

BEYOND 2006:

An Update on the Status of Long-Term Care Services in Waterloo Wellington

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Prepared for

**The Community Care Access Centres of
Waterloo Region and Wellington Dufferin**

By

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PREFACE

While our health system serves people of all ages, it is the elderly who consume the most services and the most resources. In comparison to western European countries, up until the late 1990s, Canada's elderly population had not yet reached 12%. In the last ten years, the number of people over 65 has grown at an unprecedented rate. The projections for the next 25 years indicate that this rate will accelerate. Already in Ontario our health system is experiencing crises regularly in spite of significant increases in funds for new and expanded programs. Judging from the frequency of reporting of health system challenges, it is easy to suggest that the solutions are not easily attainable.

The vast majority of those people 65 years and older believe themselves capable of self care until death. None of us want to foresee the time when this is no longer possible. As our abilities diminish, we continue to compensate. At some point, we look to others for assistance. Given the strong family tradition in Canada, many family members choose to be engaged as caregivers, rather than to seek out assistance from those who provide human services. Others do not have the availability of family to help and either engage health services or find themselves in crisis. As the abilities of elderly people deteriorate further, caregivers are called upon to do more and more and more. Strong bonds, a sense of responsibility, and, sometimes, a feeling of guilt, motivate informal caregivers to continue without seeking any assistance. Often by the time assistance is sought out, the caregiver is overwhelmed and the person being cared for has very high care needs, resulting in another health crisis.

Our health service system has evolved as primarily one that responds to emergencies. Even our regular medical checkups are designed to identify real or emerging problems, rather than focus on the delay or prevention of problems. With emergencies or health crises being the focal point of our health service system, it has been imperative that each service sector have excess capacity. From the genesis of publicly funded health services in the 1960s until the government deficit crisis in the early 1990s, capacity exceeded demand. Addressing the funding crisis resulted in the downsizing of health care beginning a decade ago. Excess capacity within all subsystems of health care disappeared. At the same time, the growth in demand, in part due to the aging population, resulted in growing waitlists and increased waiting times. For many, this has resulted in a health care system in a constant state of crisis.

The crisis experienced by the individual health service organizations impacts significantly upon caregivers. When a health care emergency arises, it is the caregiver who must find a response. Whether it is managing an episode of an acute illness because the hospital does not have sufficient space, providing post acute care following a shortened hospital stay, providing personal care due to unavailability of home care, continuing to care while awaiting long-term care placement, or partnering with home care during a palliative period, the burden always falls on the caregiver.

The Waterloo Wellington communities are experiencing a capacity problem. From emergency departments to acute care to community care to long term care, capacity seems to be a major barrier. Given the high utilization rates of the elderly population on the health services, the population demographics indicate the situation will become even more critical in the coming years. Seeking new dollars to expand existing services may be part of the answer, but experience suggests it is not the solution. The intent of this paper is to provide an analysis of the current situation and to provide recommendations for moving forward.

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EXECUTIVE SUMMARY

The purpose of this report is to provide an update on the current status of LTC services in Waterloo Wellington and to develop recommendations for moving forward to address the service and system issues identified, by:

- Examining the changes that have occurred since the report *Toward 2006: Directions for LTC Community Services in Waterloo Wellington* (2002)
- Updating population statistics and projections
- Identifying the current gaps and issues in community, facility and institutional LTC services, and
- Reviewing examples of successful programs in other jurisdictions

Summary of findings

The Waterloo Wellington Long Term Care system is at capacity and is under severe pressure across the continuum of services.

Increases in the elderly population are occurring as projected. As of 2006, using 2001 census information as a base, the numbers of people 65 – 74 has increased 3.7% and by 2016 will have increased 81%; number of people 75-84 has increased 19.3% and by 2016 will have grown 35%; and numbers of people 85+ has increased 25% and by 2016 will have grown 83%. This pattern of growth will continue to escalate well beyond 2016.

CCACs have received targeted funding increases since 2002 and are serving large numbers of clients discharged from hospital with post acute needs, many of whom are elderly. However the targeted approach is not addressing the growing needs of the frail elderly population living at home in the community, which is the fastest growing segment of the population.

Community Support Services continue to serve growing numbers of clients and are identifying higher levels of need in many of the population they serve. Volunteer recruitment is becoming more challenging and waiting lists for services are more common than they were in 2002.

LTC homes are operating at 99 % occupancy in Waterloo Region and in the Guelph area of Wellington. Monthly waiting lists in Waterloo during 2005 ranged from 688 – 846 and in 2006 to date, have increased from a low of 829 to a high of 1102. The Guelph area of Wellington is also experiencing steady growth in waiting lists which have been averaging 500 people with current levels at 612. Special needs populations, especially people exhibiting high-risk behaviors are difficult to place given the funding and staffing limitations of LTC homes.

Complex Continuing Care is primarily available at Grand River Hospital – Freeport (124 beds), Cambridge Memorial Hospital (38 beds), and St. Joseph’s Health Center Guelph (63 beds). Services include complex medical care (chronic ventilator patients) geriatric assessment, geriatric rehabilitation, and palliative care. Although there are fluctuations in palliative care, these programs are all operating at capacity with waiting lists and with patients designated as requiring Alternative Level of Care (ALC), usually

waiting for access to a LTC home. For example, in the current year to date Freeport has recorded 2,990 ALC bed days.

Acute Care Hospitals in K-W, Cambridge and Guelph are experiencing more pressures in Emergency Departments and more ALC patients than in the rural hospitals. They are reporting patient days spent in ED, and/or opening beds over capacity in order to serve patients who require admission. ALC patient days reported for time periods during 2006 are high: GRH – K-W site (6,224), Cambridge Memorial Hospital (3,326), St. Mary’s General Hospital (2,029) and Guelph General Hospital (2025).

Mental Health and Specialized Geriatric/Psycho-geriatric services are insufficient to meet the needs of elderly clients. Wellington services are better resourced through mental health funding than Waterloo. In Wellington there are 17 mental health beds at the Homewood Health Centre, and these beds are consistently at full occupancy. A coordinated model of service through partnerships between the Community Mental Health Clinic, the Wellington Dufferin CCAC and St. Joseph’s Health Centre Guelph provides access to geriatric and psycho-geriatric care however the programs are at capacity with waiting lists. In Waterloo Region there are no psycho-geriatric hospital beds – clients requiring this care access St. Joseph’s Health Centre London or Grand River Hospital’s psychiatric unit at the K-W site. In the community, Cambridge clients are served by the Seniors Mental Health Team operating out of Cambridge Memorial Hospital which provides access to geriatric and psycho-geriatric care. These services are also operating at capacity. In the K-W area the Community Geriatric Services program combines services of the CCAC of WR and GRH-Freeport for access to psycho-geriatric services. Geriatric clinics are also available at St. Mary’s General Hospital. These programs are also at capacity with limited availability of specialized nursing and geriatric expertise.

The major gap in the service continuum in Waterloo Wellington is in the area of assisted living or supportive housing, which combine residential and supportive care. There are numerous Rest & Retirement (R & R) Homes throughout Waterloo Wellington that provide this level of care on a private pay basis. Some R & R Homes have developed extra service packages which can be purchased by residents who require higher levels of care, e.g., while on the waiting list for LTC home care. This has been very beneficial for residents who can afford this option, but there are no publicly funded services that provide this level of care. The report discusses programs and services that have been successfully implemented in other jurisdictions.

It is recognized that there is no single option that will address the complex issues that have come together to create the current pressures in the LTC system. This report has flagged these issues but also notes that there has been considerable in-depth analysis of both the challenges and the potential solutions.

Recommendations

It is recommended that the MOHLTC:

- Fund a transitional bed program in Waterloo Region as an interim step to reduce acute care pressures in acute care (refer to 2004 report to MOHLTC recommending 50 interim beds)
- Provide operational funding to implement the existing Supportive Housing proposal in Waterloo Region

It is recommended that the LHIN:

- Support a LHIN-wide strategy for Supportive Housing/Assisted Living programs in affordable housing sites for seniors in urban and rural settings
- Support service enhancements to increase the capacity of LTC facilities to provide services to specialized populations
- Strike a Health Human Resources committee to address human resource shortages and issues on a LHIN-wide basis
- Ensure that new bed allocations are an accurate reflection of need in Waterloo and Wellington
- Ensure that provincial estimates for redirecting consumers from LTC Homes include an accurate reflection of current needs, existing service options and changes that will need to occur in order to achieve redirection strategies
- Support the ongoing work of the Waterloo Wellington Geriatric Services Network (WW GSN) as it addresses issues and solutions to improve services for older adults with complex needs in Waterloo Wellington
- Review the evaluation findings of the Balance of Care project to identify potential for combining CCAC and Community Support Services into intensive service packages
- Examine enhanced CCAC in-home service options such as intensive case management, enhanced levels of personal support/homemaking services for at risk clients in the community
- Support a comprehensive analysis of GRH Freeport utilization data focusing on enabling LHIN-wide access to this resource
- Support implementation of Chronic Disease Management strategies that can be applied across the health continuum
- Review the Enhanced Community Health Options for the Elderly (ECHOE) Proposal developed through the CCACWR (2001) to assess its relevance in the current context
- Support existing service networks currently working on specific issues relating to improving the long term care service system. It will be important to support the work of these groups and to develop a forum for bringing the findings of these groups together, for discussion of common elements and strategies for moving forward. Some examples include:
 - WW Geriatric Services Network
 - WW Rehabilitation Services Network
 - WW Community Support Services Network
 - WW Emergency Services Network
 - WW Hospice Palliative Care Network

1.0 **BACKGROUND**

1.1 *History Leading to Writing of toward 2006*

Waterloo Wellington stakeholders have a brief but rich history of planning health services that began in 1998 with the amalgamated Waterloo Region-Wellington-Dufferin District Health Council (WRWDDHC). Throughout 1999, community long-term care stakeholders participated in an in-depth planning project to develop a Multi-Year Strategic Plan for Community Long-Term Care Services in Waterloo Region and Wellington-Dufferin Counties¹.

The Multi-Year Plan (MYP) included an in-depth analysis of Community Care Access Centre (CCAC) services in both Waterloo Region and Wellington-Dufferin, extensive information gathering and analysis of Community Support Services (CSS) provided by 31 agencies, and a description of KidsAbility children's treatment centre service issues (formerly the Rotary Children's Treatment Centre). The MYP contained 34 recommendations in three areas:

- funding for service development and expansion (more funds for more services),
- service enhancements (strengthening quality of services through staffing improvements, education and training opportunities), and
- system improvements; e.g., examining volunteer service issues, access issues for adults with physical disabilities, caregiver support needs, health human resource strategies and coordinated geriatric/psycho-geriatric models of service to meet the needs of older adults in Waterloo Region and in Wellington and Dufferin Counties.

While the funding recommendations were valid for the full three to five year term of the plan, the context for making service system improvements changed dramatically as a result of the directives of the Health Services Restructuring Commission (HSRC) and subsequent Ministry implementation decisions which included:

- reduction in numbers of Complex Continuing Care beds
- expansion of Long-Term Care (LTC) home beds
- legislative changes to CCAC governance structures, service protocols and LTC home placement guidelines
- Regional Cancer and Cardiac Centres in process of implementation
- Mental Health Reform initiatives were moving towards implementing local mental health beds as Provincial Psychiatric Hospitals were closed

In this context of change, the WRWDDHC developed a consolidated report Toward 2006: Directions for Community LTC Services in Waterloo Region and Wellington-Dufferin Counties (Toward 2006)² to update and enhance the Multi-Year Plan. The

¹ Waterloo Region-Wellington-Dufferin District Health Council (2000). Multi-Year Strategic Plan for Community Long-Term Care Services in Waterloo Region and Wellington-Dufferin Counties.

² Waterloo Region-Wellington-Dufferin District Health Council (2002). Toward 2006: Directions for Community LTC Services in Waterloo Region and Wellington-Dufferin Counties.

purpose of the report was to review the status of Multi-Year Plan recommendations, provide updated demographic projections, report on follow-up planning activities that had occurred since 2000, and identify the system changes having an impact on community LTC services.

1.2 Why an Update is Required

The Toward 2006 report utilized population projections to examine LTC Home resources following the provincial bed expansion initiative. Projections indicated that by 2006 the provincial ratio of beds available (beds per 10,000 persons 75+) would begin to drop as the number of elderly residents 80+ increased each year, leading to a growing shortage of beds. The report concluded that the upcoming shortage of long-term care beds would place severe strain on hospital and community services unless significant development and expansion of community service options occurred. The recommendations in that report focused on the development and expansion of community-based services for elderly residents, including: Specialized Geriatric Services, Supportive Housing Programs, expanded Community Support Services, Palliative Care, Alzheimer initiatives and support for Elder Abuse Programs.

At the end of 2006, four years since the writing of the Toward 2006 report, there have been significant changes in the geographic and planning environments. These include:

- MOHLTC restructuring has resulted in 14 Local Health Integration Networks (LHINs) across the province that will be responsible for planning, managing and funding health services in each area.
- Service providers throughout the health system are identifying many of the system pressures projected in Toward 2006.
- LTC homes throughout Waterloo Region and in the City of Guelph and surrounding area are operating at 99% occupancy with large numbers of eligible consumers awaiting placement in hospital Alternative Levels of Care (ALC) beds, in the community, from out of area and in LTC homes awaiting their first choice of home.
- There are high numbers of (ALC) patients occupying acute hospital beds in Kitchener, Cambridge and Guelph. Lack of available acute care beds negatively affects all hospital programs especially Emergency Department capacity.
- LTC homes in centre and north Wellington County are operating with vacancies. Acute care hospitals have implemented a policy requiring families to take the first available bed in the area. This results in families being directed towards any available bed within 80 km of their home, placing hardships on families unable to travel long distances.
- Community service providers, the CCACs and Community Support providers are reporting serving increasing numbers of frail elderly clients with complex geriatric and psycho-geriatric needs.

Waterloo Wellington and parts of Grey Bruce form the WW LHIN geographic boundaries. The WW LHIN Chief Executive Officer has welcomed information-based considerations for future LTC services in the new area. Toward 2006 is considered a useful vehicle for examining the changes that have occurred since 2002 and for recommending directions for system improvements beyond 2006, in the short term and in the longer term.

1.3 Establishment of the Waterloo Wellington LTC Planning Project Steering Committee

In September 2006, the Community Care Access Centres (CCACs) of Waterloo Region and Wellington-Dufferin established a steering committee to guide the process of updating the Toward 2006 report, identifying key issues and developing options to address these issues. The following membership of the committee ensured broad representation across the Waterloo Wellington area:

Beatrice Mudge	Cambridge Memorial Hospital
Linda Knight	CarePartners
John Enns	CCACWR
Louise Leonard	CCACWR Former Board Chair
Kim Voelker	CCACWR
Anne Macintosh	CCACWD
Jane McKinnon-Wilson	Community Mental Health Clinic, Guelph
Nancy Kauffman-Lambert	Golden Years Nursing & Assisted Living Centre
Gloria Whitson-Shea	Grand River Hospital
Jenny Rajaballey	Integrated Mental Health Services (Grand River Hospital & Cambridge Memorial Hospital)
Janice Paul	K-W Friendship Group for Seniors
John Colangeli	Lutherwood
Rosemary Crisp	St. Joseph's Health Centre
Gail Carlin	Region of Waterloo, Sunnyside Home
Trevor Lee	The Elliott Community
Bruce Lauckner	WW LHIN
Stephen Handler	Consultant
Joan Kaden	Consultant

2.0 PURPOSE OF THE REPORT

- to summarize the current status of the main findings of the Toward 2006 report
- to examine the current status of population aging and population growth
- to identify the current gaps and issues in community, facility and institutional LTC services
- to review examples of successful programs in other jurisdictions
- to develop recommendations to address current and future capacity issues in the area served by the WW LHIN

2.1 *LTC Consumer Trends*

Toward 2006 examined the challenges and circumstances of the three specific LTC client populations: children, adults with (physical) disabilities, and older adults/seniors.

The focus of this report is on the service system pressures that have evolved since 2002.

This places priority on describing the service needs of the elderly consumer population which is growing rapidly and putting the most pressure on the long-term care service system.

Although the focus of this report is the elderly population, it is important to acknowledge that the service issues for children with special needs and of adults with physical disabilities remain challenges for the health system as well as for families. For the next 30 years these consumer groups will likely be considered as sub populations in the long-term care system due to their lower rate of growth in numbers compared to the elderly population. It is anticipated that as the restructured health system is implemented, proactive planning will form an integral part of health system management in order to ensure that the needs of these smaller consumer groups are considered as priorities.

3.0 UPDATE ON TOWARD 2006 REPORT

The Toward 2006 report focused on how changing demographics would affect the community-based LTC services, particularly the CCACs and the Community Support Sector. The following is a summary of issues these organizations identified in 2002 accompanied by commentary on their current status. Similarly, the directions contained in Toward 2006 are listed with updates on their current status. In Chapter 5, there are detailed descriptions of the current capacity, gaps and issues.

3.1 Community Care Access Centres

Toward 2006 identified the following service issues for the Waterloo Wellington CCACs in 2002:

- Increasing numbers of elderly consumers and even higher increases in the level of services (and therefore the cost) of serving frail elderly consumers with multiple diagnoses. This trend was documented in the CCAC Utilization Profile developed as part of the Multi-Year Plan³ which concluded that the utilization patterns together with population projections for high need age groups would result in a substantial increase in the demand for and cost of CCAC services by 2006.
- Increasing referrals from Community Support Services of frail elderly consumers requiring professional services of the CCACs, in addition to their services.
- Increasing referrals from acute care hospitals to serve consumers discharged from hospital “quicker and sicker” due to advances in medical technology and increases in day surgery.
- LTC homes increasingly relying on CCAC Physiotherapy, Occupational Therapy and Speech and Language Pathology services, all of which are required in a timely manner in order to be effective.
- Rest and Retirement Homes increasingly requesting CCAC services for Personal Support and, to a lesser extent, therapies for their residents. (Some of these residents had been recently discharged from acute care; some were assessed and eligible for LTC home care but were on waiting lists. Since residents are, by definition, in their home in Rest and Retirement Homes, they are eligible for some CCAC services.) The need to prioritize these referrals often results in long waits for service resulting in service gaps.
- Both CCACs had reported increases in requests for caregiver support and respite services, which impacts the Homemaking/Personal Support/Attendant/Respite service. (This is the service that has traditionally been most at risk in times of budget constraints. It is also the service recognized as helping delay institutionalization by supporting individuals and their families in the community.)

Toward 2006 noted that the demand for CCAC services would continue to escalate each year in terms of continued pressure for personal support/homemaking assistance from all referral sources, for direct client needs and caregiver support.

³Waterloo Region-Wellington-Dufferin District Health Council (2000). Multi-Year Strategic Plan for Community Long-Term Care Services in Waterloo Region and Wellington-Dufferin Counties.

The report concluded that while the introduction of new LTC home beds may ease some of the pressure on the health system in the short term, the demand for in-home services and supports would continue to increase.

CCAC Update

The CCACs have undergone significant change since the writing of the Toward 2006 report in 2002. Following is a combined overview of annual CCAC funding and client totals in the intervening years:

CCAC of WR and CCAC W-D Funding and Service Overview, 2002 - 2006		
	Total Funding CCAC WR and CCAC W-D(million)	Total Individual* Clients Served
2002-2003	\$63.4	28,177
2003-2004	\$65	29,060
2004-2005	\$69.1	30,570
2005-2006	\$76.8	33,977

**Individual clients identified through Health Insurance Numbers – recorded once per year regardless of number of times CCAC services were accessed throughout the year*

During the years 2001 and 2002 the CCACs were required to implement expenditure controls in order to avoid a deficit. While this involved all levels of the organizations, reviewing and reducing expenditures, it was the client services review that affected clients. Waiting lists were implemented for Personal Support/Homemaking services and guidelines were developed that would be applied to new and existing clients. Community partners and physicians were consulted and informed about the revised eligibility criteria and guidelines for services. Contracted homemaking service providers were required to shift to a narrower service offering which involved increased transportation costs as they served more clients within their allotted hours.

Referral levels for personal support and homemaking dropped during this period of expenditure control and continued to stay below previous baseline levels during the following year. In order to assess the impact of reduced service levels, the CCACWR conducted a study of caregiver burden before and after expenditure controls. The study found a statistically significant increase in the proportion of clients whose caregivers reported signs of increased stress or burden in their caregiving role.

During 2004-05 significant funding increases were allocated to CCAC budgets in keeping with the Federal Provincial Health Accord to address short term acute home care services aimed at shortening hospital length of stay or preventing acute care admissions. In 2005-06 increases were targeted to three provincial priorities: in home rehabilitation for post acute knee and hip replacement (part of the provincial Wait Time Strategy), acute hospital replacement care and End of Life care. The 2006-07 budgets again were targeted to acute home care, end of life care and hip and knee replacements. In the current year, additional funding was targeted to stabilizing the Personal Support Worker (PSW) workforce. While this was a worthwhile initiative, since Personal Support/Homemaking is the highest growth service of the CCACs, without additional funding for the increased volume of services each year, there will be a negative impact on the overall budgets of the CCACs.

These funding initiatives have been welcome for meeting the needs of clients targeted for these specific services. However this targeted approach does not address the increasing needs of the frail elderly population which will continue to grow in significant numbers, requiring higher levels of supports in home and/or in alternative supportive settings. This is further discussed in Section 5.1, under current gaps and issues.

The most recent change amalgamating the CCAC of WR and the CCAC of Wellington will present significant internal challenges as the new organization merges the systems, processes and organizational aspects of CCAC in home and placement services to residents within the Waterloo Wellington LHIN area.

3.2 Community Support Services

Toward 2006 reported service issues of the 34 Community Support organizations serving over 18,000 residents in Waterloo Region (20) and Wellington-Dufferin Counties (14).

Major issues reported by Community Support providers included:

- The changing nature of coordinating volunteer-provided services due to higher, more complex needs of frail elderly clients; smaller pools of volunteers; higher expectations of volunteers and needs of volunteers who are themselves aging.
- Challenges in meeting the needs of adults with physical disabilities with user-fee home support services originally designed for elderly clients.
- Demands for Home Help services to augment limitations in CCAC homemaking services; absence of Home Help in Wellington County.
- Needs for caregiver support in all forms, volunteer visiting, day programs, respite programs and specialized programs for clients with Alzheimer Disease
- Uneven availability of community supports across rural areas, especially Wellington County, and in particular transportation cost issues – increase in requests for transportation for post-hospital follow-up visits, increases in day surgery and the development of clinic services.
- The need for supportive housing for frail elderly was identified as a major service gap in Waterloo Region and in Wellington and Dufferin Counties, which have not had publicly-funded supportive housing programs for the elderly.
- The need for Palliative Care service planning to respond to the provincial Palliative Care Initiative.

Update

Despite some program development and new funding, pressures on the Community Support Services sector are growing faster than projected. Waiting lists are common for many services; volunteer recruitment and retention is changing as the nature of volunteers change; and the level of care required by clients has increased, especially in day programs for frail elderly and individuals with Alzheimer Disease. Detailed discussion follows in Chapter 5.

3.3 *LTC Homes*

The Toward 2006 report utilized population projections to estimate the future demand for LTC home beds and concluded that the 915 new beds that were being implemented in Waterloo Region (800) and Wellington County (115) would be helpful only in the short term due to the increasing numbers of elderly in the older age groups.

Update

By 2004, many of the LTC homes were operating at capacity with growing waiting lists. Currently the system is operating at over capacity in all areas of Waterloo Region and in the Guelph and south areas of Wellington County. The reasons for this overload in the LTC home sector are complex and are discussed in detail in Chapter 5.

3.4 *Directions - Toward 2006*

As mentioned in the introductory section, the Toward 2006 report was built upon the Multi-Year Plan which contained ongoing funding recommendations for the CCACs and the Community Support Services, based upon identified need. These recommendations were considered ongoing and therefore not repeated in the Toward 2006 report. The report did focus on directions to be taken in addressing the service issues that had been identified in the two years since the Multi-Year Plan. The directions were framed in three categories at varying stages of readiness. The intent was to submit proposals for funding service improvements. The categories are:

- Implementation planning for identified needs/gaps in service – activities and undertakings required to address identified needs by developing proposals and recommendations for funding that will allow projects to be implemented
- More research and documentation of need – the district-wide areas specifically flagged for further study in order to document needs and move forward in developing proposals and/or recommendations for funding support
- Monitoring and documenting the implications of changes across the health system – these are the service areas and issues that require ongoing work with community stakeholders and Ministry representatives to examine the outcomes of initiatives that have been implemented and to identify avenues for documentation of identified needs in order to provide information-based recommendations to the Ministry.

Summary of Toward 2006 Directions and Current Status of Directions

2002 Directions	Status as of 2006
(1) Implementation planning for identified needs/gaps in service (proposal development)	
Overseeing implementation of recommendations contained in the study of Service Needs of Persons with Acquired Brain Injury (ABI) including the development of a program proposal for the WRWD District	Providers in Waterloo and Wellington have received expansion funding for ABI services, however, a formal proposal for Waterloo Wellington has not yet been developed
Implementation planning for a coordinated children's rehabilitation system in Wellington and Dufferin which will enhance the children's service system across the district	Report of WD Children's Rehabilitation Services Committee completed in 2003
Implementation planning for a Specialized Geriatric Services model in Waterloo Region including the development of a proposal	Waterloo Region Specialized Geriatric Services (SGS) plan was completed in September 2002; The Program Funding Proposal for SGS in Waterloo Region was submitted to the MOHLTC in July 2003. The report was not approved for funding by Regional Office of MOHLTC
Implementation planning for the development of Home Help Community Support Services in Wellington County	Home Help services have recently been introduced in Wellington County as a result of CCAC and Community Support Services collaboration and MOHLTC support
(2) Areas for further research and documentation of need (DHC planning priorities)	
HIV/AIDS	
A Review of Palliative Care planning needs	An Overview of Palliative Care Issues in Waterloo Region-Wellington-Dufferin completed in June 2003 The Waterloo Wellington Dufferin Hospice Palliative Care Network, implemented in 2005 has become a LHIN-wide collaborative structure.
A needs assessment for Supportive Housing for Older Adults	A Needs Analysis for Supporting Housing for the Elderly in Waterloo Region, Wellington County & Dufferin County completed in January 2003
Needs of complex clients served by LTC and Mental Health systems in Wellington and Dufferin	A coordinated model of geriatric/psychogeriatric care was implemented through partnerships between Community Mental Health Clinic, St. Joseph's Health Centre-Guelph and the CCACWD

Summary of Toward 2006 Directions and Current Status of Directions (cont'd)

2002 Directions	Status as of 2006
3) Monitoring and documenting implications of change (ongoing planning)	
Provincial Alzheimer Strategy	Dementia Networks have been implemented in Waterloo and in Wellington since 2004 strengthening coordinated activities throughout Waterloo Wellington
Provincial Elder Abuse Strategy	Community Elder Abuse programs have been implemented in Waterloo and in Wellington
Children's health services Caregiver Support and Respite Needs Community Support, transportation, day programs, home help for elderly and support needs of adults with disabilities Low income barriers to service Multicultural barriers to service	With the closure of District Health Councils in April 2005, these directions were not formally addressed; however, the recent development of the WW Community Support Services Network is addressing service issues specifically for Day programs, Meals on Wheels, Transportation, Caregiver Support services and Attendant Services

3.5 *Summary Comments*

The Toward 2006 report was a consolidation and planning report, not an action report, and this is reflected in the foregoing review of the status of the directions it contained. Numerous funding proposals, planning activities and reports followed the directions contained in the report.

Notable gaps in follow up activities were:

- **The lack of follow up to develop proposals for Supportive Housing for the elderly.** With one exception, the Region of Waterloo Sunnyside Home, there have been no concerted efforts to develop programs in Waterloo and Wellington in partnership with affordable housing providers. The ROW Sunnyside proposal has received a capital allocation under the Federal-Provincial 'Strong Start' housing program, but has not received operational funding approval from the MOHLTC.
- **The lack of funding support for Waterloo Region Specialized Geriatric Services proposal** to develop a Region-wide integrated program of services linking community providers, LTC Home providers and hospital providers. The proposal was two years in the making and was a comprehensive, coordinated effort of community and hospital providers. Unfortunately, its potential value could not compete with its proposed cost when submitted to the Regional Office of the MOHLTC.

Notable successes in follow up activities were not necessarily as a result of reports and recommendations but rather as a result of the ongoing collaboration between service providers who continued to focus on improving services to consumers regardless of the success or failure of funding proposals. The development of networks dedicated to service system improvements has advanced the capacity of the Waterloo Wellington community to plan, coordinate and advocate changes to the system. These include:

- Dementia Networks in Waterloo and in Wellington-Dufferin. Supported by the provincial Alzheimer Strategy, the Psycho-Geriatric Resource Consultants in Waterloo and Wellington led the development of Dementia Networks during 2002-03. Each Dementia Network has its own work plan and goals specific to local needs, and the network coordinators have collaborated on a Waterloo Wellington basis since they began.
- Waterloo Wellington Community Support Services Network. With the assistance of MOHLTC project funding, Community Support Services (CSS) providers across Waterloo and Wellington have formed a network, conducted education and training sessions, developed work plans and engaged in planning activities directed at improving services in key areas such as: Day Programs, Attendant Services, Meals on Wheels, Transportation and Caregiver Support Services. In addition to these core activities, the CSS Network is participating in a joint research project with the University of Toronto to examine options for improving community in-home services by combining CCAC and Community Support Services with intensive case management. The study, named the Balance of Care project, is described later in this paper.
- Waterloo Wellington Dufferin Hospice Palliative Care Network. Networks in Waterloo Region and in Wellington-Dufferin Counties formed a LHIN-wide Hospice Palliative Care Network during 2005. The Network has developed its structures and created a community operating plan and priority list of initiatives that will be implemented across the area.
- Waterloo Wellington Geriatric Services Network (WW GSN). In September 2006, the WWSGSN was formed to create a mechanism that would provide leadership for relationship building, common goals and priorities and facilitating strategies to improve long-term care services across the WW LHIN area. The membership is inclusive of the entire continuum of health care which includes, by definition, linkages with each of the other Networks discussed above. The WWGSN has developed a Vision, Mission and Guiding Principles. In its inaugural forum, network members established strategic goals to be undertaken in the following areas: Quality and Best Practice, Continuum of Care strategies, Consumer Navigation and Awareness and Advocacy.

4.0 DEMOGRAPHIC UPDATE

4.1 Introduction

The focus of this section is to detail and to provide data related to the current population and the projected population growth Waterloo Region and Wellington County. As the focus of this paper is the elderly population, more detail about this group is provided. The Ontario Ministry of Finance undertakes to develop population projections on an annual basis using the most recent Census data available. The data used in this chapter are from the Ministry's 2006 report, which are projections from the 2001 Census.

4.2 Population 2001

Table 1 illustrates the 2001 Census for Waterloo Region and Wellington County by age group.

Table 1: Comparison with Ontario

Age Group	Waterloo Region		Wellington County		Ontario	
	n	%	n	%	n	%
0-19	124,589	27.3%	53,431	27.3%	3,067,397	25.8%
20-54	244,855	53.6%	101,900	52.0%	6,224,978	52.4%
55-64	37,741	8.3%	16,822	8.6%	1,090,367	9.2%
65-74	26,850	5.9%	13,548	6.9%	824,743	6.9%
75-84	17,471	3.8%	7,851	4.0%	511,811	4.3%
85+	5,261	1.2%	2,341	1.2%	155,140	1.3%
Total	456,767		195,893		11,874,436	

4.3 Population Growth: 2001-2016 for those 65 years and older.

Since the late 1970s, demographic projections have accurately predicted the major population aging trends in Canada. However, it is only since the 1990s that Waterloo Wellington, like many Ontario communities have experienced growth in both the total population and more specifically in the group that is 65 years and older. Using the 2001 census as a base, Table 2 illustrates the degree of significance in the elderly growth rate in Waterloo Region and Wellington County. For projection purposes, the chart shows five year growth rates to the year 2016 and percentage growth over 2001. Growth rate projections beyond 2016 indicate that these aging trends will continue to escalate. Since the reliability of these projections lessens over time, it will be important to update these population trends as census data become available.

Table 2: Growth Rate by Age Groups for Waterloo Region and Wellington County

Age Group	2001	2006		2011		2016	
	N	n	%	n	%	n	%
65-74	40,398	41,910	3.74%	50,090	24.0%	73,120	81.0%
75-84	25,322	30,210	19.3%	31,910	26.0%	34,200	35.0%
85+	7,602	9,500	25.0%	12,550	40.0%	13,920	83.0%

The average age for admission to a LTC Home is between 84 and 85 years old. Prior to admission to a Home, clients and their families often seek and utilize other services. Thus, with growth rates ranging from 19.3% to 25.0%, in the 75-84 age group and 85+ age group respectively, it would be expected that demand for CCAC services, for long-term care placement, and for community support services would grow at a similar rate. In subsequent sections of this report, the impact of this growth on services is described.

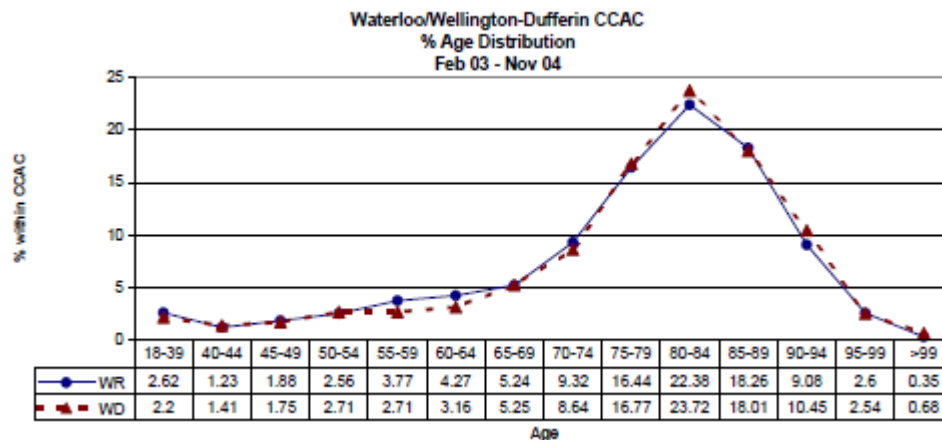
5.0 CURRENT CAPACITY, GAP ISSUES AND CHALLENGES

5.1 *Community Care Access Centres (CCACs)*

Chapter 3.1 of this report outlines the significant funding increases targeted at post acute care priorities and notes that these targeted resources do not address the needs of the frail elderly population. A profile of CCAC adult long stay clients (CCAC clients who are over 18 years and on service more than 60 days) provides useful information to better understand the needs of the frail elderly client population.

Data from the RAI-Home Care assessment instrument (a standardized assessment instrument mandated for use by all CCACs in Ontario) for the 18 month period from February 2003 to November 2004 provides a snapshot of the adult long-stay client population. The assessment data exclude paediatric clients and short stay clients many of whom would be part of the post-acute population.

Overview of Waterloo Wellington Adult, Long-Stay Clients



Age of adult, long-stay CCAC clients

- *Eighty-five percent (85%) of adult long stay clients are over the age of 65 years (Waterloo 84%; Wellington 86%)*
- *Half of adult long stay clients are over 80 years of age (Waterloo 53%; Wellington 55%)*

Co-morbidities of adult, long stay CCAC clients

More than half of the adult, long stay clients in Waterloo Wellington have more than one disease (co-morbidity); Waterloo 53.5% and Wellington 48.1%). The following table lists 29 disease or diagnostic categories which identifies two important pieces of information collected in initial client assessments: (1) the presence of a disease or condition and (2) whether or not CCAC services are provided for that condition.

For example, while approximately 13% of Waterloo clients had a previous CVA/Stroke, only 6% of those clients were receiving CCAC services for reasons directly related to the diagnosis. Similarly, in Wellington, 16% of clients had a previous CVA/Stroke, but only 3% of these clients were receiving services specifically related to that condition.

Overview

CCACs adult, long stay client population, February 2003 – November 2004

Disease/Diagnoses	Waterloo	CCAC	Wellington	CCAC
Description	No direct service	Direct service	No direct service	Direct service
CVA/Stroke	13.47	5.83	16.15	3.16
Congestive Heart Fail.	6.65	4.87	10.84	2.2
Coronary Artery Dis.	16.53	8.15	15.3	2.03
Hypertension	31.43	14.69	38.96	5.25
Irregular Pulse	5.46	1.75	8.02	1.13
Peripheral Vascular Disease	4.05	2.77	6.55	2.32
Alzheimer's	3.83	3.55	4.63	1.19
Dementia not AD	6.54	3.49	9.88	1.86
Head Trauma	0.84	0.41	1.13	0.51
Hemiplegia	1.43	1.08	3.06	0.79
Multiple Sclerosis	0.56	1.62	0.9	1.58
Parkinsonism	2.1	2.1	5.19	1.02
Arthritis	31.91	15.51	47.37	4.69
Hip Fracture	2.32	1.69	2.15	1.02
Other Fractures	4.25	3.77	5.14	1.47
Osteoporosis	13.56	6.63	18.58	1.86
Cataract	13.24	2.17	16.83	1.02
Glaucoma	3.57	1.52	6.55	0.4
Psych Diagnosis	7.86	4.72	9.54	2.03
HIV Infection	0.06	0	0	0.06
Pneumonia	1.26	0.69	1.64	0.51
Tuberculosis	0.17	0.02	0	0
Urinary tract infection	2.27	1.36	3.22	0.62
Cancer	7.34	5.24	7.51	3.27
Diabetes	12.33	8.75	15.13	3.33
Emphysema/COPD	10.79	5.55	12.08	2.43
Renal Failure	2.21	1.62	2.37	0.68
Thyroid Disease	8.43	3.34	10.5	0.73
None of the above	2.84		2.88	

While this information does not identify how many diseases individuals are living with, it does provide insight into the many age-related conditions and diseases associated with an aging population which may or may not be directly linked with CCAC services. It is noteworthy that the patterns of these multiple conditions are very similar in Waterloo and Wellington. These represent the frail elderly clients whose ongoing needs are likely going to increase over time.

The CCACs utilize standardized assessment tools with which to identify client service needs. The service capacity of CCACs however, is constrained by both fiscal constraints as well as Ministry Regulation under the Long-Term Care Act. For example, under Regulation, eligibility for receiving assistance with homemaking through the CCAC is

directly tied to the assessed need for assistance with personal care. While this eligibility criterion helps in the allocation of the most significant portion of the CCAC service budget, it does not fully address the needs of the frail elderly client population. Balancing the pressures to respond to services needs with the pressure to balance the budget is an ongoing challenge for CCACs.

Summary Comments

More than 80% of adult, long stay CCAC clients are over the age of 65 years, with more than half of them over 80 years of age. Many of these clients fit the profile of the frail elderly population that is referred to throughout this report; as hospital patients, community service clients and/or LTC home residents. This is the population who, along with their caregivers may be facing difficult decisions about what to do when they can no longer manage living in their home in the community. Those without family and social supports whose needs exceed the current capacity of CCAC supports are at risk of institutionalization. Family supports and informal caregivers caring for people with high needs are at increased risk of caregiver burnout, resulting in the need for institutionalization of the care recipient. The growing number of individuals whose combined CCAC services and informal supports no longer meet their needs highlights the increasing urgency for *reviewing long term care housing alternatives*.

The nature of the role CCACs play in the health system is one in which they are linked to acute care, long-term care and community services. Acute hospital patients are referred to CCACs for post-acute care for services ranging from post surgical to palliative care. CCACs are responsible for a range of in-home professional and support services, placement into all long-term care homes and for access to community day programs. Due to their pivotal role linking community and institutional services, when one of the other sectors experience a crisis, CCACs are frequently asked to participate in helping to mitigate it.

Much of the current challenges in health care can be linked to the aging of the population. There are more elderly people and their families are seeking help from the health care system. For CCAC this means that there are greater numbers of new referrals, that existing clients need more service to prevent hospitalization, acute hospitals are referring more patients for post acute services, and those waiting longer for LTC Home beds require more services while they wait. While the CCACs have received more funds to serve the post-acute population, their referrals have already exceeded the assigned targets. Consequently, CCACs face the choice between providing adequate service levels resulting in an operating deficit or staying on budget, but providing less service to individuals which could result in an increased number of ER visits and admissions to acute care.

The increase in the number of hospital referrals and a provincial focus on acute care has had a significant impact upon CCAC case management services. The need for a rapid response to hospital referrals in order to move patients quickly through the system and the pressure to move ALC patients quickly to LTC Homes has increased hospital staffing requirements. At the same time with increasingly complex referrals, the need to develop comprehensive service plans with clients and their families has intensified over time. The long waiting lists for LTC Homes are indicators of families having difficulty coping with caregiving responsibilities that require additional assistance from CCAC. Where clients do not have family members willing or able to act on their behalf, Case Managers are

increasingly dealing with the Office of the Public Guardian and Trustee and the Consent and Capacity Board.

As indicated above, efforts to alleviate pressures on acute care beds which include addressing the new provincial health care priorities from shortened surgical waiting times, to end-of-life care and accelerating transfers to long-term care, have resulted in increased workload and service demands for CCACs. Both the CCACs of Waterloo Region and Wellington-Dufferin have received significant budget increases to expand services to the priority groups, but expanding a mandate is much more than simply providing additional funds.

In addition to the impact on case management, service provider organizations also experienced significant challenges. In addition to recruiting and retaining adequate numbers of trained nurses, rehabilitation professionals and personal support workers to meet the growing service needs, these organizations are also finding it extremely challenging to respond on short notice to intensive service needs. As is the case with most other health care providers, efficiency demands do not allow the extra staffing levels that are now frequently required. The human resources challenges are not a new phenomenon and have been an issue for some time. The current demand simply magnifies the challenges.

5.2 *Community Support Services*

In 2002-03, Community Support Services agencies provided services to 22,000 clients, most of whom were elderly. As of 2005-06, 24,600 clients received one or more of these services, a 12% increase.

In response to an information survey, 11 community support agencies provided information concerning the changes in client needs, volunteers and service issues that had occurred since 2002. Most agencies reported having received expansion funding and enhancement funding in the interim since 2002, and serving increasing numbers of clients each year. Following are the sector totals provided by the MOHLTC Regional Office:

Overview of Community Support Services funding and client totals, 2002 and 2006

	2002-03		2005-06	
Waterloo Region	\$10,679,987	15,337 clients	\$12,760,268	17,176 clients
Wellington-Dufferin	4,526,230	6,734 clients	6,110,068	7,425 clients
Total	\$15,206,217	22,071 clients	\$18,870,336	24,591 clients

It is important to note that these figures represent a wide range of service organizations: most are small, volunteer-based agencies; some are professionally staffed day programs and respite programs; and several are programs using only paid attendant staff, e.g., for Supportive Housing and Outreach services for adults with physical disabilities.

The following are areas cited as major issues:

Waiting lists are much more common than they were in 2002 and wait times are increasing. Some services such as Alzheimer weekend respite are now limited to one weekend per month in an effort to allow space for new clients.

Client acuity has increased dramatically since 2002. In addition to serving more clients and older frail elderly clients each year, providers commented on the higher, more complex physical, cognitive and mental health needs of elderly clients, including: multiple diagnoses and conditions, mental health diagnoses, difficult behaviours, Alzheimer Disease, Developmental Disability, coupled with chronic conditions e.g., arthritis, diabetes.

Day programs and overnight respite programs are serving people with complex combinations of diagnoses/conditions including: colostomy, catheter, oxygen, diabetes injections, and infections/skin care.

Service changes resulting from serving increasingly frail clients include: more 1-1 assistance with mobility, reminders about service, repeat calls, and more caregiver stress/conflict resolution, and

More behaviour-related incidents are occurring, requiring staff intervention and management.

5.2.1 Community Support Volunteer Recruitment and Retention

The Toward 2006 report documented numerous challenges to the volunteer sector in terms of recruiting and retaining volunteers. **Provider comments confirm the report's projections for ongoing and/or increasing challenges** in obtaining and keeping volunteers in terms of:

- Increasing competition for volunteers
- Few volunteers interested in evening/weekend volunteering
- More volunteers with expectations concerning specific geographic area, type of client
- Volunteers who are unavailable in winter months due to travel plans
- Few volunteers willing to do outside maintenance, e.g., snow shoveling
- Fewer new volunteers having long-term commitment than volunteers had in the past
- Many of the current long-term volunteers are aging in place and becoming clients in the very service that they volunteered for
- More volunteers are students fulfilling educational or resume requirements, not able to commit beyond original arrangement
- Difficult to recruit volunteers who speak languages other than English
- One agency is receiving volunteers who need a sheltered work setting and have their own need for supervision

5.2.2 Gaps in Needed Services

Gaps in needed services identified by survey respondents included the following:

- Comprehensive or intensive case management of all community services for high needs older adults and frail elderly clients
- One-stop geriatric/psycho-geriatric case management (from assessment through treatment and follow up); clients currently going to London or Toronto for some of these services

- Supportive Housing for low income seniors
- In-home support post hospital discharge (e.g., transportation, shopping)
- Mental health and addiction services
- Day Programs for Adults with ABI
- Day Programs for Adults with Developmental Disabilities
- More services for younger Alzheimer clients (35 – 50) and their families, including advocacy and family support, and
- Financial subsidy program to assist low income seniors pay user fees for home supports and not shorten or discontinue their services for financial reasons.
- Overnight respite for Dementia clients in Wellington
- Transitional services for youth at 19, entering adult system

5.2.3 Summary Comments

The issues cited by Community Support providers indicate an escalation in the pressures of increased client needs and volunteer recruitment and retention challenges. The changes reported by providers suggest that the needs of many clients are on the verge of exceeding CSS capabilities. This is evidenced by providers' descriptions of complex physical, cognitive and mental health needs of clients, their referrals to higher levels of services and their perspective on additional services needed in the community.

5.3 LTC Homes

The 1998 provincial LTC home expansion was implemented by 2005, bringing approximately 800 new beds to Waterloo Region and 115 new beds to Wellington County (Guelph). These new beds filled very quickly and, since 2004, there have been long waiting lists for facility care throughout Waterloo Region and in the Guelph area of Wellington.

It is important to understand the types of LTC beds that are available. LTC homes are allowed to operate up to 60% of their beds as preferred beds (extra costs for semi private or private rooms), which provides income for the home's operations. Older homes do not have the structure to support 60% as preferred beds. As a result, these older homes do accommodate more residents in lower cost basic beds. In Waterloo Region, the breakdown is 46% basic and 54% preferred. In Wellington County, the breakdown is 49% basic and 51% preferred.

It is also important to understand the order of priority for being admitted to LTC homes. Following is a summary of the provincial prioritization criteria for admission to LTC homes which was most recently updated in September 2004 to include the spousal reunification criteria.

Category 1A (highest category, placed first)

- Crisis placement – must agree to take next available bed in their chosen homes
- In hospital, psychiatric facility or LTC bed for whom within 6 weeks there will be no bed as a result of temporary or permanent closure due to emergency or redevelopment

Category 1A1

Spousal reunification – spouse who becomes eligible for LTC care may join spouse who is already in LTC care

Category 2

- In public, private, psychiatric hospital
- In LTC home and will become homeless within 16 weeks as a result of temporary or permanent closure of all or some of the beds in the home
- In LTC home and will be discharged due to inability of home to provide secure environment; or due to the person's absence for the purpose of receiving medical or psychiatric care
- Spousal reunification – spouse who wishes to join eligible spouse in the same LTC home but who does not have care needs of his/her own
- Person resides in a LTC home and is waiting to move to the LTC home of his/her first choice
- In community* with caregiver and/or other supports and requires admission within three months because of client's condition or circumstances or because of risk to health and wellbeing of caregiver

Category 3

- In LTC home, wanting to move to another LTC home but not currently on a wait list
- In community* with caregiver and/or other supports but does not require admission within next three months as services are adequate to meet needs.

* *It should be noted that the term community includes people currently residing in Rest & Retirement Homes.*

5.3.1 Waterloo Region LTC Homes

As noted earlier, Waterloo Region has 2,559 LTC Home beds which have been operating at 98-99% occupancy since April 2004: 1,168 (46%) of these are basic and 1,391 (54%) are preferred.

Over 1,000 of these LTC beds become available each year due to the advanced age at which people are entering LTC homes. However, 70% of these bed openings are preferred accommodation with only approximately 30% being basic beds, a very different ratio than the actual distribution of beds outlined above.

One reason for the lower numbers of basic bed openings is because some residents initially accessing private/preferred beds apply for a basic bed in the same home after admission when costs become an issue for them. When a basic bed becomes available in that home, it is an internal decision to offer it to a current resident. These internal transfers from preferred to basic accommodation do not involve CCAC placement services nor are records maintained to determine aggregates. This issue has been discussed in meetings between the CCAC and the LTC home representatives who recognize the dilemma for people waiting in the community for basic accommodation who cannot afford to access preferred beds, but also need to support the needs of their residents. Some homes alternate between offering a vacant basic bed to an internal resident and then to a client on the CCAC waiting list. While this cooperation is helpful, the overall waiting list situation continues to escalate, as illustrated in the following

tables. In Waterloo Region during 2005-06 there were 63 Crisis placements from the community to LTC; during 2006-07 there have been 61 Crisis placements to date. Waterloo Region hospitals have a discharge policy which results in a significant number of placements in homes where there are short wait lists resulting in high numbers of people waiting for their first choice home.

**2005/06 – Waterloo LTC Home Waiting List
by Location Waiting**

Month/Year	Community	Hospital	OOB	1st Bed LTCH	Totals
Apr-05	285	21	35	354	695
May-05	284	38	32	362	716
Jun-05	285	32	50	325	692
Jul-05	310	36	54	288	688
Aug-05	338	47	64	397	846
Sept-05	357	41	58	382	838
Oct-05	361	31	52	367	811
Nov-05	366	34	71	343	814
Dec-05	378	33	73	330	814
Jan-06	373	29	66	330	798
Feb-06	370	32	69	333	804
Mar-06	311	52	61	341	765

Note:

- ★ OOR = Out of Region
- ★ 1st Bed LTCH = residents in LTC awaiting their preferred choice of home
- ★ These data only include people whose applications have been accepted by LTC Home

**2006/07 Waterloo LTC Home Waiting List
by Location Waiting**

Month/Year	Community	Hospital	OOB	1st Bed LTCH	Totals
Apr-06	358	56	69	346	829
May-06	398	64	73	355	890
Jun-06	414	63	84	345	906
Jul-06	455	59	93	346	953
Aug-06	481	63	81	351	976
Sep-06	507	63	96	356	1022
Oct-06	539	60	107	368	1074
Nov-06	558	44	114	386	1102

Note:

- ★ OOR = Out of Region
- ★ 1st Bed LTCH = residents in LTC awaiting their preferred choice of home
- ★ These data only include people whose applications have been accepted by LTC Home

5.3.2 Wellington County LTC Homes

From a LTC home placement perspective, the situation in Wellington County is very different when comparing the City of Guelph with Centre and North Wellington. Guelph homes have considerable wait lists while there are vacant beds in Centre and North Wellington. Wait times for admission to homes in Guelph and area, especially for basic accommodation, can be several years.

The central and northern part of the community benefited from the redevelopment of the Wellington Terrace home which has been rebuilt outside of Elora. The remaining homes in the area are older homes with less modern accommodations. As result there are approximately 18 bed vacancies in Centre and North Wellington at any given time. Guelph General Hospital has a discharge policy that results in almost all of its LTC-destined patients being directed to LTC homes in Centre and North Wellington where there are vacancies. As a result there always people in these homes that are awaiting transfer to the home of their choice which is less than ideal for the residents, their families or the LTC homes.

CCAC of Wellington-Dufferin LTC placement waiting list has grown from 505 in 2003-04 to 612 as of October 2006. Of the 612 people currently on the LTC waiting list, 138 are awaiting transfer to their choice of home, 398 are waiting at home in the community (which includes Rest and Retirement Homes), 24 are waiting in hospital and 46 are waiting out of the area.

The placement challenges also include finding beds for those with special needs. Generally, those with special needs require higher levels of care beyond the care funded in the homes with available space. As a result, people with special needs are directed out of the area or to shorter-term homes to treat these problems as if they were short term. Homewood, the local mental health facility, does admit a significant number of frail elderly with cognitive and behavioral problems, but this is a time-limited service and upon discharge, patients' needs may still be too high to find appropriate placement in a LTC home.

5.3.3 Summary of LTC Home Issues

Respite Care and Convalescent Care beds are in short supply. The need for admission to a LTC home may result from a number of circumstances. Often, with appropriate community services, some admissions can be delayed. Respite services offer one means for families to get the necessary break from caregiving to enable caregiving to continue. In the absence of the respite, some families lose the ability and the desire to continue. There are not sufficient numbers of respite beds in Waterloo Wellington. The demand significantly exceeds the supply and some families reserve spaces up to two years in advance.

Waterloo Region has eight (8) respite beds located in various LTC homes. Wellington has five (5) respite beds. Waterloo has the Alzheimer Weekend Respite program but Wellington has no equivalent. Providers from both Waterloo and Wellington indicated that there are insufficient respite options for families who are caring for a relative with dementia.

The addition of 10 MOHLTC-funded Convalescent Care beds at Sunnyside Home in

Kitchener has been an important service addition which facilitates the return home of elderly patients. While eligibility for these beds is not limited to people living in Waterloo Region, geography can be a barrier. Wellington does not have any convalescent beds and, to date, funding proposals to develop convalescent care beds have been unsuccessful.

Ongoing Access Issues

The vacancy rate in Waterloo Region and the City of Guelph and area is virtually non-existent with long waiting lists at most homes. The increased demand for LTC beds and the current practice of prioritizing those waiting for placement has resulted in very limited access to some home for those in category three.

The fact that preferred and basic beds are at capacity is more a reflection of need rather than ability to pay. As a result of the long waiting list, but higher turnover of preferred beds, some families pay the additional costs for preferred accommodation to gain more timely access to a bed in their home of choice. In some cases, residents then apply to have their accommodation changed once admitted, although there can be a significant wait time before the accommodation level can be changed. This contributes to the reduced number of basic beds that become available to people waiting outside the home.

As clients' needs change, they may be placed higher on the priority list. However because of the large numbers of clients eligible and waiting for placement on an ongoing basis, spaces that do become available are for the most part accessed by clients in crises situations and by those who are deemed a category two in the hospital and in the community. Those community clients defined as Category 3 (managing with supports in the community) and waiting for a basic bed may have very long waits unless they choose one of a few homes with a shorter wait list, or their condition changes altering their priority designation.

Last but not least, throughout Waterloo and Wellington there are a significant number of residents in LTC homes who are awaiting a bed in the home of their choice, which presents challenges at all levels. Challenges include relocation adjustment issues for residents, especially those who have dementia and/or mental health issues, and for families who may visit frequency may be affected by transportation barriers. There are challenges for staff in the homes related to the turnover of interim placed clients.

Barriers to Access

Clients who have special needs face additional difficulties in finding appropriate LTC home accommodation:

- Deinstitutionalization of services for older adults with developmental disabilities as well as chronic physical health conditions eliminated the institutional placements that provided custodial care for individuals during the latter part of their lives. The community-based systems that were developed to replace these services have supported these individuals throughout their adulthood. These service systems have not as yet evolved to address the unique challenges of these groups, respectively, in their elder years. As a result, long-term care homes have become the only available source to serve multiple needs of these populations. The funding base and the training of personnel for the LTC homes do not recognize the impact of serving

these populations. The Ministries of Health and Long-Term Care and Community and Social Services are currently working together to develop protocols that will allow these clients to be placed in LTC homes with additional supports appropriate to their special needs.

- Aging clients with mental health conditions and with complex medical needs, are difficult to serve and homes frequently do not have expertise of the staffing resources to care for them. The combination of mental health problems and complex medical conditions requires higher service levels and mental health expertise. While most mental health clients are elderly, some are considerably younger than the average LTC residents. Many clients are also aggressive and in the absence of higher staffing ratios and specialized funding, serving these individuals in a LTC home results in redirecting limited resources from other clients. In addition, in some situations those with dementia/Alzheimer's Disease may also display aggressive and difficult-to-control behaviour. As a result, most homes are reluctant to admit people with these characteristics.
- Aging, physically disabled clients are requiring LTC home care. The availability of community attendant care and supportive housing has enabled many young adults with 24 hour care needs to live either with family or independently in the community. With aging, comes the loss of parental or family support, and often an increase in the severity of their chronic health conditions. When this occurs living in the community is no longer an option. Admission to a LTC home, which has neither the funding, nor the expertise to serve this population, offers another serious challenge to particular homes and to the health system in general.
- People who are exhibiting potentially dangerous behaviours that could put themselves or others around them at risk, face major barriers to accessing LTC home care. Whatever the underlying cause is – mental health diagnoses, severe dementia, acquired brain injury – these consumers are the most difficult to place. When problems occur requiring hospital care, some of these patients are not able to return to their prior home location. Recent research has identified high-risk behaviour as the most significant factor working against placement in LTC homes.
- End-of-Life (palliative) care is needed in all LTC homes. LTC Home funding and staff practices in many homes have not as yet benefited from the new developments in the end-of-life care. Also, new funding for end-of-life care has not been directed to LTC homes. With so many very frail and elderly being admitted to homes, new end-of-life strategies and practices need to be introduced into all LTC homes.

In summary, the major LTC system challenges to be addressed are:

- lack of beds availability in Waterloo Region and Guelph and area
- LTC home placement far away from family
- staffing and funding limitations of LTC homes to serve people with special needs
- a perpetually high number of people waiting for LTC home care in inappropriate settings, particularly acute care hospitals

5.4 Complex Continuing Care (CCC)

There are 252 Complex Continuing Care beds in Waterloo Wellington, 162 in Waterloo Region and 90 in Wellington County. The table below details the distribution of beds by hospital site.

Overview of Complex Continuing Care in Waterloo Wellington						
	Freeport - Grand River Hospital	Cambridge Memorial Hospital	St .Joseph's Health Centre Guelph	Groves Memorial	N.Wellington Louise Marshall	N.Wellington Palmerston
# of CCC beds	124	38	64	18	4	5
CCC programs	15 Neuro-behavioural 17 Geriatric Assessment 15 Palliative 13 Non Cancer Palliative/ Complex Medical 64 Slow Stream (Geriatric) Rehab (Functional Enhancement Unit)	32 CCC 6 ALC (Alternative Level of Care and Palliative)	64 CCC which includes • 4 Palliative • 1 Respite	18 CCC	4 CCC	5 CCC
Additional beds	32 longer term rehab					
CCC Waiting lists/times	Variable - Neuro-behavioural, Geriatric assessment, Palliative are high demand services	Yes, in all programs	Variable - Up to a year for CCC, less for Palliative			
Backup pressures in Acute Care?	Yes GRH-K-W SMGH	Yes CMH acute	Yes Guelph General Hospital	No	No	No
ALC for LTC Apr – Nov 06	2990 days	See acute table 5.5.1	197 days			

Most CCC contacts referred to the fluctuation in demand that can occur in complex Continuing Care. St. Joseph's Health Centre-Guelph has experienced an occasion when there was no waiting list and on another occasion a client waited for almost a year to be admitted to a specific CCC program or unit. When CCC beds are operating at capacity, inaccessibility contributes to the backlog at referring acute care hospitals in all the urban centres in the region and county.

Palliative Care services do not fare well under the MDS funding formula which regulates the funding for Complex Continuing Care. Palliative patients are recorded as relatively low in acuity yet they require high levels of care, which translates into insufficient funding for the level of care being provided. This puts pressures for efficiency on hospital sites with significant numbers of palliative beds such as Freeport, which forms part of the global funding for Grand River Hospital Corporation. Within the past month, 15 beds have been closed in Freeport's Complex Medical/Non Cancer Palliative unit.

While none of the programs have been designated as "Regional" resources, Freeport has evolved to become a resource to individuals residing across the Waterloo Wellington area due to its capacity. GRH K-W site and St. Mary's General Hospital refer patients to Freeport on a regular basis. Groves Memorial Community Hospital refers high needs patients to Freeport. North Wellington Hospital Corporation – Louise Marshall site refers high need patients to Freeport; while the Palmerston site may refer to Freeport or to Listowel depending upon where the patient resides. Guelph General Hospital refers to Freeport but some patients prefer to wait for a bed at St. Joseph's Health Centre-Guelph, because it is closer to family and home.

Historically Cambridge Memorial Hospital has referred few patients to Freeport, citing limited accessibility to its programs. Since the criteria for admission to Freeport does not differentiate between referral sources, it remains unclear why referrals from Cambridge are lower than from K-W, Guelph and Wellington hospitals.

Community providers accessing complex continuing care in Waterloo Region are of the opinion that the number of beds in the Region is far short of the need. They state that admission criteria are difficult to meet for admission and people with relatively high levels of continuing complex care needs are sent to nursing homes. LTC homes find it difficult to meet the needs of this group of patients. The need for more chronic ventilator care has been noted.

Freeport representatives indicated that the work of the WW Rehabilitation Committee has identified that the system would benefit from a more comprehensive analysis of its utilization data. The findings of the committee suggests that there would be great value in identifying common utilization indicators across the LHIN area to ensure that Freeport programming decisions are based on facts that are inclusive of the system as a whole. Without accurate information about Freeport's utilization across the LHIN, a future decision to close more of the beds at Freeport could result in less availability of beds across the Waterloo Wellington area at a time when the need for LHIN-wide system integration is at its highest. In discussing these findings, the WW LTC Planning Project Steering Committee expressed concern that these programs should be evaluated on their own merit and not be negatively impacted by changes in the acute site.

5.4.1 Summary Comments

This brief overview of Complex Continuing Care in Waterloo Wellington confirms the role of CCC programs and services in providing a key level of care between hospital acute care and community-based care. While community providers access Complex Continuing Care, it is the acute care hospitals that are most dependent upon these services in order to maintain their focus on short-term acute care. When CCC hospitals/units are at capacity, there is pressure on the acute system, notably Grand River Hospital – K-W site, St. Mary’s General Hospital, Cambridge Memorial Hospital, and Guelph General Hospital. This would include Alternative Level of Care patients in acute hospitals who could also benefit from geriatric rehabilitation. For purposes of this report, the recommendation that Freeport’s utilization data be examined from a LHIN-wide perspective is an important component of planning for future CCC and geriatric needs across Waterloo Wellington. Equally important is the work of representatives from all Complex Continuing Care hospitals in the LHIN area who are currently working together in the Waterloo Wellington Rehabilitation Committee to expand the focus on geriatric rehabilitation services throughout Waterloo Wellington.

5.5 Acute Care Hospitals

5.5.1 Current Pressures

Acute hospital care is increasingly becoming geriatric care as a result of the large numbers of elderly patients being admitted. While rural hospitals have high demands on emergency services, the interplay between acute care and long-term care is most evident in urban hospitals.

Information from Guelph General Hospital, Grand River Hospital-K-W site, St. Mary’s General Hospital and Cambridge Memorial Hospital illustrates the dual challenges in acute care: high volumes of Emergency Department (ED) admissions and high numbers of patients no longer requiring acute care, waiting for discharge to Alternative Levels of Care (ALC).

The following table indicates that all four hospitals are experiencing capacity issues. It should be noted that the information reported in the table is for different time periods during 2006. Therefore the table is useful for illustrative purposes only, not comparative purposes.

There are insufficient numbers of available acute care beds to address the number of patients requiring admission in the Emergency Departments (ED). These pressures are either expressed in terms of patient days spent waiting in ED for a bed or by the numbers of unfunded beds that hospitals open to address the problem. In order to alleviate the pressure in EDs and maintain their core services, hospitals are either opening Over Plan (Unfunded) Beds or admit patients to beds Off Service, meaning that they find beds in units not organized to meet their particular need.

The consistently high number of ALC patients in all four hospitals exacerbates the ongoing inpatient bed shortage. Many of these ALC patients are high need elderly residents who are assessed and waiting for access to a LTC home.

Overview of Pressures on Urban Acute Care Hospitals				
	Cambridge Memorial Hospital	Grand River Hospital – K-W site	St. Mary’s General Hospital	Guelph General Hospital
# Acute Beds	162	329	160	181
Daily Avg. # of Admitted Patients Waiting in ED for Bed	Apr – Sep 2006 0	Jun – Oct 2006 51	Oct – Nov 2006 49	Apr – Sep 2006 14
Total Patient Days in ED	0	173	398 (Meditech)	496 (using Meditech midnight #s)
Monthly Avg. Patient Days Over Plan (unfunded beds)	218	302	183	In process of implementing overflow beds for over-capacity times
Monthly Avg. Off Service Days	75	58		Should be reduced by above
Total ALC Patients	Apr – Nov 06 222	Apr – Nov 06 318	Apr – Sep 2006 108	Jun – Oct. 2006 325
No. ALC Days	3326	6224	2029	2025
No. of ALC LTC Patients	Majority of ALC	126	24	47
No. of ALC LTC Patient Days	Majority of ALC	3694	874	376

Waterloo Region hospitals have a discharge policy whereby ALC patients must choose at least 1 home with a short waiting list. When ALC clients are referred to the CCAC for placement, every effort is made to locate an appropriate bed as close to the patient’s home as possible. However, in many cases, given the 80 km radius policy for finding a home, the location found is less than ideal for the patient and his/her family. The hospitals and the CCAC have agreed not to enforce the discharge policy in cases where it would negatively impact a patient, e.g., having an elderly spouse who could not possibly visit the proposed location. However, if a patient has family members living in another community, beds in that area will be explored with the client and family. This has resulted in some local ALC patients being placed in other communities.

CCAC placement services are pivotal in making the best of this less than ideal situation. By working with hospital personnel, a plan of action can often be worked out that will allow a CCAC to search for beds outside the home area while respecting the client’s need to be close to family. The practice of reviewing out-of-area bed vacancies using vacancy lists that are posted by CCACs, is common across the province.

Guelph General Hospital is experiencing similar pressures in its ED to Waterloo Region hospitals and has high ALC numbers and days. However, of the total of 2025 ALC bed days between June and October 2006, only 376 were for patients waiting for LTC home placement, and the average wait for these patients was 8 days. The remaining ALC patients were designated for home care with CCAC, Complex Continuing Care at St. Joseph's, Freeport or Groves, Functional Enhancement at Freeport, Long Term Rehab at Freeport or St. Joseph's, Palliative care at Freeport and/or St. Joseph's, Rest and Retirement Homes and for short term rehab at St. Joseph's. The average wait times for non-LTC designated ALC patients ranged from 3 days for CCAC in-home services to 33 days for Complex Continuing Care.

Representatives from Guelph General Hospital (GGH) made it clear that while the average wait for LTC home placement is 8 days, there are often exceptions, especially when ALC patients have behavioural issues that cannot be addressed in a LTC home. When this occurs, patients can and have waited months at GGH before appropriate placement is found.

Guelph General Hospital's discharge policy often results in ALC patients being accepted into LTC homes in Centre and North Wellington, where there are vacancies. While this addresses some of the ALC issues for Guelph General Hospital, staff are very aware of the difficulties this places on the families, particularly when the main caregiver is an elderly spouse with no means of transportation to the LTC home.

5.5.2 Summary Comments

Despite the best efforts of hospital discharge planners and CCAC placement staff, the length of ALC stay in hospital will be longer for people with special needs that cannot be met in LTC homes, including those homes that have available beds. These issues are discussed in more detail in the LTC Home section of this chapter.

5.6 Specialized Geriatric Services – Mental Health/Geriatric Psychiatry

Meeting the mental health needs of older adults with complex physical conditions requires the expertise of geriatricians and geriatric psychiatrists working together. These services are referred to as Specialized Geriatric Services. Following is an overview of Psycho-geriatric and Specialized Geriatric Services in Waterloo Region and Wellington County.

5.6.1 Waterloo Region

Waterloo Region does not have psycho-geriatric beds. Residents requiring this level of care are referred to St. Joseph's Health Care-London (formerly London Psychiatric Hospital) or the psychiatric unit at GRH – K-W site. The Neurobehavioural Unit at GRH-Freeport is utilized for assessment of LTC residents. Plans for longer term mental health beds and psycho-geriatric beds at GRH - Freeport site have been underway since the recommendations of the Health Services Restructuring Commission in 2000. Current plans are for 50 longer term mental health beds. Of those beds, 11 will be designated

psycho-geriatric beds and services will include a small day hospital. Construction is slated to commence in the summer of 2007 and be completed by the fall of 2009.

Waterloo Region residents access community-based geriatric/psycho-geriatric services through two models of service:

Cambridge and area

Cambridge Memorial Hospital's Seniors' Health Services includes five services:

1. Seniors Health Clinic (Geriatrician, Nurse Clinician, Social Worker, CCAC [OT, PT])
 - Memory Clinic
 - Falls Clinic
 - Medical Consultation
2. Outreach Geriatric Services (to LTC homes in Cambridge, working with CCAC Psychogeriatric Resource Consultants)
3. In-patient Geriatric Consult Team
4. Geriatric ER Management Team (Geriatrician, Nurse Clinician)
5. Seniors' Mental Health Clinic (Geriatric Psychiatrist, Social Worker and Psycho-geriatric Nurse)

It should be noted that this full range of programs is primarily delivered by one full-time geriatrician, one full-time nurse clinician, one part-time Geriatric Psychiatrist, one Psycho-geriatric Nurse and a part-time Social Worker, with clinical services such as OT and PT provided through the CCACWR.

Kitchener-Waterloo and area

Community Geriatric Services (CGS) is a partnership between the CCACWR and Grand River Hospital. This partnership is not funded as a dedicated program with mental health funding, as is the Wellington model. CGS operates as an outreach assessment and short-term intervention team, providing multi-disciplinary service to residents of Kitchener, Waterloo and the Townships. Referrals are made through CCAC intake and require a physician referral.

- CCACWR provides 1 FTE Case Manager, 1 FTE administrative support, as well as 2 specialized visiting Nurse Assessors, Occupational Therapy and Social Work services through contracted provider agencies.
- GRH provides client and team consultation with a Psychologist and Geriatric Psychiatrists who also provide clinics at LTC homes in the K-W and surrounding area (working with CCAC Psychogeriatric Resource Consultants)
- Freeport operates a Geriatric Assessment Unit (GAU) and a Neuro-behavioural Unit. Geriatric rehabilitation is also provided at Freeport.
- Geriatric expertise is also available through two geriatricians at St. Mary's General Hospital who offer outreach clinics.

Community Geriatric Services (CGS) has not been in a position to expand to meet the growing demand for consultation. This is primarily due to inability to access Geriatrician expertise for patient and team consultation on a sustainable basis. There have also been

challenges in recruiting nurses with specialized geriatric and psychogeriatric nursing expertise. Because GRH has experienced significant difficulties in recruitment and retention of Geriatrician expertise, the CGS service currently focuses primarily on the psychogeriatric population.

Through the provincial Alzheimer Strategy in 2001-02, the CCAC of WR became the host agency for the approved 1.5 FTE Psychogeriatric Resource Consultants (PRCs) who provide case-based consultation and staff education to LTC homes. The PRCs have become an integral part of the geriatric/psychogeriatric service system in Waterloo Region.

5.6.2 Wellington County

Wellington County residents have access to psychogeriatric beds at the Homewood Health Centre in Guelph where mental health programs for older adults are provided in two units. Homewood's Hamilton 2 unit has 26 beds, 4 of which are basic, and serves older adults with mental health diagnoses and addiction issues. These beds are always full, with waiting lists. The Hamilton 3 unit serves dementia patients. The unit has 23 beds, 13 of which are basic. The beds are also always full. Although the ideal goal of this program is for elective admission of patients for assessment for up to 45 days, most of the admissions to the program are crisis admissions, which stay up to 73 days due to the complexity of their conditions.

Wellington County has a history of strong psychogeriatric services for seniors in the community that have grown over time through the Community Mental Health Clinic (CMHC). One of its established community programs is the Seniors' Mental Health Clinic which with mental health funding, provides geriatric psychiatry consultation, clinical and outreach services to seniors throughout Wellington and Dufferin Counties.

As a result of the provincial Alzheimer Strategy, the Community Mental Health Clinic became the host agency for a full time Psychogeriatric Resource Consultant (PRC) to LTC homes for case-based consultation and staff education. This program has enhanced care to LTC home residents and day program clients and is coordinated with CMHC's Consultation Clinic services which provides geriatric psychiatry expertise to LTC homes

A new Specialized Geriatric Services model has recently been developed in a deliberate effort to broaden this service to include geriatric expertise. The Expert Geriatric Services Project was initiated in February of 2004 with funding from Regional Geriatric Program central (RGPC). The planning project resulted in a model for the delivery of specialized geriatric services in Wellington-Dufferin. Implementation of the model has been led by a partnership of three agencies: Community Care Access Centre of Wellington-Dufferin (CCACWD), Community Mental Health Clinic (CMHC) and St. Joseph's Health Centre-Guelph. The model, which was implemented during 2005, is described below:

The Wellington Dufferin Specialized Geriatric Service (SGS) is a blend of new and existing services and builds on the expertise of the current CMHC Seniors Service, consisting of a Geriatric Psychiatrist, skilled mental health workers, the Psychogeriatric Resource Consultant (PRC) and a Geriatrician. The SGS Service integrated these existing services and extended them through the addition of outreach geriatric medical assessors (RNs) through the CCAC who work primarily

with the Geriatrician.

Referrals to the new integrated service now flow through a single common intake operated by CMHC. All referrals that previously were directed to the geriatrician, to the Geriatric Psychiatrist, or the CMHC Seniors Team now go through this common intake. A referral form was implemented to:

- Collect the information necessary to accurately assess priority and ensure safety of the outreach (in-home) assessor;
- Guide the assessment process and ensure that the referral question/concern is addressed; and
- Reduce duplication of assessment for the senior by utilizing existing assessment information and test/investigative results.

5.6.3 Summary Comments

Wellington's psychogeriatric and specialized geriatric programs are better resourced, more developed and more coordinated than those in Waterloo Region. Yet providers have indicated that these services are stretched to meet the needs of the rapidly growing elderly population.

In Waterloo Region, Cambridge residents appear to be well served by the range of programs at Cambridge Memorial Hospital. However, as noted in the description of these services, the staffing levels are not high and these services also have been described as stretched/at capacity.

The addition of Psychogeriatric Resource Consultants (PRCs) in Waterloo Region (1.5 FTE) and in Wellington (1.0) have strengthened psychogeriatric consultation, education and supports to LTC homes and community services. Although these resources are stretched to capacity, they have become an integral part of the geriatric/psychogeriatric service system in both communities.

There are increasing signs that the shortage of psychogeriatric services is resulting in unmet needs of elderly residents, their family caregivers and their professional caregivers. These unmet needs have been identified in the Summary of Waterloo Wellington Geriatric Services Network (WW GSN) Consultation Sessions on Seniors' Mental Health and Addiction⁴.

⁴ Waterloo Wellington Geriatric Services Network (2006). "Summary of Waterloo Wellington Geriatric Services Network (WWGSN) Consultation Sessions on seniors' Mental Health and Addiction".

6. SUMMARY OF GAPS AND ISSUES IN LTC SERVICES

The following table summarizes the current state of LTC services identified in this report

Summary of Gaps and Issues in LTC Services in Waterloo Wellington

Long-Term Services			Short-Term Services	
Community	Assisted Living	LTC homes	Hospitals	CCC hospitals
<p>CCAC in-home services are operating at capacity and referring to CSS, CCC and specialized services; many clients are on waiting list for LTC home care.</p> <p>Community Support Services are operating at capacity and referring to CCAC and higher intensity CSS services, e.g., (day programs)</p> <p>Community Specialized Geriatric Services are stretched in Wellington, Cambridge and even more so in K-W area due to HR shortages, (physician, specialized nursing) and need for coordination</p>	<p>There are no publicly-funded assisted living programs or supportive housing in Waterloo Wellington</p> <p>Rest and Retirement (R&R) Homes (private pay)</p> <p>CCAC support services are provided to augment packages purchased by residents</p> <p>Some R&R have additional packages of services available for high need residents, many of whom are on waiting list for LTC home care</p>	<p>LTC homes in Waterloo Region and Guelph and surrounding area are operating at capacity with waiting lists</p> <p>LTC homes in North Wellington are receiving clients from urban areas who are on waiting list for home of their choice</p>	<p>Acute hospitals in Waterloo Region and Guelph are operating over capacity with unfunded beds and off-service beds</p> <p>High numbers of ALC patients and ALC bed days at all 4 urban hospitals</p> <p>High numbers of ALC patients waiting for LTC at GRH-KW, Cambridge Memorial Hospital and St. Mary's General Hospital</p> <p>Psychogeriatric Service</p> <p>Wellington residents access a unit at Homewood Health Centre. Waterloo Region residents access beds at St. Joseph's Health Centre-London (formerly LPH)</p>	<p>Complex Continuing Care Hospitals and Units are operating at capacity at GRH-Freeport, Cambridge Memorial Hospital and St. Joseph's Health Centre-Guelph</p> <p>High numbers of ALC bed days for patients waiting for LTC home care at GRH-Freeport, Cambridge Memorial Hospital and St. Joseph's Health Centre-Guelph.</p>

6.1 Discussion

The continuum of long-term care services available in Waterloo Wellington lacks publicly funded assisted living services and supports. The literature describes this level of care as a key component in delaying or preventing premature institutionalization. These findings are substantiated in areas in which significant resources are dedicated to this level of care. Examples are discussed in detail in subsequent sections.

The shortages of Health Human Resources have been widely acknowledged in general and cited by all information sources contacted for this report. As health care increasingly becomes geriatric care over the next decades the shortages in geriatric expertise to provide appropriate care to geriatric patients, residents and/or clients will increase. The challenges affect the full range of providers: geriatricians, psycho-geriatricians, geriatric nursing specialists, nursing and therapy professionals, personal support workers and trained volunteers in the Community Support sector. The MOHLTC has recognized that this is a province-wide issue and is heading a provincial working group led by the Health Human Resources Policy Branch of the Ministry. Local Health Integration Networks (LHINs) will also be addressing these issues.

Within the existing range of services available in Waterloo and Wellington, the pattern of formal care seeking starts in the community when age-related changes result in a need for assistance with instrumental activities of daily living (e.g. housework, shopping, transportation). Community Support Services (CSS) are primary providers of these services and the sector has grown substantially over the past 10 years. As physical functioning declines and when age-related medical conditions occur, CCAC services are frequently required. Many of the clients receiving services through CSS agencies also receive CCAC services, and many of them are between 80 and 90 years of age.

In spite of celebrating the fact that they are helping so many elderly people remain in their own homes in the community until 85 to 90 years of age, community-based providers are frequently concerned with the unmet needs of these older frail clients who are at risk in their current independent living arrangement. This raises the question: **How can we enhance the ability of community services to support frail elderly to live longer and well in their own homes?**

This report identifies a second service issue in Waterloo Wellington services – that of mental health/specialized geriatric and psychogeriatric services to older adults. As discussed previously, the community specialized geriatric services mix is satisfactory in Wellington, but stretched with waiting lists. Similarly in Cambridge, the coordinated Seniors Health and Mental Health programs are stretched in terms of human resources. Waterloo Region North is more limited by shortages of specialized nursing, geriatric/psychogeriatric expertise for consultation, and the need for more coordination of the various services available. All these programs have advocated for service expansion and all these programs have waiting lists. These service and system issues have been detailed in the recently completed Summary of Consultation Sessions on Seniors' Mental Health and Addictions by the Waterloo Wellington Geriatric Services Network (WWGSN).

In Waterloo Wellington the next level of care is LTC home care. The average age of admission is about 85 years, though the restrictions of community-based services may

result in premature admission. As indicated above, the recent and projected growth in the 80+ age category of the population has resulted in full facilities and long waiting lists. These population projections have been known since the early 1980s. When the provincial LTC home bed expansion was implemented, the primary goal was to equalize the availability of beds across the province and this goal was met in the sense that the average number of LTC beds per 10,000 people over 75 years of age became more equalized across the province. This gross estimate does not address differences in service options available in communities across the province.

Given the cost of LTC Homes and the addition of 20,000 new spaces, provincial policy is becoming focused on how best to appropriately redirect people away from LTC home care. To reduce pressures on the facility system, there is a need to strengthen alternative community options. The findings of this report support this direction by identifying the gap in assisted living options. However, for appropriate redirection from LTC home care, it will be very important to ensure that the provincial formulas currently being developed to estimate the numbers of people not requiring LTC home care are based on factual, evidence-based information.

When disease, illness or trauma occurs, people of all ages go to acute care hospitals. However, upon discharge from acute care, unlike their younger counterparts, many frail elderly patients find themselves in the position of no longer requiring acute care, but not being able to return to their previous setting for a variety of legitimate reasons. They become Alternative Level of Care (ALC) patients. Many ALC patients are waiting for LTC placement, but others also require other care prior to or as an alternative to placement. This would include:

- Convalescent care (10 beds in Waterloo Region, 0 beds in Wellington)
- Respite care (8 beds in Waterloo Region, 5 beds in Wellington)
- Complex Continuing Care – geriatric assessment, geriatric rehabilitation, neuro-behavioural treatment
- Psychogeriatric hospital care – assessment and/or medium-term psychiatric treatment (Homewood Health Centre in Guelph or St. Josephs Health Centre-London)

All of the above options are time-limited treatment and rehabilitation services. Upon completion of these programs, some patients may be able to return to their home in the community (e.g., after convalescent care). However, many patients find themselves in the same spot that they were when they no longer required acute care, being designated again as an ALC patient, usually waiting for LTC home care.

Perhaps the question should be asked: **What are we expecting of our LTC home system?** There is much to be done to ensure consistency in LTC homes' capacity to provide the highest level of services within their mandate. However, it is also important to examine the special needs that pose barriers to accessing LTC home care, identified in Chapter 5, assess whether these needs can be appropriately met within LTC homes' mandate, and if so, how they can be met.

There is no single option that will address the complex issues that have come together to create the current pressures in the LTC health system. To a large extent, it is the result of demographics, gaps in service development, and delays in examining the number of LTC home beds required based on the needs of consumers and the alternative service/housing

options available or required in communities.

This report has flagged these issues but there has also been considerable in-depth analysis of both the challenges and the potential solutions.

In May 2006, a collaborative position paper entitled Alternate Level of Care – Challenges and Opportunities was submitted to the MOHLTC by the Ontario Hospital Association (OHA), the Ontario Association of Community Care Access Centres (OACCAC), Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) and the Ontario Long-Term Care Association (OLTCA). The position paper was submitted to the MOHLTC for further action.

The position paper was provided as background for this report for the purpose of examining the recommendations it contained in the context of the Waterloo Wellington service and system issues being identified in this project. The position paper provides an in-depth analysis of ALC issues from all perspectives, identifying 14 Challenges to be addressed. The paper makes 10 recommendations, many of which are designed to address more than one of the identified challenges. The paper is a significant collaboration between the four major provincial associations with agreement on the steps that need to be taken to develop practical solutions to the ALC pressures.

Several of the paper's recommendations are directly related to the findings in this report – e.g.,

- *Increase Community-Based Comprehensive Care and Facilitate Innovative Service Options*
- *Match Resources to Demographic Composition and Income Level of Specified Regions*
- *Identify Best Practices and Strategies to Enhance System Navigation for ALC Patients*

While the status of the position paper is not known at this point in time, the paper is recommended as worthwhile reading for Waterloo Wellington stakeholders working together, including community, facility and hospital service providers, LHIN planners and MOHLTC staff.

7. REVIEW OF RELATED DIRECTIONS AND PROGRAMS IN OTHER JURISDICTIONS

Across western jurisdictions, a conventional framework for the provision of care to non self-supporting seniors has emerged. The framework contains three categories: Services to people living at home, assisted living, and long-term care. All existing and new program advances seem to fit in these categories. Size and composition of a community as well as its urban or remoteness, funding, and political priorities seem to be the factors which have impacted upon how each jurisdictional system has emerged. It is unlikely there is one approach which is more effective than another, however various trends have emerged.

Historically, the choices were limited to institutional placement or family support. Mobility, changing roles for women, and an increase in longevity, necessitated the development and implementation of more comprehensive approaches. Most jurisdictions continue to have a continuum of programs with services in all three categories. However, the emphasis does differ. In Ontario, for example, there has been greater emphasis on the expansion and redevelopment of long-term care, while in Alberta there is much more emphasis to using community-based services to avoid the need for long-term care.

In this section, there is a review of a few initiatives in other jurisdictions. The intent of this section is to increase awareness as to how other communities are addressing the current challenges facing Waterloo Wellington. Too often, when faced with wait lists, service providers call for the expansion of existing programs and services. The awareness of approaches from other jurisdictions may not be suitable to duplicate, but they are helpful in developing new approaches and initiatives.

7.1 Local Initiatives - Proposed, Planned or Underway

The recognition of the need for supportive housing options is clearly articulated in A Needs Analysis of Supportive Housing for the Elderly in Waterloo Region, Wellington County, and Dufferin County⁵. The report, initiated at the request of the Central West Regional Office of the MOHLTC, enthusiastically endorsed the need for development of supportive housing options in the locale. It even set targets for the number of units needed for 2006 and 2011 respectively. The benchmark used was 4% of the 75+ population. Had the recommendations been undertaken, the community would have 1598 living units by the end of this year. **The number of new units developed since this report was distributed is zero.** Efforts have been made to develop proposals, but the priorities of the Ministry of Health and Long-Term Care since the report was written have not included supportive housing.

It should be noted that the Regional Municipality of Waterloo has developed a comprehensive proposal for a supportive housing program to be developed on the site of its Sunnyside LTC home. An application for the capital costs has been submitted to a new Federal/Provincial housing program, known as Strong Start. The Municipality did receive approval for the capital request. The barrier to moving forward has been the lack of support for the operational funds from the Ministry of Health and Long-Term Care.

⁵ Waterloo Region-Wellington-Dufferin District Health Council (2003). A Needs Analysis of Supportive Housing for the Elderly in Waterloo Region, Wellington County, and Dufferin County.

Because the request for the operating funds was rejected, the Municipality was not prepared to initiate the project. It should also be noted that this proposal meets provincial requirements and is supported by a number of community partners.

Most Rest and Retirement Homes would consider themselves to be assisted living programs. Some have expanded their options and developed assisted living programs (e.g., life lease) which provide services similar to supportive housing programs in designated housing units. However, the costs to individuals for these programs exceed the costs of publicly funded long-term care. Thus, affordability is a major barrier. The lack of affordable assisted living is partly the reason why the wait list for long-term care exceeds those in other jurisdictions where there are more assisted living options.

Enhanced Community Health Options for the Elderly (ECHOE) in Waterloo Region⁶: Recognition of the need to increase options for supporting the “functionally frail, the medically fragile and demented elderly living in the community” was a concern of the CCACWR in 2000. As a result, a consultant was hired to develop a program to provide a “comprehensive, integrated approach to health services” which would enable program participants to remain in the community. The program model was based upon similar models operational in the United States and in Alberta. The model required provincial government funding and approval, which was rejected. The model remains valid as an alternative to long-term care placement. Given the capacity issue in the region, it would be beneficial to review the proposal and determine its relevance in the context of the current environment.

Balance of Care in Waterloo Wellington: In June of 2006, the Waterloo Wellington Community Support Services Network, the University of Toronto’s School of Health Sciences, and Ryerson University received funding to undertake a pilot project to implement the Balance of Care model in Waterloo Wellington. The model has been developed in Great Britain and is another approach aimed at delaying or preventing long-term care admission by providing community services. The methodology involves the assessment of the needs of a particular client population, in this case those waiting for long-term care placement. A service plan is developed and provided. Outcomes are measured to determine impact. The British experience has shown that when services are tailored to well-defined needs, positive results are achieved in terms of delayed admission and cost savings.

7.2 Supportive Housing for Seniors in Ontario: Brief Descriptions of Several Programs

The report referred to above includes descriptions of seven different supportive housing programs operated in neighboring Ontario regions. It is not useful to simply re describe these programs in this report, as the information is easily accessible on line as referred to above. The report covers a range of programs and several programs’ models for those planning similar programs in Waterloo Wellington.

In the Toronto area, there are also several mature supportive housing programs. Storefront Humber Inc., a community support service provider, has one of the largest

⁶ Von Schilling Consulting (2001). “Proposal: Enhanced Community Health Options for the Elderly (ECHOE) in Waterloo Region.”

supportive housing programs in Ontario. The organization provides a range of support services to 200 clients at five different locations. (Services include: case management, 24 hour security, personal support services, congregate dining and meal delivery options, and access to day programs.) All of the locations are geared to income apartment type accommodations operated by the Toronto Housing Company. Four of the five buildings are exclusively for seniors. The program has been operational for nine years, and it has a long wait at all sites. The program is located in the former area municipality known as Etobicoke, where two other community support service agencies also have supportive housing programs. The LTC homes in the area consistently have vacancies.

St. Paul's L'Amoreaux Centre operates a similar program, in the Scarborough area. The services are very similar to the Storefront Humber program. This program serves about 90 individuals in two buildings. Both programs suggested that there is a critical mass issue. In order to provide 24/7 care, there are a minimum number of people required at each location. For a new single site program, it was suggested starting with 40 clients is a workable number. Both programs fundraise from other sources (e.g., United Way, local fundraising events, etc.) to support services and costs that exceed Ontario guidelines.

7.3 Supportive Living in Alberta

In November 1997, the Alberta Health Minister called for a review of Long-Term Care to address pressures on their continuing care system and to develop long-term strategies to address the impact of aging on the Alberta health system. The final report known as Healthy Aging: New Directions in Health Care⁷ was made public in November of 1999. The mandate of the Advisory Committee that prepared the report had two major challenges: “The challenge of meeting short term needs and the challenge of moving forward with a fundamentally new direction for continuing care”⁸ by developing a comprehensive health services approach to meet the needs of an aging population over a period of 10-25 years. The final report made recommendations to address immediate issues and longer-term issues. Not unlike Ontario, Alberta had a care system with long waiting lists for LTC with outdated and inadequate LTC homes, stretched home care resources, and pressures on acute care beds to discharge elderly people as soon as possible. The committee believed that short-term actions were required, but wanted to ensure that they would be consistent with a long-term vision. That vision called for the expansion of home care services to meet the needs of people with long-term care needs. Immediate steps were taken to increase home care services in supportive housing arrangements. The longer-term vision included a scenario with three distinct service streams: home living, supportive living and facility-based care. It calls for supporting independence at home as a first choice, and “expanding supportive housing considerably allowing most people to stay in flexible arrangements with increasing levels of service provided to meet their needs”⁹. The Committee also warned that “unless there is adequate home care available and appropriate supportive housing options for people to age in place, the province will face mounting pressures to build thousands of long-term care beds by 2016.”¹⁰

⁷ Alberta Health (1999). Healthy Aging: New Directions in Health Care

⁸ Ibid. p. 3

⁹ Ibid. p.4

¹⁰ Ibid. p.4

In response to the new provincial directions, the Capital Health Regional Health Authority and others developed Continuing Care Strategic plans which included significant expansion of supportive housing programs. The encouraging environment resulted in the creation of many new forms of supportive housing including one referred to as designated assisted living, which serves as an alternative to facility-based long-term care. It should be noted all of Alberta's health regions have sponsored the development of new programs since 2002. Those readers who require more detail should contact any of the Alberta health regions.

In August 2006 in Alberta, enough new supportive housing programs had developed a common framework and clarifying roles, responsibilities and terminology became a priority. The framework is available on line and is a useful tool for those developing new assisted living proposals¹¹.

7.4 Services for Older People in Great Britain

In 2001, the British National Health Service (NHS) published a report known as the National Framework for Older People¹². At the time the document was prepared, there was recognition that the NHS was not addressing the specific needs of the elderly and that the number of people over the age of 80 would increase by more than 50% in 15 years, placing even greater challenge on the publicly-funded health system. The framework is a strategic document and it set the agenda for the next 10 years. As a result, eight standards described within the framework became the basis for many initiatives introduced subsequently. While not all of the standards apply directly to the subject matter of this report, noting all of them helps to understand those programs that are relevant. The standards are as follows: rooting out age discrimination in the delivery of services; person centered care; improvements to intermediate care; improvements to general hospital care; stroke care; falls; mental health care; and the promotion of health and active life in older age.

In a 2004 document, known as, Changing Times: Improving Services for Older People, an initiative known as "Social and Health Care Change Agent Team"¹³, is discussed. The underpinning for the initiative is the recognition that coordination at the client level is weak and often results in unnecessary utilization of more costly services. The initial focus was on those who have had delayed discharges because the appropriate services were not in place to address client needs. Subsequently, the focus of the team extended beyond the hospital group. The key was to have a team with coordination responsibilities and access for funds to pay for less costly services in alternative to hospital settings. The work of the team resulted in the fostering of partnerships at both the point of delivery and at senior management levels. The model developed started with a comprehensive assessment of client needs, and the design of a smooth path to address them. In addition to coordinating execution, the team directed system issue to policy and decision-makers to enable the introduction of system changes. In effect, the team serves as a system navigator for their elderly clients. The notion of system navigation in Ontario has been

¹¹ Alberta Health (2006). "Supportive Living Framework"

¹² National Health Service United Kingdom (2001). National Framework for Older People.

¹³ National Health Service United Kingdom (2004). Changing Times: Improving Services for Older People. p. 4.

explored in a 2005 paper prepared by the Ontario Association of Community Care Access Centres¹⁴, however, communities have yet to embrace the concept.

7.5 Choices for Care in the State of Vermont

The State of Vermont operates health programs under the US government Medicare/Medicaid program. (The Medicare program is directed to the eligible elderly people and it includes many different kinds of health services.) One of the services available under Medicare is long-term care. About 15 years ago, Vermont received a waiver from the Medicare program to use federal funding to provide alternatives for people who have been declared eligible for nursing home placement. The alternatives to nursing homes included assisted living in smaller housing programs or services at home provided by means of an employment arrangement. The proviso being that the client becomes the employer and is capable of directing the services provided. Relatives other than spouses are eligible to be service providers. There is no restriction on where the service provider lives.

In 2006, the state received approval from Medicare, on a pilot basis, to include spouses as potential paid care providers. The actual process starts with an application and an assessment. If the applicant is determined to be eligible for long-term care placement a care needs plan is developed. As indicated above, the client can choose between three options. Where the in-home option is chosen, a relative or significant other (other than spouse) becomes the employee of the client. The state government has a department that serves as a fiscal intermediary. This department sets up the formal employer administrative work, collects time sheets and pays the employee on behalf of the client. It also provides workman's compensation and other benefits. The cost to the government is \$ 14.55 per hour and the employee receives \$10. Hours of service provided are based upon state standards and similar to those used in LTC homes. The care plan is pre-determined and sets limitations in minutes for each care activity. The administrative requirements are rigidly enforced.

Vermont is a rural state with small communities, where health care providers are in short supply. Its urban areas also do not have sufficient health care providers. Consequently, Choices for Care offers an alternative.

¹⁴ Ontario Association of Community Care Access Centres (2005). Addressing Health System Navigation in Ontario.

8.0 PLANNING CONSIDERATIONS FOR WATERLOO WELLINGTON

8.1 *Introduction*

The demographic challenge before the Waterloo Wellington community suggests that there is an immediate and future need to increase service capacity. Since 2002, in spite of program and service expansion over the last four years, all publicly funded service areas are serving more individuals and have more people waiting for service than in 2002. The WW LHIN has already indicated that service to this population is a priority, however, in the absence of new funds, it may be difficult to take any action. Nevertheless, the community needs to determine its own priority for program expansion. Once determined, it will be necessary to promote the plan and seek the funds to implement.

A useful approach to establish priorities is to develop a planning framework that encompasses the current system of services. Since the late nineties, however, provincial priorities have driven local service enhancements. The local agenda has been to implement the provincial agenda. New programs and services have been implemented based on a provincial analysis. Local challenges and service configurations have not been part of the provincial decision-making process other than at a highly abstracted level. With the introduction of the LHINs and the intended capacity to plan and execute health services at a regional level, there is an opportunity to develop a more strategic approach, one based upon and responsive to local circumstances and conditions.

8.2 *The Services Continuum*

When one examines community long-term care services across many jurisdictions, there is a continuum with three common components. For the purposes of this report, they will be referred to as: Services at home, Assisted living, and Long-term care services. (The Alberta framework calls its continuum the community living system and refers to its components as: Home living, Supportive living and Facility living.)

Services at home can be broadly referred to any service that enables a person with limited self care ability to remain in their home. It can include any type of professional health service, a personal care/homemaking service, a range of community services including transportation, day programs, and congregate dining. Duration or frequency is not a factor in defining this term.

Assisted living refers to an arrangement where there is a programmatic link between accommodation arrangements and support services provided. It can be distinguished from services at home, by the requirement to live in specific housing where the services are provided.

Long -term care refers to a facility that provides 24 hour care, seven days a week for an extended period of time.

Most regions in Ontario have a range of programs across this continuum as do most other jurisdictions. The difference is in where the emphasis is placed. In some locations, there is a greater emphasis on aging in place while others view long-term care as the priority.

Limited research has been conducted, so that it is difficult to base a service continuum on service outcomes. Often other considerations influence the decisions as to what programs are further developed and extensively available. Since capacity is an issue in most jurisdictions, clients in need of services will line up wherever the services exist.

Since the late nineties, the priorities in Ontario have been to expand the home care sector and to expand and redevelop the long-term care sector. The combination of demographic changes and hospital restructuring across Ontario has resulted in unprecedented demand in all aspects of acute care. The priority of all hospitals is to discharge patients as soon as possible to enable greater utilization of each hospital bed. It has been the prevailing view of Ontario's recent health ministers, that enhancing funding to CCACs to increase post acute care and building more LTC homes would reduce the demand on acute care hospitals. An unsought result where there is a mismatch between population need and funding for beds and services, is longer waitlists for LTC beds and decreased capacity by CCACs to provide in-home support to the frail elderly who do not require acute care.

The experience in many jurisdictions is that admission to long-term care can be delayed or eliminated by means of the provision of enhanced services at home/community and/or assisted living. Examples are described above. In Ontario, most medium-size to large-size communities have had community support services provided by not-for-profit agencies for more than 25 years. These organizations provide very good services at low or subsidized costs. Unfortunately, enhancement and expansion of this sector has not been a priority of the current or recent governments. More recently, the Ontario government has increased funding to this sector, however it is relatively minor compared to expansion of the LTC home sector with the addition of 20,000 new long-term care beds and the hundreds of millions of dollars added to CCAC budgets.

8.2 Assisted Living in Ontario

Publicly funded assisted living programs for seniors have been limited to supportive housing programs in Ontario. The Waterloo Wellington area has not been successful in obtaining funding for supportive housing for seniors.

Supportive housing in Ontario refers to a specific model developed in the mid 1980s. The model links together accommodations and services, but administratively there is a separation between the service provider and accommodation provider. Since the program was developed to serve a wide variety of client groups, the policy makers wanted to ensure that failure to succeed in the program would not jeopardize the accommodation arrangement. Also, there was a desire to avoid creating new institutions. The majority of people living in supportive housing are adults with disabilities or chronic conditions. The model has been adapted successfully to serve frail elderly. A few community support service programs for the elderly were successful in obtaining supportive housing funding many years ago, however there have been a limited number of new programs created over the years.

Rest and Retirement Homes (R & R homes) have filled the gap in assisted living in the absence of government funded programs.

Both Waterloo and Wellington have numerous private R & R homes providing a range of accommodation options including assistive living or supporting housing, life

lease units, single/shared rooms, apartment like accommodations, respite and convalescent care. Initially, rest and retirement homes provided safe accommodations, meals, and housekeeping in institutional-type settings. The homes were very similar to the publicly funded Homes for the Aged. The typical client was self sufficient in activities of daily living, without cognitive impairment and stable. People move to retirement homes, because their living arrangement no longer matches their ability to live independently. However over time, as rest and retirement home clients experience health problems and often develop chronic conditions, homes have developed the capacity to provide supportive and personal care services for residents who become more frail. There are extra charges for these additional packages of service. The impact has been to delay or prevent many residents from being transferred to LTC homes. Many residents are managing in R & R while on the waiting list for LTC home care. However, since R & R homes are private, for-profit organizations, they are neither funded nor regulated by the MOHLTC. For this reason, this level of care is not affordable for many residents in Waterloo Wellington.

As indicated above, many jurisdictions commit public funds to assisted living programs. The prevalence of programs across so many different jurisdictions suggests that there is both a cost benefit and improved outcomes in these programs. The longevity of many supportive housing programs in Ontario would also suggest that assisted living is an important component to the continuum.

9.0 RECOMMENDATIONS

The following are recommendations for addressing the Waterloo Wellington service and system issues identified in this report. MOHLTC staff are already involved in working out some options and the WW LHIN Integrated Health Services Plan contains action priorities that are consistent with many of these recommendations.

It is recommended that the MOHLTC:

- Fund a transitional bed program in Waterloo Region as an interim step to reduce acute care pressures in acute care (refer to 2004 report to MOHLTC recommending 50 interim beds)
- Provide operational funding to implement the existing Supportive Housing proposal in Waterloo Region

It is recommended that the LHIN:

- Support a LHIN-wide strategy for Supportive Housing/Assisted Living programs in affordable housing sites for seniors in urban and rural settings
- Support service enhancements to increase the capacity of LTC facilities to provide services to specialized populations
- Strike a Health Human Resources committee to address human resource shortages and issues on a LHIN-wide basis
- Ensure that new LTC Home bed allocations are an accurate reflection of need in Waterloo and Wellington
- Ensure that provincial estimates for redirecting consumers from LTC facility care include an accurate reflection of current needs, existing service options and changes that will need to occur in order to achieve redirection strategies
- Support the ongoing work of the Waterloo Wellington Geriatric Services Network (WWGSN) as it addresses issues and solutions to improve specialized geriatric services in Waterloo Wellington
- Review the findings of the Balance of Care project to identify potential for combining CCAC and Community Support Services into intensive service packages
- Examine enhanced CCAC in-home service options such as intensive case management, enhanced levels of personal support/homemaking services for at risk clients in the community
- Support a comprehensive analysis of GRH Freeport utilization data focusing on enabling LHIN-wide access to this resource
- Support implementations of Chronic Disease Management strategies that can be applied across the health continuum
- Review the Enhanced Community Health Options for the Elderly (ECHOE) Proposal of the CCACWR (2001) to assess its relevance in the current context
- Support existing service networks currently working on specific issues relating to improving the long term care service system. It will be important to support the work of these groups and to develop a forum for bringing the findings of these groups together, for discussion of common elements and strategies for moving forward. Some examples include:
 - WW Specialized Geriatric Services Network
 - WW Rehabilitation Services Network
 - WW Community Support Services Network
 - WW Emergency Services Network
 - WW Hospice Palliative Care Network

10.0 CONCLUSIONS

The current range of long-term care supports and services in the Waterloo Wellington area is insufficient to address the needs of frail elderly who require substantial personal care assistance. With LTC homes running at nearly 100% occupancy, and with a limited amount of CCC beds for individuals with very special needs, the only alternatives are to remain in hospital, to hire private care in the home, or to seek admission to Rest and Retirement homes, where costs for individuals with significant care need can be very high. While acute care hospitals treat the acute care needs of the frail elderly, they do not have the capacity to continue to provide for ongoing needs once the acute care needs are met. When care alternatives are unavailable, however, post acute ALC patients may remain inappropriately in an acute care bed for lengthy periods of time, rendering the acute care bed unavailable for other use. This ALC population has been the target of program thrusts in other locations in Ontario, however, to date, Waterloo Wellington has been unsuccessful in obtaining program funding to develop transitional or interim solutions.

In anticipation of this type of scenario, the provincial government added 20,000 new LTC beds during the last five years. In Waterloo Wellington over 900 new beds have been added, however, they were soon filled by pent up demand and waiting lists grow daily. With the unprecedented growth in the 80+ population, in the absence of the development of new service options or the expansion of the existing ones, the community will continue to find its emergency rooms overwhelmed and acute care beds being filled by ALC patients. Families will struggle to look after their frail elderly relatives until crises occur and those frail elderly living alone will needlessly deteriorate and rely on the acute care system.

This report offers an analysis of the current status of the services for frail elderly in Waterloo Wellington. Though there have been some service additions since 2002, the demographic changes neutralized the impact of these additional services. More people are waiting for long-term care than in 2002 and acute care hospitals have not seen a reduction in the ALC patients or less full emergency departments. There were service gaps in 2002 and there are service gaps in 2006.

In this paper, service gaps have been identified and alternatives from other jurisdictions are discussed. Recommendations are provided to address both gap and system issues. All recommendations will require additional funds. With limited resources, it is important that the community choose those alternatives that will have the most impact. Thus, it is very important that those responsible for local funding decisions support a flexible approach that will permit the inclusion of new programs and ideas.

Appendix 1—Terminology

Alternative Level of Care (ALC) is the term for hospital patients that have been assessed as no longer requiring acute or complex continuing care in a hospital. These patients have been referred to an alternative level of care which they are waiting to access. ALC patients in acute care may be waiting for complex continuing care services such as rehabilitation; they may be waiting to access a LTC Home or another service. Patients in complex continuing care hospitals may have received rehabilitation services and now be waiting to access a LTC Home or another service. The majority of ALC patients are eligible for and waiting to access a LTC Home.

Community Care Access Centres (formerly known as Home Care) provide case management services and arrange for nursing, therapy services and for assistance with personal care/homemaking and respite through contracted agencies as well as providing placement services which coordinate access to LTC Homes. Services are available to eligible clients at all ages.

Community Support Services are provincially subsidized services which provide supportive care to adults with disabilities and older adults in order to help them maintain independence at home in the community. Examples of services include Meals on Wheels, Friendly Visiting, Day Programs, Volunteer Transportation, Home Maintenance, Congregate Dining, Alzheimer Caregiver Support, Home Help and Palliative Care support. Most of these services are provided by trained volunteers with the exception of outreach and supportive housing services for adults with disabilities which are provided by paid attendant workers.

Complex Continuing Care (formerly known as chronic care) is longer term, non-acute hospital care which may include a range of programs, e.g., rehabilitation, geriatric assessment, complex medical care (ventilators), and end-of-life or palliative care.

Convalescent beds are usually located in LTC Homes to provide time limited supportive care, usually to patients who are being discharged from acute care hospitals and who are not yet able to return to their home in the community.

Local Health Integration Networks (LHINs) are recently created organizations responsible for planning, managing and funding local health services. The Waterloo Wellington LHIN#3 area includes the Region of Waterloo, the County of Wellington and parts of Grey-Bruce Counties. LHIN#3 offices are located in Guelph.

Long Term Care Homes (formerly known as Nursing Homes and/or Homes for the Aged) provide provincially regulated and subsidized accommodation with 24 hr nursing, support and programming services for adults with disabilities and elderly residents assessed as eligible for this level of care.

Long Term Care Service System referred to in this report refers to the range of community and institutional health and support services designed to assist people of all ages who require health services on a long-term basis. This includes community support services, Community Care Access (home care) services, Acute hospital care, Complex Continuing Care in hospitals, and Long-Term Care Homes.

Rest and Retirement Homes provide a range of retirement living options on a private basis. They are neither funded nor regulated by the Ministry of Health and Long Term Care.

Respite care beds are usually located in LTC Homes to provide temporary or short term caregiver relief for family caregivers.

Specialized Geriatric Services is becoming recognized as the term for the combination of geriatric and psycho-geriatric expertise required to appropriately diagnose and care for elderly people with complex combinations of physical, emotional and mental health needs.

Transitional beds or Interim bed programs are provincially funded, time limited alternatives to LTC Home beds.

Appendix 2—List of Informational Contacts

Goldie Barth	Wellington County Social Services
Heather Burke	Wellington/Guelph Housing
Jim Bowman	City of Waterloo Day Program
Gloria Cardoso	WW Community Support Services Network
Karen Conway	Grand River Hospital-Freeport
Cheryl Cowden	Guelph General Hospital
Terrie Dean	CCAC of Waterloo Region
Audrey Devitt-Wilson	St. Joseph's Health Centre Day Program
Perry Doody	OACCACA
Adele Edelman	State of Vermont
Deb Gemmel	RAISE Home Support
Mary Hansen	Storefront Humber Inc.
Toby Harris	Participation House
Sandra Hett	St. Mary's General Hospital
Ray Hould	Victoria Place
Karen Keleher	Homewood Health Centre in Guelph
Lisa Krukowski	Saint Luke's Place Day Program
Anne Macintosh	CCAC of Wellington-Dufferin
Marie Morrison	RM of Waterloo
Monica Morrison	Cambridge Meals & Community Home Support
Bea Mudge	Cambridge Memorial Hospital
Shelly Nicol	Eden House Rest Home
Ruth Nolan Flores	MOHLTC Toronto Region
Irene O'Toole	Waterloo Home Support
Janice Paul	K-W Friendship Group
Betty Perrin	Sunnyside Alzheimer Programs
Jenny Rajaballey	GRH and CMH Mental Health Programs
Glenn Roach	CCAC of Waterloo Region
Warren Robin	Alberta Health
Linda Rock	Marsdale Manor
Shirley Scott	North Wellington Hospitals – Groves Memorial/Louise Marshall
Nora Sewell	Heritage House-Guelph
Steve Sherrer	Luther Village on the Park
Bil Smith	Independent Living Centre
Barbara Sutcliffe	Winston Park Retirement
Kathy Tschirhart	St. Joseph's Health Centre-Guelph
Kim Voelker	CCAC of Waterloo Region
Anne Waller	Guelph Services for People with Disabilities
Georgina White	OACCAC
Gloria Whitson-Shea	Grand River Hospital-KW
Glynis Williams	CCAC of Wellington-Dufferin

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- 5) Waterloo Wellington Community Services Website. www.wccsnetwork.com
- 6) Canadian Research Network for Care in the Community, www.crncc.ca
- 7) Waterloo Wellington Local Health Integration Network www.lhins.on.ca