Transforming health care to prepare for our future

Advice on the 2013 Ontario Budget
From Ontario's Community Care Access Centres
March 21, 2013

Ontario's 14 Community Care Access Centres (CCACs) help people get care where and when they need it throughout the province. CCACs help Ontarians of all ages understand their care options, access high quality home and community-based health services and resources, and receive timely and coordinated care at home.

Last year CCACs helped over 637,000 Ontarians receive care, by:

- Supporting over 16,000 people come home from hospital each month
- Assisting more than 300,000 seniors to live safely at home
- Providing services to over 79,000 children to help them live at home and attend school
- Helping over 134,500 people to find a primary care provider,
- Providing compassionate end-of-life care to help 26,000 people spend their final days at home with their loved ones,
- Helping 26,000 people move into the long-term care home of their choice,
- Making thousands of referrals each day to other community support services to wrap all needed care around patients,
- Helping people to smoothly transition to other places in the health care system such as complex care beds, rehabilitation beds, palliative care beds, residential hospices, assisted living programs and supportive housing, and
- Helping thousands of others find information and health services through our self-serve on-line resources, call centres and with the assistance our information and referral specialists.

Ontario's health care system is undergoing a significant transformation. Our health care system was originally designed to provide acute and primary care for a population that mostly needed

treatment for acute illness, trauma care and maternal and family care. As our population ages, the challenge is to design a sustainable system that promotes healthy aging and addresses the increasing burden of chronic disease and age-related frailty. This transformation is occurring in the midst of Ontario's recovery from the worst economic crisis in decades, where unrestrained investment in health care is not affordable.

More care is being provided in the community than ever before. Ensuring a continuum of home and community care that it is integrated, coordinated and easy to access is critical, as is recognizing the wide-ranging impacts of this change -- on hospitals, primary care practitioners, long-term care homes and the expectations for informal caregivers, to name a few.

In 2012 in the Ontario Budget and Ontario's Action Plan for Health Care, the government outlined a plan for targeted investments in key services including home and community care and long-term care, while holding the line in other parts of the health care system including hospitals and physician reimbursement. Maximizing investment in home and community care will ensure that people have access to most cost-effective care in the right place, and protect capacity in hospitals and long-term care homes for the people who need this level of care. Change of this magnitude is not easy, but it's the right thing to do for the people of Ontario.

To support health care transformation, ensuring a thriving system is there now and in the future for our children, our parents and ourselves, CCACs are committed to keeping administrative costs low and maximizing efficiency through technology advancements and reducing duplication in partnership with health system partners. And CCACs recommend:

1. **Maximize investment in home and community care so that Ontarians have equitable and timely access to the care they need**

    - Focus on improving population-focused, coordinated care through Health Links and better integration with primary care, rather that costly structural transformation that doesn't benefit patients.
    - Grow CCAC base budgets by 4% as committed in the 2012 Ontario Budget and target new funding to address growth pressures and reduce historical inequities between CCACs.
    - Increase the stability and predictability of funding to avoid rapid up-swings and down-swings in service levels and reduce wait times. This can be accomplished with proactive multi-year planning, timely communication and enabling CCACs and other community service providers to manage surpluses and deficits over multiple years.

2. **Recognize the broad impact of health system transformation and ensure a balanced continuum of care.**

   - Ensure a continuum of care in the community that includes stable, resilient home care with robust care coordination that is linked to other parts of the health care system to support a broad range of needs.
   - Continue to grow community support services and assisted living programs by 4% per year to ensure a balanced continuum of care in the community.
   - Ensure that long-term care homes have the resources they need to support residents with complex needs, and
   - Make the necessary changes to capital funding models to encourage redevelopment of older homes, ensuring the best possible use is made of existing long-term care home capacity.

3. **Provide leadership and continue to engage the public and private sectors broadly to find innovative ways of supporting informal caregivers.**

1. Creating a Coordinated Continuum of Community Care

A recent analysis of health care spending in Ontario by the Health System Performance Research Network (HSPRN) revealed that 1% of Ontario's population accounts for over a third of health care spending, and 5% of Ontarians account for two thirds of spending. The vast majority of the people in the top 1% are seniors over the age of 65 years and most have chronic diseases or conditions including heart failure, chronic obstructive pulmonary disease, myocardial infarction, cancer, strokes and hip fractures.[1]

The HSPRN concludes that we cannot afford to continue to spend the way we are currently spending on health care and we need to better manage care and spending for older adults. The solutions they propose focus on population-based health care and person-centred care for particular populations.

In 2011 CCACs began to make this change, implementing a new population focused-model of care that matches services and care coordination to population needs and strengthening connections with family physicians. This year, the Ministry of Health and Long-Term Care introduced Health Links in 19 early adopter communities that are designed to improve

[1] "High Cost Users: Driving Value with a Patient-Centred Health Care System" Health System Performance Research Network, December 2012.

coordinated, person-centred care for seniors and other complex patients who use high levels of health services. **CCACs are committed to supporting Health Links and we will ensure every Health Link has dedicated support from our care coordinators to ensure that the most complex patients receive rapid response, intensive case management and integrated care from their care team. We believe this approach has great potential to improve value for patients and improve the integration of care without requiring costly structural reform of the health care system.**

CCACs and home care service providers are also working together to transform the delivery of home care through a joint initiative – Quality and Value in Home Care (QVHC). This collaborative project is laying the foundation a home care delivery system that:

- Builds care around patients and enables integrated, interdisciplinary team care,
- Creates incentives and rewards results based on quality and the achievement of health outcomes through new outcome-based care pathways and payment models,
- Maximizes accountability, transparency and value for money, and
- Builds a sustainable basis for ongoing collaboration to drive system-wide innovation and promote evidence-based care.

Investment in home and community care

We know that Ontarians want to live, age and receive care in their own homes as long as possible. We also know that caring for people at home is cost effective and provides value for every health care dollar spent.

- It costs **$384 per day less** to care for a patient with high needs in the community as compared to an "alternate level of care" day in a hospital.[2]

- It costs approximately **$50 per day less** to care for a senior with moderate needs in the community as compared to a long-term care home.[3]

- By supporting people at home and in the community, CCACs and community support services together have created economies totalling approximately **$210 million** over the

[2] Data Source: Ontario Hospital Association (2012), OACCAC Utilization Reports Q1-Q3, FY11/12, Ministry of Health and Long-Term Care Mar 2012; Boston Consulting Group's Valuing Home and Community Study 2010.

[3] ibid.

last three years by shifting care from more expensive parts of the health care system to the community.[4]

Through collaborative discharge planning based on a Home First philosophy and targeted investments in community alternatives, the number of people waiting in acute and post-acute beds for alternate levels of care decreased by 15% between January 2009 and January 2013.[5] While progress has been made, over 1 in 10 hospital beds are still occupied at any given time by patients whose health care needs could be better addressed at lower cost and with better outcomes in other parts of the health care system.

Improved access to home care and efforts to improved integrated care planning and delivery between hospitals, primary care and CCACs, have also reduced inappropriate emergency room use, unnecessary hospitalizations and reduced re-admissions. Since 2009, the number of CCAC patients returning to emergency departments has decreased by over 2%, and the number of patients moving directly from hospitals to long-term care homes has decreased by 22.5%[6].

Wait times for home care for patients referred from hospitals and the community have gone down. Fifty percent of patients referred from hospitals receive home care within 1 day, and 9 out of 10 receive it within 6 days. Nine out of ten people referred to CCACs from the community receive services within 34 days, down from 43 days three years ago. With further investment, CCACs can continue to reduce home care wait times[7] (See Appendix A for more information on CCAC wait lists and wait times).

Consistent with the 2012 Ontario Budget commitment, investment in CCACs grew provincially at just over 4% last year. However, not all CCACs received the same level of investment and the allocation of new funding was not targeted at reducing long-standing regional funding inequities that have been noted by the Auditor General of Ontario[8]. **CCACs recommend maximizing investment in home and community care in 2013, including increasing CCAC base allocations by 4% to address population growth, aging and improve access to the right care in the right place at the right time. We further recommend that, if additional funding is available, a portion should be used to close the long-standing gap in equity between CCACs.**

[4] Data Source: Ontario Hospital Association (2012), OACCAC Utilization Reports Q1-Q3, FY11/12, Ministry of Health and Long-Term Care Mar 2012; Boston Consulting Group's Valuing Home and Community Study 2010.

[5] OHA ALC survey results – November 2007 to June 2011; WTIC: ATC – July 2011 to Jan. 2013

[6] "Putting People at the Heart of All We Do: CCAC Quality Report 2011/12".

[7] Ibid

[8] 2010 Annual Report, Office of the Auditor General of Ontario, chapter 3.04 Home Care Services

Improve stability and predictability of funding for home and community care

Improved access to timely home care could be achieved by simply creating greater stability and predictability of funding. Three structural challenges are inherent in the way CCACs are funded, creating barriers to providing timely, responsive care. These challenges will be exacerbated as the health care system transitions to new patient based funding models:

- Funding commitments in the provincial budget are announced broadly for home and community care, encompassing CCACs, community support services, community mental health and addictions services and other initiatives related to home and community care. The allocation of funding to individual services and organizations occurs primarily at the Local Health Integration Network (LHIN) level and individual LHINs make differential investments across all of these services. As a result CCACs and other community service providers have no basis for predicting actual funding levels until they receive confirmation of their funding allocation.
- Funding allocations are rarely confirmed until the second half of the fiscal year, and sometimes as late as the fourth quarter, and are often accompanied by new service targets. In practice, this process forces CCACs to restrict service levels in the first half of the year until funding is confirmed, ramp services up quickly in the second half of the year to meet targets and optimize use of resources, then bring service levels down to achieve a balanced budget by the end of the fiscal year and ensure sustainability into the next year.
- Unlike hospitals, CCACs are not permitted to carry over any surplus from year to year, nor are they permitted to incur a deficit. Our analysis indicates that while most in-year CCAC deficits pressures are in the magnitude of 1% of overall funding, a disproportional level of effort is required to ensure any deficits are eliminated by the end of the fiscal year. More importantly, unnecessary uncertainty and frustration is created for our patients and health care partners.

Taken together, these factors make planning and delivering a consistent level of services very difficult. A “gas on/gas off” pattern emerges that is hard for CCACs to manage and for patients and our health care partners to understand. Simple ‘no cost’ changes in the funding process would help CCACs better manage people’s long-term needs, improve confidence in the home and community care system and eliminate unnecessary administrative attention.

To increase the stability and predictability of home care, CCACs recommend:

- **LHINs and CCACs collaborate on a multi-year funding framework aimed at increasing the predictability of resources.**
- **Set benchmarks for the communication of budget allocations to local providers within six weeks of confirmation of provincial estimates.**
- **CCACs and other community service providers should be treated in the same manner as hospitals and have the ability to retain in-year surpluses and manage deficits over multiple years to enable greater stability of service volumes.**

Improving efficiency and reducing duplication

CCACs keep their administrative and overhead costs low and looking for new ways to reduce duplication and maximize investment in patient care (See Appendix B). Over the past 3 years, CCACs provincially reduced administrative costs from 4.6% to 4.3% of their total expenditures. An additional 1.4% spent on office and clinic space and 2.5% spent on information technology to support integrated patient care has been held flat over the same period. CCACs continue to seek ways to do even better.

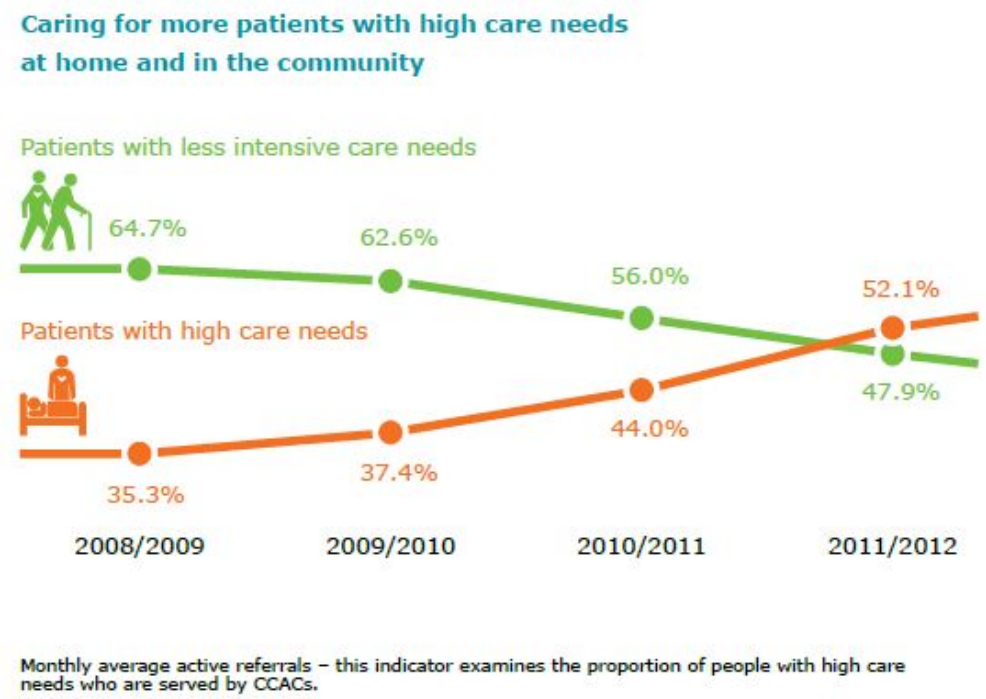
Our investment in technology has made CCACs an e-health success story. CCACs have fully developed and implemented a single electronic record province-wide – the Client and Health Related Information System (CHRIS) – that supports care coordination and daily business functions, and enables health information to be securely shared with all members of a patient's health care team, including family physicians, hospitals, long-term care homes and community support services providers. Enhancements to this system are enabling electronic interactions that support care teams.

2. *Recognize the broad impact of health system transformation and ensure a balanced continuum of care*

CCACs are seeing a dramatic shift in the care people need. In 2011/12, over half (52%) of CCAC patients had high care needs, up from 35% in 2008/09. It costs $1, 125 per month to care for someone with complex needs at home. While still less than the cost of care in an institutional or residential setting, the care of these patients costs approximately 2 to 3 times more each month than the care for patients with low to moderate needs.

Build capacity across the continuum of community care

While CCACs are devoting more resources to relieve pressures on hospitals and support people with higher care needs in the community, more seniors with stable, less complex or intense needs for support are being referred to Community Support Services for services such as home support/homemaking, meals-on-wheels, transportation services, home maintenance and adult day programs. These programs play a critical in helping seniors to remain independent and safe in their homes and communities.



Assisted Living Programs for High Risk Seniors are also a key part of the continuum of community care. While these programs have great potential to fill the gap between home care services and long-term care for seniors at risk who require periodic rapid-response services rather than scheduled assistance, access to these services varies widely across and within LHINs.

CCACs recommend continued investment of 4% per year to build capacity in community support services and assisted living to ensure that seniors are able to access the most appropriate support services to meet their needs and to prevent or delay their need for higher, more costly levels of care.

Strengthening long-term care homes to meet emerging needs and expectations

Enhanced community capacity means that the people moving into the long-term care home system are now almost always people with heavy personal care needs, medical complexity and advanced dementias, often with related challenging behaviours. In the past, long-term care homes were able to balance admissions of people with high care needs with admissions of people with more moderate needs (See Appendix C). **Long-term care homes need:**

- **Staffing with skills matched to the more complex care needs of the populations that they are now serving,**
- **Outreach support and strong linkages with other care sectors to address the needs of residents who require more complex health care or behaviour management,**
- **More specialized capacity/units with adequate resources to address the needs of the most complex residents, including those with severe mental health problems, dementia and aggressive behaviours.**

Matching long-term care capacity with the needs and choices of Ontarians

There has been much discussion and debate about wait times to access long-term care home beds and how much long-term care home capacity Ontario needs. A key confounding factor in this discussion is the mismatch between the current long-term care home bed capacity and the needs and choices of Ontarians.

As of March 2012, there were still approximately 35,000 long-term care home beds awaiting redevelopment. Many of these older homes are challenged to fill their capacity. In their March 2012 report "WHY NOT NOW? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults" the Long Term Care Innovation Expert Panel outlined the challenges long-term care homes are experiencing in financing redevelopment costs. The report makes a series of recommendations, including the need for new capital financing models that will preserve operator viability while offering accommodation and amenities that are aligned with the needs and choices of Ontarians. **CCACs support the need for new capital financing models for long-term care homes and recommend that the priority must be to align our current capacity with the needs and choices of Ontarians before decisions are made to invest in creating additional long-term care home capacity.**

3. Supporting caregivers

As our population ages, supporting the needs of family and other informal caregivers must be a continuing priority. Approximately 1 in 5 Ontarians is a caregiver for a family member or friend. In a Canadian Health Consumer Survey conducted by Deloitte in 2009[9], 10% of Canadians reported that they have a family member who requires constant care. It has been estimated that family caregivers provide 80% of all care needed by people with long-term health problems saving the Ontario health care system billions of dollars every year.

In August 2010 the Canadian Institute for Health Information released a report[10] indicating that one in six people providing informal care for seniors experiences distress. People caring for seniors with Alzheimer's or other dementias experience the highest levels of stress. Without supports, caregivers are at risk for health problems, depression and other negative outcomes that impact their ability to live productive, satisfying lives and continue providing care.

A number of positive steps have been taken. In 2008/09, the Ministry of Health and Long-Term Care undertook a long-term scenario planning process with respect to caregiving. In developing Ontario's Seniors Strategy, Dr. Samir Sinha consulted broadly with Ontarians about the needs of seniors and their caregivers and has made recommendations to improve access to information and services. The Healthy Homes Renovation Tax Credit and the introduction of proposed amendments to the *Employment Standards Act* will help to reduce the financial burden on caregivers and provide additional job security for those who need time away from work to care for a seriously ill family member.

While government leadership and a flexible range of services and supports for caregivers are critical, the solutions and responsibility go well beyond government. Broad engagement of employers, private insurers, unions, community organizations, community planners, technology leaders and other stakeholders is needed. To sustain caregivers now and in the future Ontario will need:

- Private and public sector employers that embrace flexible work options that support workers to be productive while balancing their caregiving responsibilities;
- Technology solutions that help caregivers to care from a distance;
- Private insurance options designed around the needs of seniors and their caregivers to augment publicly funded services; and

[9] "2009 Survey of Health Care Consumers: Key Findings, Strategic Implications", Deloitte Center for Health Solution, 2009.
[10] "Supporting Informal Caregivers – The Heart of Home Care", Canadian Institute for Health Information, 2010.

- Community development and housing options that provide safe, supportive environments and facilitate multi-generational living.

CCACs support the recommendations of the Ontario Caregivers Coalition that include:

- **Government leadership in engaging public and private sector employers, insurers, unions and caregivers to develop and test workplace policies and income supports to benefit caregivers,**
- **Building on the government's long-range scenario planning process "Caring about Caregivers" to develop solutions to support caregivers, and**
- **Incorporating caregiving as a cross-cutting issue within all government health projects and programs.**[11]

In summary

Ontario CCACs are fully committed to supporting the transformation of health care to address the changing needs of Ontario's population and ensure the sustainability of the health care system Ontarians cherish. Successful transformation will depend on a continuum of care in the community that includes stable, resilient home care with robust care coordination that is linked to other parts of the health care system, a focus on supporting healthy aging and innovative, forward-thinking solutions to support informal caregivers. Stable and predictable funding, that can be managed over longer time frames than a single year is a key enabler of improved access to timely, reliable care.

About the Ontario Association of Community Care Access Centres

The Ontario Association of Community Care Access Centres (OACCAC) supports Ontario's 14 CCACs to work with their health system partners to deliver quality home and community care. The mission of the OACCAC is to:

- Provide leadership, inspiration and serve as the collective voice for the contribution made by the CCACs to an integrated health care system
- Champion innovation, performance improvements and value proposition of community-based services, and
- Deliver high quality products and services which assist our members and partners in fulfilling their mission and mandate.

[11] "Ontario Caregiver Coalition Position Paper", April 2011

Appendix A – CCAC Home Care Wait Lists and Wait Times

As discussed in Chapter 4 of the report on Ontario's Seniors Strategy, "Living Longer, Living Well"[12], investment in home care has contributed to a reduction in the number of people waiting for one or more home care services from approximately 10,000[13] people in 2010 to just over 6,100 in December 2012.

The majority of those waiting, just over 3,300 people, are waiting for personal support services. The others are waiting for therapies, social work and dietetic services. There are no waiting lists for home care nursing services.

Wait times for home care have also gone down. In 2010, 9 out of 10 people referred from the community received services within services within 43 days; in 2012, 9 out of 10 people received services within 34 days, a 21% improvement[14].

CCACs use information derived from patient assessments, including validated indicators from the RAI-HC assessment, to determine each individual's priority for service. Every effort is made to initiate services for clients at high risk immediately. The majority of people waiting for services are at low risk for adverse outcomes as a result of the wait, and CCAC care coordinators monitor risk throughout the waiting time.

[12] "Living Longer, Living Well: Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on Recommendations to Inform a Seniors Strategy for Ontario", Dir. Samir K. Sinha, December 20, 2012.
[13] 2010 Annual Report, Office of the Auditor General of Ontario, Chapter 3.04 Home Care Services
[14] CCAC Multi-sector Accountability Agreement Reporting Indicators

Appendix B - Improving Efficiency and Reducing Duplication

This year CCACs undertook a new initiative "Transformation Begins at Home" to improve integrated care delivery, reduce duplication and further reduce administrative costs. Five improvement opportunities have been targeted for the initial phase of work:

- The OACCAC, on behalf of CCACs, it has initiated a project aimed at identifying additional opportunities for administrative savings and greater efficiency, particularly in supply chain processes.
- A provincial analysis has been completed that examines opportunities to optimize our existing technology capacity to further improve care and administrative efficiency by eliminating any remaining paper-based systems that rely on faxing and mailing of reports.
- CCACs are improving integration with primary care through alignment of CCAC care coordinators with family health teams, community health centres and other family health care providers, along with the adoption of provincial standards for communicating with family care providers about patient care.
- CCAC s are working with the Community Support Services sector to minimize the duplication of assessments and improve information sharing, and are sharing CCAC assessment information with other health care providers securely through the province's Integrated Assessment Record.
- By the end of this fiscal year, CCACs will have completed implementation of the thehealthline.ca across the province, creating a single provincial database of more than 50,000 health services and a common provincial portal designed to guide users to their local CCAC.

Appendix C. Strengthening Long-Term Care Homes to Meet Emerging Needs and Expectations

As the capacity grows in the home and community care sector to care for people with more complex and intense care needs, the people moving into the long-term care home system are now almost always people with heavy personal care needs, medical complexity and advanced dementias, often with related challenging behaviours. In the past, long-term care homes were able to balance admissions of people with high care needs with admissions of people with more moderate needs. Now, over 82% of long-term care home admissions fall into the high or very high categories of the MAPLe algorithm, a validated measure of risk of adverse outcomes that is derived from the RAI-Home Care assessments completed by CCACs. Of the other 18%, most are people with significant cognitive impairments as a result of Alzheimer's or other age-related dementias. This trend will continue.

The creation of short-term transitional care capacity through the expansion of the Convalescent Care Program will make it possible for more people to build strength and reach their optimal level of recovery before making the decision to move to long-term care. Many people will be able to return to live in their own homes and delay transition to long-term care after a stay in hospital or a health crisis in the community. This is a very positive step to meet the desire of most aging Ontarians to live in their own homes as long as possible, but it means that only people with the highest long-term needs will move on to long-term care homes.

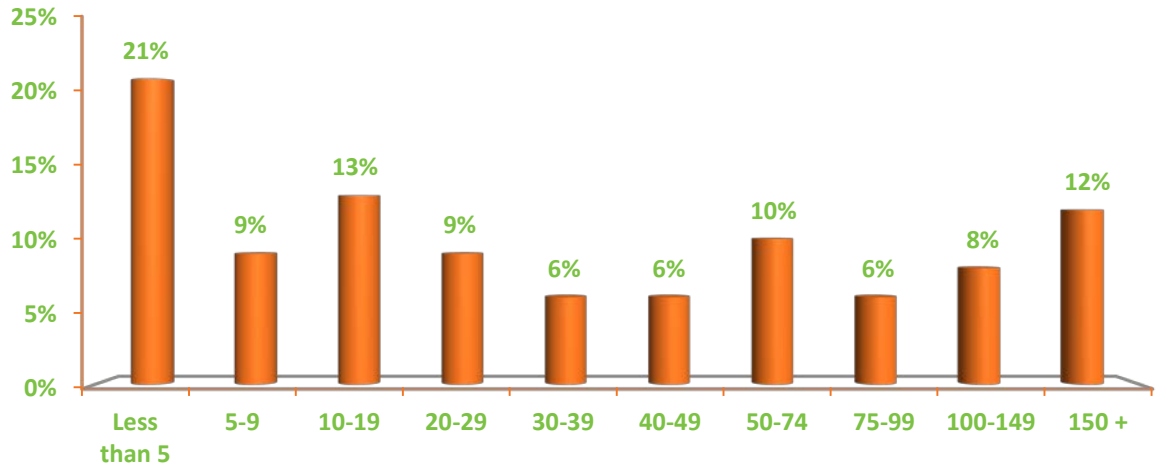
Matching long-term care capacity with the needs and choices of Ontarians

There has been much discussion and debate about wait times to access long-term care home beds and how much long-term care home capacity Ontario needs. A key confounding factor in this discussion is the mismatch between the current long-term care home bed capacity and the needs and choices of Ontarians.

Ontarians currently pay a co-payment of $1,674.14 per month for basic accommodation in a long-term care home and this fee can be reduced based on a person's ability to pay. Preferred accommodation rates for semi-private and private accommodation range from $1,917.47 to $2,274.86 per month. CCAC data indicates that approximately 60% of long-term care home applicants are seeking basic accommodation and this figure has been stable over many years; however, only 40% of current long-term care home capacity is basic accommodation.

There is also considerable unutilized or under-utilized capacity in the current long-term care home system. Since 1998, the Ontario government and long-term care homes have invested in redeveloping older homes to meet the current design standards. As of March 2012, there were still approximately 35,000 long-term care home beds awaiting redevelopment. Many of these older homes are challenged to fill their capacity. An analysis based on 2010/11 CCAC data indicates that more than 1 in 5 long-term care homes had fewer than 5 people on their waiting lists and some beds are chronically idle, meaning that there are no applicants waiting for these beds. At the other end of the spectrum, 20% of mostly newer homes had more than 100 people waiting for admission, and 12% of homes had more than 150 people waiting.

Number of Applicants on the Waiting List for Long-Term Care Homes (July 2010 to June 2011)



1 in 5 long-term care homes have less than 5 people of their waiting lists

In their March 2012 report "WHY NOT NOW? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults" the Long Term Care Innovation Expert Panel outlined the challenges long-term care homes are experiencing in financing redevelopment costs. The report makes a series of recommendations, including the need for new capital financing models that will preserve operator viability while offering accommodation and amenities that are aligned with the needs and choices of Ontarians.