Waterloo Wellington
Local Health Integration Network

AGING AT HOME STRATEGY

Directional Plan
October 31, 2007

Waterloo Wellington
Local Health Integration Network
Aging at Home Directional Plan

TABLE OF CONTENTS

Provincial Framework for Aging At Home……………………..…..…Page 3

Introduction and Rationale……………………………………….….Page 5

Links to Government and Ministry Priorities…………………..……Page 6

WWLHIN Aging at Home Strategy……………………………..……Page 6

Objectives and Priorities……………………………………………….Page 7

Objectives of the Service Plan………………..……..….Page 7
Broad Parameters of the Plan…………………………...Page 8
Community Engagement…………………………....…Page 8
Cross Sectoral Participation……………………..…...Page 11
Innovative Ideas & Best Practices…………………..… Page 11
Proposed Benefits to our Community……………..… .Page 12

Performance Measures and Outcomes…………………………….Page 13

Alignment with IHSP/Benefit to Seniors……………….Page 14
Health System Outcomes………………………………Page 14
Performance Indicators…………………………………Page 14

Workplan ………………………………………………..…………Page 15

Ongoing Community Engagement……………………Page 16
Research, Data Analysis & Planning Methodologies..Page 16
Priority Activities……………………………………………Page 17

Policy/Legislative Enablers…………………………………..………Page 17

Opportunities and Risks…………………………….....................Page 17

Summary……………………………………………………..……..Page 18

WWLHIN Aging at Home Directional Plan

The Provincial Framework for Aging at Home

The Aging at Home Strategy is a provincial initiative launched in August 2007 by the Ministry of Health and Long-Term Care. The strategy aims to support seniors in their desire to live independently for as long as possible, in a home of their choice. The strategy represents a $700 million investment over three years.

The strategy covers the following services and supports:

1. Community support services
2. Home care
3. Assistive devices
4. Supportive housing services
5. Long-term care beds
6. End-of-life care, plus
7. Innovative services

The strategy has three objectives:

1. To provide seniors with a continuum of supports that will enable them to stay healthy and live with independence and dignity in their homes

2. To provide a comprehensive plan for an integrated continuum of care that includes:

    - community support services
    - home care
    - supportive housing
    - long-term care beds
    - end-of-life care

3. To offer preventive supports to sustain the healthiest population of seniors possible

The Strategy has four goals:

1. **Broadening the range of options to call "home".** Increasing residential options such as supportive housing and long-term care homes, increasing access to mobility devices, and improving safety in homes to prevent injury.

2. ***Creating supportive social environments.*** Strategies to reduce or eliminate social isolation for both seniors and their caregivers, including adult day centres, supportive housing, caregiver relief and respite, friendly home visiting.

3. ***Providing senior-centred care that is easy to access.*** Coordinating access to a flexible continuum of services and supports across sectors; improved case management and care coordination; improving transportation services; and augmenting specialized geriatric services (i.e. exploring opportunities to augment

or partner with Family health Teams (FHTs) and Community Health Centres (CHCs) in the provision of preventative, maintenance and restorative services/programs).

4. ***Identifying innovative solutions to keep seniors healthy*** Including a minimum of 20% of funding earmarked for Ministry-approved innovative approaches to deliver innovative prevention and wellness strategies, and partnerships with non-traditional providers that allow and recognize "informal services".

The province has adopted the following guiding principles to guide local strategy development:

- The design and delivery of services should respond to the needs of seniors
- Services should be community-based and integrated within the broader health care system
- Demographic and geographic challenges must be considered to reach a goal of equitable access to services
- The best care at optimal cost, recognizing the benefits of volunteerism, can contribute to cost-effective and sustainable services
- Services should be results oriented, with those results being defined and measured
- Services should build on capacity in local neighborhoods and within communities of common ethno-cultural, linguistic, religious and sexual orientation cultures

Customizing the Strategy at the LHIN Level

Ontario's 14 Local Health Integration Networks (LHINS) have been tasked with developing plans that will identify the specific services and supports needed in their areas to implement the provincial Aging at Home Strategy. The Ministry of Health and Long-Term Care has set out a provincial framework to guide local planning efforts and provided each LHIN with a funding allocation for three years (2008/09 to 2010/11).

In Waterloo Wellington, the Aging at Home Strategy represents a financial investment of:

- $ 4.8M in 2008/09 (beginning April 2, 2008)
- $11.9M in 2009/10 and
- $ 21M in 2010/11

Ontario's 14 Local Health Integration Networks are now planning for the allocation of this funding by building on existing plans, including the Integrated Health Services Plan and Annual Service Plan, to develop their own, community-customized plan to address Aging at Home. This directional document reflects the high level goals and objectives of the WWLHIN's Aging at Home Strategy, with further refinements being submitted to the MOHLTC by the end of January 2008.

INTRODUCTION

The goal of the WWLHIN's Aging at Home Strategy is to provide a suite of services for seniors to enable them to live as independently as possible, for as long as possible, in a safe home of their choice.

To deliver this strategy, the WWLHIN plans to make significant investments in community care and long-term care systems. These investments will include increasing community support services, creating assistive and supportive housing arrangements, as well as assessing the WWLHIN's Long Term Care Bed capacity considering the potential impact of planned enhanced community support services. In addition, the strategy will addresses the health promotion and disease prevention needs of seniors focusing on community-based, innovative partnerships.

Improved funding to the community will address the increasing demand for services required by people who have complex medical issues, including those with chronic diseases such as Alzheimer's disease. This strategy will reduce demand on hospitals, and create efficiencies related to alternate level of care (ALC) days.

RATIONALE

Ontario is home to approximately 1.5 million seniors; 40 percent of Canada's seniors. By 2028, the number of senior citizens in Ontario will double. In Waterloo Wellington the 65 years and older population is expected to increase from 11.5% (80,600) of the population in 2005 to 14% (112,060) by 2015. This represents a 21.7% increase from 2005 to 2015. The escalating trend in population aging is also seen in the population in Waterloo Wellington, aged 85 years or older, which increased by 25% from 2001 to 2006 and is projected to increase by 83% by 2015. This trend has important health system implications, as health care usage increases with age.

Currently in the WWLHIN area, seniors receive care in multiple settings in a fragmented manner. As health care usage increases with aging, the system impact is felt in the acute care, long-term care and community care sectors.

Acute care pressures are found in wait lists for emergency departments and high rates of ALC days. Seniors are not transitioning back home or into long-term care beds appropriately, due to a lack of supports available, and high occupancy rates in WWLHIN long-term care homes.

Further pressures are found at the community level as demonstrated by long wait lists for professional and non-professional services. Additional options for long-term care such as assisted and supported living accommodations have the potential to serve the needs of such individuals. Community based care has been found to be 40-75% less costly than facility care, and seniors are less likely to call for emergency services during the night. However, the WWLHIN is one of only two LHINs in the Province that receives no, or limited, funding for assisted and supported living accommodations arrangements.

The literature suggests that the acuity or level of care that seniors require in long-term care homes is increasing over time. Currently, staff in long-term care homes are not

offered a coordinated, standardized approach to training and development to meet the growing demand of medically complex seniors.

A comprehensive Aging at Home Strategy can address population growth and expected increased service provision requirements for seniors who account for the largest use and costs to the system.

LINK TO GOVERNMENT AND MINISTRY PRIORITIES

The focus on Aging at Home in the WWLHIN is consistent with provincial priorities of providing better health to Ontarians, providing greater access to care when people need it, and by finding efficiencies in the system to ensure it is sustainable for the future.

Aging at Home further encourages integration and system coordination of providers to ensure that people have the care and services available to them when they need it.

LINK TO MINISTRY-LHIN ACCOUNTABILITY AGREEMENT (MLAA)

Specifically, the elements of WWLHIN's Aging at Home Strategy achieve the requirements and obligations set out in the Ministry-LHIN Accountability Agreement:

> Schedule 3, Part C, Sections 17 to 31 regarding operational obligations for long-term care services

The WWLHIN AGING AT HOME STRATEGY

The WWLHIN Aging At Home Strategy will:

- Make investments into community and long-term care settings. The strategy will improve access to care by assessing long term care bed capacity, and by building supportive housing units

- Enable seniors to remain at home for as long as possible by implementing innovative health service delivery models, and funding more community based services

- Increase the skills and knowledge of staff in the long-term care system to more effectively manage their medically complex needs

- Enhance innovative health promotion strategies to keep seniors well

The current inventory of accommodations and services available to seniors in the WWLHIN varies. The majority of seniors have care and supports provided to them in their own homes. When a transition to a higher level of care is required, supportive housing can offer personal supports and homemaking to residents in a permanent home-like setting. Characteristically, supportive housing is offered to low income and vulnerable populations. However, there are no supportive housing services available to seniors in the WWLHIN.

Alternatively, retirement homes provide a higher level of care for seniors who need assistance with daily routines. Retirement homes generally can offer a suite of services but costs for support are billed directly to the individual.

Long-term care is considered to be 24-hour nursing care provided primarily to seniors in a safe and secure setting. The highest level of care available to WWLHIN residents is complex continuing care; it is defined as longer-term, non-acute hospital care which may include rehabilitation, geriatric assessment, medically complex patients and palliative and end of life support.

The WWLHIN also offers 'continuum of care' communities or large seniors' campuses that offer a range of accommodations in one geographic location. The options may include privately-owned or leased condominiums, retirement homes and long-term care centres. The literature suggests that these communities offer significant socialization, support and quality of life benefits for seniors who can afford these options. The WWLHIN considers building on the capacity of 'continuum of care' communities to provide the infrastructure and potential locations of new developments in the Aging at Home Strategy.

OBJECTIVES AND PRIORITIES

The goal of the WWLHIN's Aging at Home Strategy is to provide a suite of services for seniors to enable them to live as independently as possible, for as long as possible, in a safe home of their choice.

Objectives of the Aging at Home Service Plan:
The objectives of the plan are:

- To determine the needs of seniors living in the WWLHIN, specifically those seniors who may be particularly vulnerable due to low income, social isolation, lack of family or community support, those in rural areas and the multicultural population
- To identify gaps in services for seniors across the continuum of care
- To identify and implement a model of integrated service delivery for Complex Geriatrics as well as the Frail Elderly
- To identify, prioritize and choose innovative service delivery model (s) (such as Home At Last, Balance of Care model, Echo)
- To assess the long term care bed capacity within the WWLHIN
- To identify Supportive Housing model(s) based on best practice and suitability to our area; review existing WWLHIN Supportive Housing proposals against best practice, and recommend a proposals for implementation
- To deliver the Aging at Home Strategy, the WWLHIN plans to make investments including increasing community support services, creating supportive housing units and increasing funding to long-term care homes.

The WWLHIN's Aging at Home Service Plan will address the unique and diverse needs of seniors residing in the WWLHIN by:

- Listening to the specific needs of seniors living in the WWLHIN as articulated in focused community engagement activities
- Purposefully engaging marginalized senior populations to ensure that their unique circumstances and needs are reflected in the strategy
- Utilizing the expertise and community wisdom of members participating on the WWLHIN's Communities of Interest to ensure that recommended strategies are based in best practice
- Build on the strong spirit of innovation and knowledge transfer that exists in our LHIN, capitalizing on the dynamic relationship between our health service providers and local research and academic institutions.

BROAD PARAMETERS OF THE PLAN

Community Engagement

The WWLHIN Aging at Home Strategy has been informed by information and insights generated from numerous community engagement activities with both the public as well as health service providers. The following local community engagement activities have been particularly valuable for informing our plan:

1. "Champions of Change Symposium"
On September 25th 2007, the WWLHIN held a symposium for local Health Service Providers, health professionals and community organizations called "Champions of Change". The Symposium highlighted local examples of "Excellence through Collaboration and Innovation" and included presentations by local leaders on two innovative health service delivery models: the "Home at Last" project as well as the "Balance of Care" model.

2. WWLHIN Health Service Provider Planning Sessions
The WWLHIN has facilitated a series of joint planning sessions with its Health Service Providers beginning in September 2007, in order to encourage organizations to "work together differently", as well to address the community engagement requirement of Health Service Providers' Service Accountability Agreements. Organizations present their challenges or "pressures" within the larger health system context, and are then guided through a facilitated discussion to identify innovative solutions involving traditional and non-traditional providers. This planning approach has allowed the WWLHIN to identify specific health system issues which are relevant to our Aging At Home Strategy, and to encourage providers to think differently about how they might address the issues.

3. Focus Groups with WWLHIN Seniors
The WWLHIN has worked collaboratively with various community partners, to hear directly from seniors themselves. To date, four focus groups have been conducted, with

one additional focus group planned for October 31st 2007. Focus groups were held at the following organizations: Alzheimer Society of Cambridge, Evergreen Centre in Guelph, Groves Memorial Hospital in Fergus, the Kitchener Downtown Community Health Centre. The planned focus group at a long term care home in the northern area of our LHIN will round out the geographical representation. Each of the focus groups has yielded rich information about the diverse needs of seniors, including those dealing with a complex medical condition, those who are particularly vulnerable due to low income, social isolation, and being newcomers to Canada. We also heard from the "well" seniors; those who enjoy robust social support and have fewer barriers to receiving care. These seniors also provided a much needed perspective specifically relating to system navigation. The community engagement work to date has been a key component of our strategy, and will continue throughout the planning and implementation phases.

4. Building on the Capacity of the WWLHIN's Community of Interest Tables
The WWLHIN's planning approach builds on the local expertise and community wisdom of members of its Communities of Interest (COIs) tables. The WWLHIN's Aging At Home Steering Committee is comprised of the co-chairs of eight of these COIs. These co-chairs along with WWLHIN staff are informing and educating COI members about the Aging at Home strategy, and facilitating input and feedback to the Steering Committee on unique perspectives, such as Rural Health, Mental Health and Addictions.

5. Validation of Previous Research through Existing Networks
The WWLHIN Aging at Home workplan calls for a validation of a recent needs assessment conducted in the WWLHIN (Beyond 2006) which described the needs of seniors, our current inventory of services, as well as gaps in service. This document is being vetted through the WWLHIN's Services for Seniors COI to various existing networks, to ensure that this document is relevant and up-to-date. This process effectively engages members of area networks who have community-based experience and intelligence to inform and validate this aspect of our environmental scan.

Based on community engagement activities to date, the following themes have been identified:

- Providing Services to those with Complex Needs for those seniors with complex needs as well as the frail elderly population. Seniors' services experts within the WWLHIN have identified the need for an integrated service delivery model of care for complex geriatric residents and the frail elderly

- Alternative Models and Level of Care: There has been an identified need for an innovative service delivery model to assist those residents at risk of requiring care within the LTC to receive essential services within their home (Balance of Care, Home at Last models of care)

- Long Term Care Beds: The need to assess the Long Term Care bed capacity within the WWLHIN

- Supportive Housing: The need for Supportive Housing units within the WWLHIN to provide an appropriate level of care for those adults and seniors requiring services outside Long Term Care homes

- Multicultural Specific Concerns: The need for community supports, interpretive services, transportation services, English as a Second Language classes and socialization opportunities for multicultural residents to alleviate social isolation and resulting mental health issues

- Transportation: The need for affordable, accessible transportation in both urban and rural settings, in order for seniors to access medical services and social and recreational opportunities or to visit loved ones in hospital or long term care facilities

- Adult Day Programs: Access to Adult Day programs and informal recreation opportunities for seniors in the early stages of dementia (including Alzheimers)

- Access to Home Care: Improving access to high quality homecare services, specifically refining eligibility criteria and improving the amount, range and quantity of home care services; allowing residents to have choice over what services they require to live independently

- Caregiver Support: Increasing programs, services and respite programs to assist family members to care for their senior loved ones at home

- Increased Knowledge Base: Increasing health care providers' knowledge of community supports

- Transportation: Improving access to transportation services in order to attend medical appointments, social activities, LTC to visit spouse etc.

- Socialization and Recreation: Addressing the needs of isolated seniors for socialization and recreation

- Assistive Devices: Improve funding for Assistive Devices and home safety modifications to allow seniors to live independently in their homes

- Culturally Appropriate Supports: Our multicultural population identified social isolation and resultant emotional and physical impairment as a key issue. Transportation and translation services were seen as key enablers for this community to address their needs.

These issues will be considered by the WWLHIN Aging at Home Steering Committee, and directed to an appropriate WWLHIN Community of Interest (COI) or ad hoc Working Group of the Services for Seniors COI for full consideration. Long Term Care bed capacity will be addressed internally by WWLHIN staff with expert knowledge of the issue.

CROSS-SECTORAL PARTICIPATION

The Aging at Home Strategy requires participation from acute care, long-term care, community health centres, primary care, community care access centre, mental health and addictions and community support services. The WWLHIN has launched several

Communities of Interest (COI) planning tables to provide recommendations regarding supports required for seniors. The Communities of Interest directly related to this strategy are Supportive Housing, System Navigation, and Services for Seniors.

Senior leadership and front line staff from health service providers, with community members, will meet regularly to suggest evidenced-based best practices, and revised service delivery models to improve the continuum of care. The WWLHIN will collaborate with agencies through websites, the media and newsletters to communicate any system changes for seniors' care.

INNOVATIVE IDEAS AND BEST PRACTICES

The WWLHIN is considering several innovative ideas and best practices in the implementation of the Aging at Home Strategy. The "Research to Reality" Working Group will identify and prioritize innovative services for implementation in the WWLHIN in 2008/2009. Models for consideration include, but are not limited to, Home At Last, Balance of Care, Echo and Choice. Additional innovative models will also be considered by this Working Group.

The following two models were showcased at the WWLHIN's "Champions of Change" Symposium held on September 25 2007, and exemplify the types of models that the Working Group will consider.

Home At Last

WWLHIN has been the pilot site for a Home At Last Program. The Home At Last program is an innovative collaboration between hospitals, community support service sector (CSS), and the community care access centre (CCACs) in Waterloo Wellington which facilitates the safe and smooth transition of patients from hospital to home. This transition is achieved by coordinating an enhanced hospital discharge process, where a personal support worker accompanies a discharged hospital patient to their home and assists them with tasks such as picking up prescriptions, groceries, preparing a meal, and then remaining with the patient until a family caregiver arrives home or 9:00 p.m. at the latest. The next day, the Home At Last Coordinator will follow-up with the patient and family to arrange and monitor needed community services and supports in partnership with the CCAC community case manager (if applicable) so the patient can remain at home and reduce the possibility of readmissions to the hospital.

Community Care Concepts is the lead agency for Home at Last. Its partners are Grand River Hospital, Guelph General Hospital, St. Mary's General Hospital, City of Waterloo Home Support, Independent Living Centre of Waterloo Region, St. Joseph's Health Centre Adult Day Program, Waterloo-Wellington Community Care Access Centre and Guelph Services for Persons with Disabilities.

An evaluation of the progress and outcomes analysis will be conducted by the Working Group overseeing the Home At Last Program. It is anticipated that the results of the evaluation will be shared at the WWLHIN Services for Seniors Community of Interest planning table (Innovative Services Working Group) in order to assist in the identification of potential service delivery recommendations for implementation in 2008/09.

Balance of Care Model

WWLHIN has also been the pilot site for the Balance of Care model. The Balance of Care approach aims at determining the most appropriate mix of institutional and community resources at the local level to meet the needs of an aging population. Dr. David Challis and his colleagues at the Personal Social Services Research Unit (PSSRU) at the University of Manchester, UK developed the Balance of Care (BoC) model to determine the appropriate balance of institutional and community based care for frail seniors at risk of losing independence and being admitted to a long-term care facility.

In collaboration with care managers from across the continuum of care in Waterloo Wellington (community, long-term care, acute etc.) researchers at the University of Toronto applied this model to 800+ seniors waiting for long-term care facility placement in Waterloo. The aim was to assess what proportion could be diverted from the LTC wait list if given an appropriate mix of community-based services. The project results indicated that a significant percentage of those on the wait list could be maintained in the community given current home and community services.

PROPOSED BENEFITS TO OUR COMMUNITY FROM THE AGING AT HOME STRATEGY

In Waterloo Wellington, the 65 years and older population is expected to increase from 11.5% (80,600) of the population in 2005 to 14% (112,060) by 2015. This represents a 21.7% increase from 2005 to 2015. The escalating trend in population aging is also seen in the population in Waterloo Wellington, aged 85 years or older, which increased by 25% from 2001 to 2006 and is projected to increase by 83% by 2015. This trend has important health system implications, as health care usage increases with age.

Currently, in the WWLHIN area, seniors receive care in multiple settings in a fragmented manner. As health care usage increases with aging, the system impact is felt in the acute care, long-term care and community care sectors.

The proposed plan benefits seniors of all ages and abilities, and will benefit the health system in numerous ways.

For healthy seniors caring for loved ones, increased access to caregiver supports, respite services, enhanced recreation and socialization opportunities will increase quality of life for themselves and those they care for. This strategy requires an investment in the CSS sector, and has the potential to reduce the demand for long term care beds if families are appropriately supported in their efforts to care for an individual within their home.

For frail seniors or those dealing with complex chronic diseases, innovative models of health service delivery will enable them to remain safely in their homes and avoid admission to a long term care facility. In addition, providing community-based supports and medical services in the home and community will lead to a decrease in non-emergency admissions to the ED and hospital.

Building supportive housing units and placing appropriate seniors in this setting provides an option other than long term care for those individuals who require more intensive, round-the-clock assistance. This model of care has the potential to alleviate ALC

pressures in the hospital setting, reduce the demand for long term care beds and will reduce non-emergency admissions to hospital.

Assessing long term care bed capacity will increase the community's ability to meet the needs of some seniors who are best cared for in this environment.

Providing community based programs for our multicultural senior residents including transportation, opportunities for social and recreation, language instruction and translation services will alleviate the hidden suffering that this community faces.

WWLHIN'S Aging at Home Strategy will address population growth and expected increased service provision requirements for seniors who account for the largest use and costs to the system

PERFORMANCE MEASURES AND OUTCOMES

Alignment with the WWLHIN IHSP/Benefit to Seniors:

In the development of the WWLHIN's first Integrated Health Service Plan, members of the community identified several needs, service gaps and priorities for seniors' services in the area. Specifically, residents identified a lack of services available to support seniors living in their own homes.

Town hall participants also indicated a need to:

- enhance assisted living for seniors
- address wait times for long-term care homes
- improve the placement process
- coordinate mental health services

The need to improve the education and training levels of long-term care staff was also identified in community consultations.

The WWLHIN Aging at Home Strategy aligns with the IHSP health system integration priorities: improving access to health services, improving the health of the population, enhancing system effectiveness, and building community capacity to achieve a sustainable health system.

Population Health

The health of the population will be positively impacted by this Aging at Home Plan due to the increased community capacity to support people to live longer, healthier lives at home.

Accessibility
This plan will improve access to care for seniors by developing supportive housing units and by reducing wait times for long-term care beds.

System Effectiveness and Sustainability
System opportunities and efficiencies will be found from fewer ALC days and fewer inappropriate visits to hospital emergency departments.

Health System Outcomes

The successful implementation of the WWLHIN Aging at Home Plan will result in enhanced, integrated and higher quality service provision for seniors. The plan will create sustainability in the WWLHIN as seniors use services that are better coordinated, more effective and more efficient than currently available.

Performance Indicators

WWLHIN's expectation is that the impact of the Aging at Home plan will be reflected through positive change in the following performance measures:

- Decreased median wait time to long-term care placement from community
- Decreased median wait time to long-term care placement from acute care
- Achieve compliance to clinical practice guidelines in integrated case management models as reported by system performance data
- Increased efficiency in the system by reducing ALC days
- Reduced time of first post-acute home care visit
- Reduced rate of hospitalizations for ambulatory care sensitive conditions that could be managed elsewhere
- Reduced emergency department (ED) costs as measured by ED visits that could be managed elsewhere

Workplan

The attached workplan identifies the following directional plan activities:

- Innovative, Integrated Health Service Delivery Models

  a) Complex Geriatrics Working Group - Identify an integrated service delivery model for Complex Geriatric patients

  b) Research to Reality Working Group - Identify a framework and methodology for pilot testing innovative service delivery model, e.g. Home at Last, Aging at Home, Choice etc.

  c) Frail Elderly Working Group – Develop an integrated service delivery model for the Frail Elderly

  d) Keeping Seniors Healthy Working Group – Identify and implement programs and services focusing on innovative health promotion initiatives with new and non-traditional partners

- Supportive Housing - Review existing supportive housing proposals for the WWLHIN

- Long Term Care Bed Capacity Review - Assess WWLHIN's long term care bed capacity, considering the potential impact of planned enhanced community support services.

- Ongoing Community Engagement

The WWLHIN will support the Aging at Home Strategy by allocating time and resources of one of its senior staff members to serve as project lead. This person will participate on the Ministry-LHIN provincial working group and chair the WWLHIN Aging at Home Steering Committee, and work closely with an external consultant hired to provide project coordination and planning support to the Steering Committee, Working Groups and Communities of Interest (COIs) as required.

Planning dollars, made available through the Strategy, will be used to hire a project coordinator who, together with the WWLHIN staff lead, will support the work of the Steering Committee as well as provide planning support to the Services for Seniors Working Groups and Supportive Housing COI.

The Work Groups will be required to develop a workplan clearly describing activities, deliverables and timelines. Workplans will be submitted to the Aging at Home Steering Committee for review, and then forwarded to the WWLHIN Senior Team for recommendation and approval.

Community engagement will be particularly important as working groups generate ideas and recommendations. Recommendations from each of the Working Groups will be brought forward to the Aging at Home Steering Committee for discussion. The Steering Committee will also identify which Communities of Interest will consider the Working Groups recommendations as a way to ensure that their particular perspective (i.e. Rural Health, System Navigation, Primary Care, Chronic Disease Prevention and Management etc.) has been taken into consideration. Feedback from the relevant Communities of Interest will be brought back to the Steering Committee via the co-Chairs, and then forwarded to the appropriate Working Group/COI for consideration. Working Groups will then modify their recommendations as needed, and then forward a final recommendation to the Steering Committee for their endorsement. These Working Group recommended activities will then be presented to the WWLHIN's Senior Team for consideration and approval.

Ongoing Community Engagement:

As mentioned before, the WWLHIN will facilitate input from and cooperation between key stakeholders and partners to its Aging at Home Strategy by building on its existing COI structure and through the strategic formation of its Aging at Home Steering Committee. The Aging at Home Steering Committee will be comprised of the co-sponsors of eight Communities of Interest (COIs) with particular expertise and perspectives that will inform our plan.

These COIs include: Services for Seniors, Mental Health and Addictions, Primary Care, System Navigation, Supportive Housing, Rural Health, Chronic Disease Prevention and Management, End of Life/Palliative Care. Members participating on the WWLHIN's COIs include: health service providers, health professionals, non-LHIN service providers, other Ministries, community members, municipal and regional elected officials as well as academics from area universities who provide their expertise and perspective to the issues at hand.

Community Engagement activities will take place through existing Communities of Interest (COI), existing networks, other LHINs via a Ministry/LHIN working group; and through targeted community engagement activities (focus groups, questionnaires) reaching out to specific vulnerable populations i.e. those with dementia, seniors living in rural areas, those with low income, isolated seniors, and those within the multicultural population.

Research, Data Analysis and Planning Methodologies:

The WWLHIN has worked alongside five other LHINs in developing a Health System Integration Methodology (HSIM). This work is now completed and will support the development and implementation of innovative health system integration, in order to support the transformation of the health system. The HSIM is a five step review process to manage complex program and population integrated service delivery innovation. As well, for projects that focus on smaller, less complex improvement projects there is a three step/review quick win process. Specifically, Step 2 and Step 3 of the HSIM methodology will inform the model development and establishment of review criteria.

Community Based Participatory Action (CBPA) is a research methodology that brings together researchers and community members so that they can work together to identify problems faced by the community, to empower community members to collaboratively work together to create solutions to those problems, action those solutions and improve conditions in the community. The principles and phases inherent within a Community Based Participatory Action Research methodology will ground and compliment the HSIM methodology that we will be using.

CBPA principles include: citizen participation; recognizing the value of local knowledge; working cross-sectorally as well as cross-organizationally; seeking out and including a wide range of participants (specifically, marginalized groups who may have less of a voice); choosing research methods to “fit” the situation, as well as involving those affected by the issue to define the issues, and shape strategies and solutions.

The COIs will utilize quantitative and qualitative data analysis in completing its work. Quantitative data analysis will draw on the results of previous environmental scans in order to complete a current gap analysis. Qualitative data analysis will be supported through focused community consultation activities targeted to support the work of the COIs. Where appropriate, COIs will conduct best practice research and will consider aspects of the HSIM’s Building Block Framework for Integrated Service Delivery Model design as follows: target population, mission/guiding principles, scope of services, points of access/entry, approach to assessment, care coordination, information requirements and flow, linkages to and fit within the continuum, oversight and accountability, performance and financial management.

Priority Activities:

Please refer to the attached Aging At Home Strategy Workplan

Policy/Legislative Enablers

With respect to the proposed addition of long term care beds, it is recommended that the RFP process for new and redeveloped B, C long term care beds should be completed in partnership with WWLHIN. The WWLHIN would like input as to where any new beds should go and which beds need redevelopment.

Opportunities and Risks

The following opportunities and risks have been identified for our Aging At Home Strategy:

Risks

Risk 1

- Ability of the Services for Seniors COI to identify and implement a model of health service delivery within a short time frame.
- Risk Management. Acquire additional planning support to facilitate this process

Risk 2

- Increasing community based services may have HHR implications i.e. an increased demand for Personal Support Workers etc. Our Strategy assumes that organizations providing new or enhances services will be able to hire and retain staff.
- Risk Management. The WWLHIN's HHR Council group will be asked to address this issue.

Risk 3

- Enabling seniors to live independently longer may decrease the need for LTC beds within the WWLHIN, thereby impacting this sector.
- Risk Management. Alternative usage of LTC beds e.g. respite, convalescence or palliative care, could be a focus of the Services for Seniors COI.

Opportunities

System opportunities and efficiencies will be found from fewer ALC days, and fewer visits to the hospital emergency department.

This strategy will improve access to care for seniors by developing supportive housing units and by reducing wait times for long-term care beds.

The health of the population will be positively impacted by this strategy due to the increased community capacity to support people to live longer, healthier lives at home.

SUMMARY

The Waterloo Wellington Local Health Integration Network's development and implementation of an Aging at Home Strategy for seniors will provide a suite of services for seniors to enable them to living as independently as possible, for as long as possible, in a safe home of their choice.

To deliver on this strategy, the WWLHIN plans to make significant investments in community care and long-term care systems. These investments will include: increasing community support services, the creation of supportive housing units and increasing funding to long-term care homes.

Increased funding to the community will address the higher demand of services required for people who have complex medical issues and people with Alzheimer's disease. This strategy will improve the quality of life of WWLHIN seniors by reducing demand on hospitals, and create efficiencies related to alternate level of care days.

Further delineation of our plans and implementation schedule will be provided in the January 2008 detailed plan submission.

Waterloo Wellington Local Health Integration Network
Aging at Home Strategy 2007
Workplan as of October 31, 2007

WWLHIN Aging at Home 2007 Strategy
Workplan as of October 31, 2007

Milestones for Aging at Home Strategy

September 25, 2007 - October 31, 2007	Phase 1 Community Engagement Activities
October 15, 2007	Formation of WWLHIN Aging at Home Steering Committee
October 31, 2007	WWLHIN directional plan submitted to MOHLTC
October 2007 – November 2007	Establishment of Working Groups (e.g. Complex Geriatrics, Research to Reality, Frail Elderly, Supportive Housing etc.)
Late November 2007	MOHLTC feedback to LHIN on directions, and legislative and policy enablers
November 1, 2007 - December 1, 2007	Innovative Model Development and Community Engagement
December 1, 2007	Issuance of RFP
December 31, 2007	Return of RFP to WWLHIN
January 7 -11 , 2008	Review of RFPs by WWLHIN Aging at Home Steering Committee for recommendation to WWLHIN Senior Team
January 24, 2008	WWLHIN Board reviews Aging at Home Detailed Service Plan
January 31, 2008	LHIN detailed service plan for 2008/09 submitted to the MOHLTC
February 2008 to March 2008	Ongoing Community Engagement and Service Delivery Implementation Planning
March/April 2008	Announcement of 2008/09 Funding
August 31, 2008	LHIN submits 2009/10 plan as part of Annual Service Plan submission
April 2008 - March 2009	Ongoing Implementation of Aging at Home Activities and Community Engagement
August 31, 2009	LHIN submits 10/11 plan as part of Annual Service Plan submission

Proposed Workplan to Aug 08

Priorities Activities	Purpose/ Objectives	Timeline	Resources
Phase 1 - Initial Community Engagement to Inform High Level Plan			
1. Community Engagement Conduct Community Engagement activities with specific seniors groups. Conduct 5 focus groups across the WWLHIN: • Alzheimers Society of Cambridge • Evergreen Centre in Guelph • Groves Memorial Hospital in Fergus • Kitchener Downtown CHC • Saugeen Valley LTC facility in Mount Forest • Distribute questionnaires to seniors attending the Woolwich Adult • Health Fair in Elmira • Review and Incorporate findings of the Woolwich CHC's • Wellesley site Senior's Advisory group	To ensure that the views of vulnerable/ marginalized and "at risk" seniors are reflected in the WWLHIN Aging @Home plan	October 1 -17th, 2007	WWLHIN Staff
2. September 25th Champions of Change Symposium • Highlight intersectoral collaboration and innovation with respect to services for seniors via the Balance of Care, Home at Last programs	Introduce innovative models of care to HSPs and community partners Introduce the Aging at Home Strategy	September 25, 2007	WWLHIN Staff

Priorities Activities	Purpose/ Objectives	Timeline	Resources
3. Health Service Provider Planning Sessions Incorporate learnings from the HSP planning sessions to identify the health care needs of WWLHIN seniors which present as health system pressures.	Identify health system pressures which indicate a need for a more efficient, integrated continuum of care for seniors	September 2007 – December 2007	HSPs (funded and non funded), municipal and regional government
4. Introduction of the Strategy at COI tables Introduction and initial COI table discussion of Aging @Home Strategy at: Services for Seniors and Rural Health COI members are HSP, health professionals, members of the public, cross-sectoral representation.	Introduce strategy, stimulate thinking on innovative approaches	October 2007	WWLHIN Staff leads for COI tables
5. Presentation to WWLHIN Board	Endorsement of Aging at Home Directional Plan for WWLHIN	October 25, 2007	WWLHIN Aging at Home Lead
6. High Level plan submitted to MOHLTC		October 31, 2007	WWLHIN Aging at Home Lead
7. MOHLTC provide feedback on high level plan		November 30, 2007	

Priorities Activities **(Phase 2 – Activities to Support Implementation of Directional Plan)**	**Purpose/ Objectives**	**Timeline**	**Resources**
1. Aging @ Home Steering Committee Formation of WWLHIN Aging at Home Steering Committee which will provide oversight and direction to the COIs involved in developing detailed implementation plans.	Expert advice to guide and inform the WWLHIN Strategy, and ensure community engagement Forum for reviewing recommendations from COIs	October 15, 2007 first meeting (Bi-weekly meetings)	WWLHIN Staff, Co-Chairs of COIs
2. Community Engagement Activities Review	Review findings of the October 2007 Aging @ Home community engagement activities. Community engagement results to inform direction of plan	November 1 -30th, 2007	Aging @ Home Steering Committee
3. Environmental Scan/ Needs Assessment Review and update the current state analysis of gaps in service needs for seniors across the continuum of care Gap analysis to be reviewed by relevant COIs as determined by the Aging @Home Steering Committee	Assess gaps, needs, and opportunities (effectively updates the Beyond 2006 document)	October 10 – mid November 2007 November – December 07	Services for Seniors COI Aging @ Home Steering Committee

Priorities Activities **(Phase 2 – Activities to Support Implementation of Directional Plan)**	**Purpose/ Objectives**	**Timeline**	**Resources**
4. Working Group **a) Complex Geriatrics Working Group** Establish a Complex Geriatric Working Group focusing on development of model(s) for integrated service delivery incorporating best practices for complex geriatric care.	Identify model	November 1, 2007- December 1, 2007	Services for Seniors COI and WWLHIN Aging at Home Project Coordinator
Based on the environmental scan/ needs assessment and the results of the complex geriatrics model development, identify and describe those populations requiring enhanced services including a current state analysis: • identify existing programs currently providing these services through inventory mapping • assess ability of these existing programs and services to meet the increased demand through examination of wait lists, current service volumes, predicted need		November 1, 2007 - December 1, 2007	Complex Geriatrics Working Group of the Services for Seniors COI
Carry out an RFP process for the implementation of the integrated service delivery model for Complex Geriatrics	To identify appropriate service providers able to deliver the service consistent with the criteria established by the WWLHIN	December 1, 2007 issuance to be returned to WWLHIN by December 31, 2007	Complex Geriatrics Working Group of the Services for Seniors COI

Priorities Activities (Phase 2 – Activities to Support Implementation of Directional Plan)	Purpose/ Objectives	Timeline	Resources
		RFP issued by WWLHIN to be reviewed by WWLHIN Aging at Home Steering Committee January 7 to 11, 2008	
b) Frail Elderly The Frail Elderly Working Group will focus on development of a model for frail elderly integrated service delivery and incorporating best practices Based on the environmental scan/ needs assessment and the results of the model development, identify and describe those populations requiring enhanced services including: - identify existing programs currently providing these services through inventory mapping - assess ability of these existing programs and services to meet the increased demand through examination of wait lists, current service volumes, predicted need	Identify model	July, August September 2008	Frail Elderly Working Group of the Services for Seniors COI Frail Elderly Working Group of the Services for Seniors COI

Priorities Activities **(Phase 2 – Activities to Support Implementation of Directional Plan)**	**Purpose/** **Objectives**	**Timeline**	**Resources**
c) Research to Reality Working Group			
Establish a Research to Reality Working Group focusing on the identification and prioritization of innovative services for implementation in the WWLHIN in 08/09 (e.g. Home at Last, Echo, Balance of Care, Choice, etc.)	Explore and identify model(s) with proof of concept for implementation	November 2008 – January 2008	Research to Reality Working Group of the Services for Seniors COI
Identify framework and methodology for pilot testing of prioritized models.		January 2008 – March 2008	Research to Reality Working Group of the Services for Seniors COI
Describe an innovative service delivery option (s) that address service gaps	Description of innovative service delivery option (s) to include the following: • Description of these seniors (e.g. low income, multicultural, rural, isolated, chronic diseases etc.) • geographic location of these seniors • description of specific services required	January 2008 –March 2008	

Priorities Activities **(Phase 2 – Activities to Support Implementation of Directional Plan)**	**Purpose/ Objectives**	**Timeline**	**Resources**
	• determine levels of increased service/programs required through gap analysis • identify existing programs currently providing these services through inventory mapping • assess ability of these existing programs and services to meet the increased demand through examination of wait lists, current service volumes, predicted need • identify potential new programs required to meet the increased demand for implementation in April 2008 • conduct Community Engagement activities to provide feedback on the proposed model, e.g.		

Priorities Activities (Phase 2 – Activities to Support Implementation of Directional Plan)	**Purpose/ Objectives**	**Timeline**	**Resources**
	Focus groups, involvement of COI extended membership		
Carry out an RFP process for the implementation of the innovative service delivery model	To identify appropriate service providers able to deliver the service consistent with the criteria established by the WWLHIN	December 1, 2007 issuance to be returned to WWLHIN by December 31, 2007 RFP issued by WWLHIN to be reviewed by WWLHIN Aging at Home Steering Committee January 7 - 11, 2008	Research to Reality Working Group of the Services for Seniors COI

Priorities Activities **(Phase 2 – Activities to Support Implementation of Directional Plan)**	**Purpose/ Objectives**	**Timeline**	**Resources**
7. Provincial and Local Community Engagement Activities Participate in Provincial community engagement activities on Dec. 12th a.m., complimented by a local community engagement activity focused on innovation in the afternoon	Engage community stakeholders	December 12, 2007	Project Coordinator and Aging @Home Steering Committee
8. Long Term Care Bed Capacity Assess WWLHIN's Long Term Care Bed capacity, considering potential impact of planned enhanced community support services	LTC Home capacity review to inform Services for Seniors COI model development	2009/2010	WWLHIN staff HSP Liaisons
9. Supportive Housing Develop or identify supportive housing service delivery model(s) to be validated by relevant COIs. COIs will review supportive housing models to ensure the model reflects the issues currently under review (e.g. complex geriatrics, mental health and addiction, rural health etc.) • Validate model with extended COI members and community with focus groups Review existing WWLHIN area proposals for Supportive Housing. Assess current proposals with respect to: • best practices • meeting the needs of vulnerable groups • ability of sponsoring organization/business to implement in April 2008 Recommend proposal to WWLHIN for funding and implementation in April 2008	Identify or develop Supportive Housing model(s)	November 15, 2007 – December 2007 November 15, 2007 – December 2007	Supportive Housing COI Supportive Housing COI

Priorities Activities (Phase 2 – Activities to Support Implementation of Directional Plan)	**Purpose/ Objectives**	**Timeline**	**Resources**
Implement an RFP process for the implementation of a new supportive housing service delivery model	To identify appropriate service providers able to deliver the service consistent with the criteria established by the WWLHIN	December 1, 2007 issuance to be returned to WWLHIN by December 31, 2007 RFP issued by WWLHIN to be reviewed by WWLHIN Aging at Home Steering Committee January 7 to 11, 2008	Supportive Housing COI
10. Keeping Seniors Healthy Implement an RFP process for the implementation of enhanced services to keep seniors healthy	To identify appropriate service providers able to deliver the service consistent with the criteria established by the WWLHIN and themes highlighted in the community engagement activities	December 1, 2007 issuance to be returned to WWLHIN by December 31, 2007	RFP issued by WWLHIN to be reviewed by WWLHIN Aging at Home Steering Committee January 7 to 11, 2008