>
<tr>
<td>Alzheimer Society of Ontario (ASO)</td>
<td>Ontario Gerontology Association (OGA)</td>
</tr>
<tr>
<td>Association of Local Public Health Agencies (ALPHA)</td>
<td>Ontario Home Care Association (OHCA)</td>
</tr>
<tr>
<td>Association of Family Health Teams of Ontario (AFHTO)</td>
<td>Ontario Home Respiratory Services Association (OHRSA)</td>
</tr>
<tr>
<td>Association of Jewish Seniors</td>
<td>Ontario Hospital Association (OHA)</td>
</tr>
<tr>
<td>Association of Municipalities Ontario (AMO)</td>
<td>Ontario Injury Prevention Resource Centre (OIPRC)</td>
</tr>
<tr>
<td>Association of Ontario Health Centres (AOHC)</td>
<td>Ontario LHIN CEOs</td>
</tr>
<tr>
<td>Behavioural Support Ontario (BSO)</td>
<td>Ontario Long-Term Care Association (OLTCA)</td>
</tr>
<tr>
<td>Canadian Academy of Health Sciences (CAHS)</td>
<td>Ontario Long-Term Care Physicians (OLTCP)</td>
</tr>
<tr>
<td>Canadian Association of Physician Assistants (CAPA)</td>
<td>Ontario Medical Association (OMA)</td>
</tr>
<tr>
<td>Canadian Association of Retired Persons (CARP)</td>
<td>Ontario Network for Prevention of Elder Abuse (ONPEA)</td>
</tr>
<tr>
<td>Canadian Hearing Society</td>
<td>Ontario Nurses' Association (ONA)</td>
</tr>
<tr>
<td>Canadian Home Care Association (CHCA)</td>
<td>Ontario Pharmacists' Association (OPA)</td>
</tr>
<tr>
<td>Canadian Hospice Palliative Care Association</td>
<td>Ontario Physiotherapy Association (OPA)</td>
</tr>
<tr>
<td>Canadian Mental Health Association Ontario</td>
<td>Ontario Podiatric Medical Association (OPMA)</td>
</tr>
<tr>
<td>Canadian Pensioners Concerned (Ontario Division)</td>
<td>Ontario Primary Care Physician LHIN Leads</td>
</tr>
<tr>
<td>Canadian Red Cross</td>
<td>Ontario Public Health Association (OPHA)</td>
</tr>
<tr>
<td>CancerCareOntario</td>
<td>Ontario Retirement Communities Association (ORCA)</td>
</tr>
<tr>
<td>Care Watch</td>
<td>Ontario Seniors for Home and Community Care</td>
</tr>
<tr>
<td>Caregivers' Association of Ontario</td>
<td>Ontario Seniors' Secretariat</td>
</tr>
<tr>
<td>Caring, Advocacy, Research for the Eldery (CARE)</td>
<td>Ontario Society (Coalition) of Senior Citizens’ Organizations</td>
</tr>
<tr>
<td>Centre for Movement Disorders</td>
<td>Ontario Society of Nutrition Professionals in Public Health</td>
</tr>
<tr>
<td>Centric Health Seniors Wellness</td>
<td>Ontario Society of Occupational Therapists (OSOT)</td>
</tr>
<tr>
<td>Chartwell Seniors Housing REIT</td>
<td>Ontario Telemedicine Network (OTN)</td>
</tr>
<tr>
<td>Council of Academic Hospitals in Ontario (CAHO)</td>
<td>Pfizer Canada</td>
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**Waterloo Wellington LHIN**

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**South East LHIN**

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<td>Community Care Durham</td>
<td>Psychiatric Assessment Services for the Ederly (PASE)</td>
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<td>County of Haliburton Emergency Medical Services</td>
<td>Ross Memorial Hospital</td>
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<tr>
<td>Fairhaven Long-Term Care Home</td>
<td>The Scarborough Hospital</td>
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<td>Lakeridge Health</td>
<td>The Canadian Continence Foundation (TCCF)</td>
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<tr>
<td>Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)</td>
<td>Yee Hong Centre for Geriatric Care</td>
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About Dr. Samir K. Sinha MD, DPhil, FRCPC

As the appointed expert lead of Ontario’s Seniors Strategy, Dr. Samir Sinha is a passionate and respected advocate for the needs of older adults. Dr. Sinha currently serves as the Director of Geriatrics at Mount Sinai and the University Health Network Hospitals in Toronto. He is also an Assistant Professor of Medicine at the University of Toronto and the Johns Hopkins University School of Medicine and further serves as the Chair of the Health Professionals Advisory Committee of the Toronto Central LHIN, is a Medical Advisor to the Toronto Central CCAC and an Associate Fellow with interRAI.

A Rhodes Scholar, after completing his undergraduate medical studies at the University of Western Ontario, he obtained a Master in Medical History and a Doctorate in Sociology at the University of Oxford’s Institute of Ageing. After returning to pursue postgraduate training in Internal Medicine at the University of Toronto, Dr. Sinha went to the United States where he most recently served as the Erickson/Reynolds Fellow in Clinical Geriatrics, Education and Leadership at the Johns Hopkins University School of Medicine.

Dr. Sinha’s breadth of international training and expertise in health policy and the delivery of services related to the care of the elderly have made him a highly regarded expert in the care of older adults. He has consulted with and advised hospitals and health authorities in Britain, Canada, the United States and China on the implementation and administration of unique, integrated and innovative models of geriatric care that reduce disease burden, improve access and capacity and ultimately promote health.
Acknowledgements

In preparing this report for submission to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors, it has been astounding to look back over the last six months to assess how significantly this opportunity has enabled thousands of Ontarians to come together with me in developing a Seniors Strategy for Ontario.

With such a broad mandate, and with so much to consider, it is understandable why no other province appears to have developed a strategy as comprehensive as this. While it became clear that this was Ontario’s time to lead, it was also apparent that I could not have researched, contemplated, developed, or confirmed these recommendations without a great deal of support. Therefore, I would like to acknowledge the contributions of those individuals within and beyond the provincial government who have provided me with thoughtful guidance and expertise thus far in my appointment.

I would first of all like to thank the Minister of Health and Long-Term Care and the Minster Responsible for Seniors and their staff for their unwavering interest and support of this work. I would also like to thank the Deputy Minister of Health and Long-Term Care and the Ministry staff for their incredible support from the outset of my appointment. More specifically I would like to thank Catherine Brown, Rachel Kampus, Ann Schrager, Elizabeth Garfin, Ann-Marie Case, Sharan Bassi, Sarah Burrell, Beatrix Ko, Sherisse Pascual, Barbara Richmond, and Janelle Ritchie for their daily dedication to seeing through the consultation process and the completion of this report.

I would also like to thank the leadership teams of each LHIN who facilitated our team’s engagements with local municipal leaders, regional health, social, and community care organizations and providers, and most importantly local older adults and their caregivers. While I was able to meet and engage in person with thousands of Ontarians over the past six months, thousands more that I never had the privilege of meeting in person took their time to allow our team to know their thoughts through the submission of letters, emails and by partaking in our public consultation surveys. What was so important to our team was that as many Ontarians as possible, especially older Ontarians, their families and their caregivers, could participate in this process. Indeed, this level of engagement was integral and responsible for many of the findings and recommendations presented in this report.

It was important to me that throughout this process that I continue my leadership, clinical, teaching and research responsibilities at Mount Sinai and the University Health Network Hospitals and the University of Toronto. I am privileged to work with an outstanding group of colleagues, staff and students at these institutions and I very much appreciated them, along with my patients, giving me their unwavering support and the time I needed to also pursue see the successful completion of this report. More specifically I would like to thank Joseph Mapa, Robert Bell, Tom Stewart, Ed Cole, Howard Abrams, Jocelyn Bennett, Shabir Alibhai, Barry Goldlist, Mark Nowaczynski, Karen Ng, Selma Chaudhry, Phoebe Tian, Wendy Levinson, Sharon Straus, and Camilla Wong for their incredible support. Many of these and other colleagues and collaborators gave freely of their time in serving as members of my informal “kitchen cabinet” of advisors. I will be forever grateful to them who always made themselves readily available to help me further my thinking or find me the answers I needed as our team considered various issues.
I would also like to thank Dr. David Walker for whom I had the privilege of serving as a member of his ALC Action Team a year earlier leading up to the development of his report. I am very grateful to the time and advice he has provided thus far which allowed me to build on the important foundational work of him and others. I would also like to thank the minister for allowing me to make this work a teaching opportunity for my research students at the University of Toronto – Nicola Goldberg, Ameya Bopardikar, and Dr. Nathan Stall – each of whom was able to make important contributions to the development of this report. I would also like to thank my colleagues and friends Dr. Mark Nowaczynski and Mr. Kevin Kelly who captured many of the incredible images that illustrate this report that portray the care being delivered across the continuum for older patients in Toronto.

I also want to recognize the ongoing support of my mentors Drs. Charles Bernstein at the University of Manitoba, Charles Webster at the University of Oxford, and Bruce Leff at Johns Hopkins University. Working with each of them has been an honour and privilege, and their continual support and interest in my personal and professional development and work will never been forgotten.

The greatest acknowledgement, however, belongs to my family, and especially my parents, Drs. Meera and Sach Sinha, both of whom are excellent examples of aging with grace. The fact that my parents also served as impromptu advisors, research assistants, and copy editors during the development of this report, illustrates how they have and continue to be a great source of personal support to me. They instilled in me a love of learning and have given me so many opportunities to broaden my thinking and understanding of the world. Always backed by their encouragement and their continued and unconditional love and support, words could not even begin to express my appreciation of them.