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*Integration Priority & Action Plan:*

# **Building Linkages Across the Continuum – All Seniors, and Adults with Complex Needs**

October 31, 2006



## **Building Linkages across the Continuum - All Seniors, and Adults with Complex Needs**

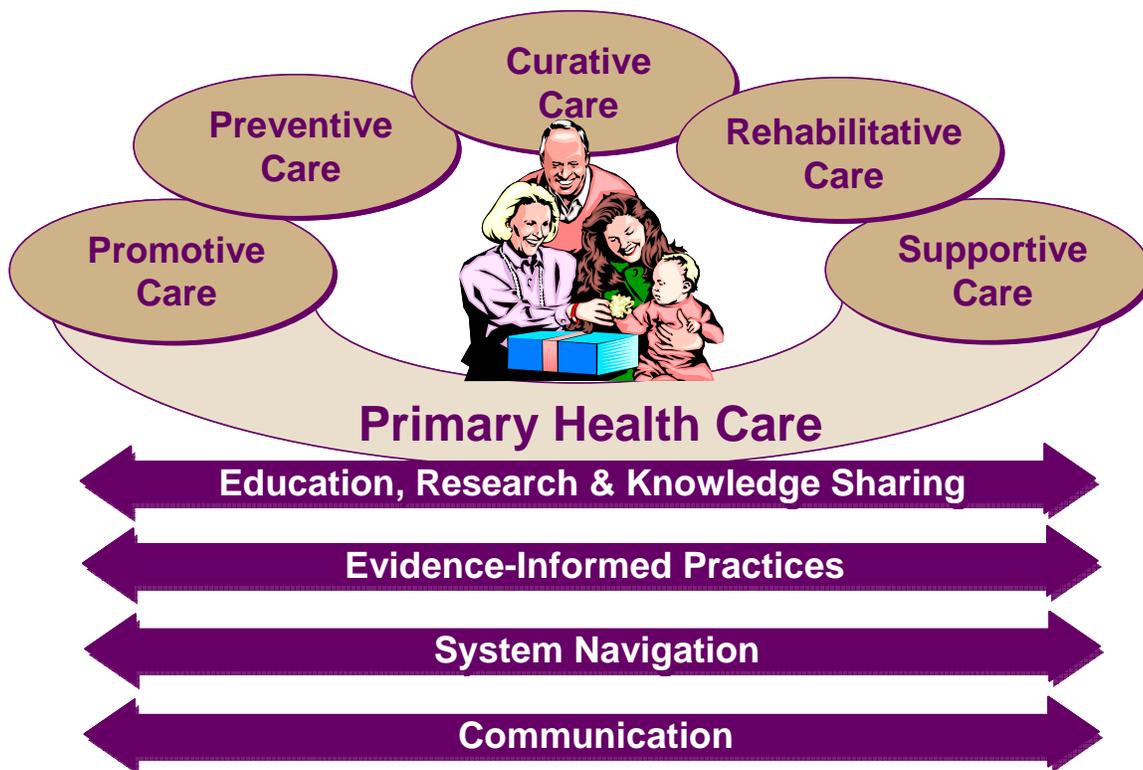
### **Description**

No single organization can or does provide the entire spectrum of services required by a population. To ensure that consumers can move through the system easily, service providers across the continuum must work collaboratively to achieve the optimal health outcomes for that population. There must be a sense of shared responsibility for population outcomes. If certain targets are not achieved, then providers must collectively determine appropriate responses to obtain improvement. This requires a fundamentally different way of working together. Methods must be found to improve access, consistency in care provision, responsiveness to clients, sharing of information across providers, client empowerment, and reductions in duplication of assessments and treatments. It is recognized that there are past achievements that can be leveraged and applied broadly, such as the work of the South Western Ontario Geriatric Assessment Network.

To build linkages across the continuum, we will need to consider all seniors, from those who are healthy and aging in the community, to the frail elderly and those with more complex needs. Adults with complex needs have also been included in the priority as they often access long term care services that are currently geared to seniors. Complex needs is a broad term that will require further definition, but in this case refers to those with physical disabilities or cognitive impairment that require specialized procedures or treatments on an ongoing basis. In the last several years, District Health Councils in the South West have undertaken extensive analysis of issues facing adults with complex needs, and this will provide an important foundation for further work in this area.

### **Access to the Continuum of Care for All the Lifecycle Stages**

The continuum of care diagram depicted here illustrates the range of services accessed by people throughout their lives – from cradle to grave. The components of the continuum focus on the types of care provided rather than on the setting within which the care is provided. The continuum of care approach allows us to focus on individual populations such as mothers and babies, children and youth, adults or seniors to examine the services available as well as the unique challenges of delivering and accessing quality care. The continuum will focus on ensuring that the right provider is providing the right service at the right place to achieve a sustainable system.



**Primary Health Care** serves a dual function in the health care system:<sup>1</sup>

- Direct provision of first-contact services (by providers such as family physicians, nurse practitioners, pharmacists, and telephone advice lines); and
- Coordination to ensure continuity and ease of movement across the system, so that care remains integrated when individuals require more specialized services (with specialists or in hospitals, for example).

Primary Health Care is positioned as the foundation for the continuum of care, which is comprised of five key components, including:

**Promotive Care:** "Health promotion is the process of enabling people to increase control over, and to improve, their health."<sup>2</sup> The focus is on strengthening the skills and capabilities of individuals so they can make decisions about the adoption of healthy choices and lifestyle. Access to education and information is necessary to achieving the participation of the individual and the community. In addition, there must be a focus on modifying social, environmental and economic conditions to alleviate their impact on both public and individual health.<sup>3</sup>

<sup>1</sup> Health Care Renewal in Canada: Accelerating Change, Health Council of Canada, January 2005.

<sup>2</sup> Ottawa Charter for Health Promotion, World Health Organization, Geneva, 1986.

<sup>3</sup> Ibid



**Preventive Care:** Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to stop its progress and reduce its consequences once established.<sup>4</sup> Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to stop or slow existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions.

Disease prevention is sometimes used as a complementary term to health promotion. Although there is frequent overlap between the content and strategies, disease prevention is considered the action which usually originates from the health sector dealing with individuals and populations identified as exhibiting risk factors.

**Curative Care:** Curative care is episodic in nature and is comprised of medical or paramedical services aimed at relieving symptoms of illness or injury, reducing the severity of an illness or injury, or protecting against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function.<sup>5</sup>

**Rehabilitative Care:** Rehabilitative care comprises services that emphasize improving the functional levels of individuals where the functional limitations are either due to a recent illness or injury or of a recurrent nature. Included are services delivered to persons where the onset of disease or impairment to be treated occurred further in the past or has not been subject to prior rehabilitation services. Rehabilitative care can be provided in the hospital, in the community or in a person's home and plays an important role in both prevention and reactivation after an illness or hospital stay.

Rehabilitative care comprises services where the emphasis lies on improving the functional levels of the persons served and where the functional limitations are either due to a recent event of illness or injury or of a recurrent nature (regression or progression).

**Supportive Care:** Supportive care is an umbrella term that covers a wide range of services, provided by a wide range of individuals and organizations. These services include self-help and peer support, the provision of information and education, psychological support and therapy, pain and symptom control, social support, rehabilitation, complementary therapies, spiritual support, palliative care and bereavement care. Supportive care is the provision of the necessary services, as defined by those living with or affected by a long term disease or illness, to meet their physical, informational, emotional, psychological, social, spiritual, and practical needs during the pre-diagnostic, diagnostic, treatment and follow-up phases.<sup>6</sup>

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<sup>4</sup> Reference adapted from Glossary of Terms in Health for All series. World Health Organization, Geneva, 1984.

<sup>5</sup> Organisation for Economic Co-operation and Development, Health Data, June 2006.

<sup>6</sup> Adapted from Cancer Care Ontario, 1994.



The focus on and support of **individuals and their families** is central to the continuum of care concept and recognizes the important role that individuals and families play as health care partners. Self-care refers to the decisions and actions taken by people to maintain and improve their health<sup>7</sup> (Health Canada, 1997) while supporting self-care includes supporting the person (conveying acceptance, listening, etc.), sharing knowledge, facilitating learning and personal development, helping the person build support networks and providing a supportive environment. An effective continuum of care will include strategies that support self-care and enable individuals and their families to take responsibility for and participate in making decisions about their health.

The following four supporting themes are key elements of an effective continuum of care:

- Education, Research and Knowledge Sharing;
- Evidence-Informed Practices;
- System Navigation; and
- Communication.

To achieve a truly integrated and seamless continuum of care that provides easy access and movement through the system, providers across the continuum will need to embrace a focus on life-long education and continuous service delivery improvement. Results from research and ongoing evaluation will translate into evidence-informed practices that will require dissemination through knowledge sharing across all providers. The application of evidence-informed practice through knowledge transfer will result in behavioural change in service delivery that will have a direct impact on health outcomes. For individuals with complex health needs, the development of an enhanced care coordination role will enable better care management and system navigation. To achieve the significant benefits of this continuum of care, enhanced communication among providers and consumers is needed to ensure a consistent level of care across the system and a seamless experience for the consumer.

### **Building Blocks of an Integrated Service Delivery Model**

An integrated continuum of care for seniors and adults with complex needs will have to address the following building blocks of an integrated service delivery model:

- ***Mission, Vision, Principles, Goals***  
The *Vision* is a description of the desired future state. The *Mission* reflects the mandate of the integrated service delivery continuum. The *Principles* will guide the thinking, design and decision making for the development of the integrated service delivery model for seniors and adults with

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<sup>7</sup> *Supporting Self-care: A Shared Initiative 1999-2002*, Published by the Canadian Nurses Association with support from Health Canada, March 2002



complex needs. *Goals* reflect the specific objectives the organization would like to achieve, relating to areas such as operations or performance levels.

- ***Population Definition***  
This specifies the characteristics of the model's target population.
- ***Size of Population***  
This provides estimates of the number of people that will be utilizing the model. It can be determined based on catchment or residence.
- ***Points of Access or Entry***  
This describes how an individual will gain initial access to the service delivery model.
- ***Scope of Services***  
This defines the basket of services and supports that will be available to the target population and the timeliness of such services.
- ***Approach to Assessment***  
This is the method used to determine the appropriate level of care and services for the individual.
- ***Consistency of Care Classification***  
This refers to how the terminology and classifications of care are defined among different service providers and whether agreed-upon definitions exist.
- ***Linkages and Fit within the Continuum***  
This refers to how different service providers interact, communicate, share information with one another in order to create a seamless integration model.
- ***Information Requirements and Flow***  
This describes how the client's health information is coordinated and communicated with various service providers, the individual and the family.
- ***Accountability***  
This identifies who is responsible for the specific outcomes, joint outcomes, maintenance of the system, and managing risk. Given our cross-provider, inter-sectoral integration requirements, the definition for accountability is critical.
- ***Performance Management***  
This provides for a description of the indicators that are used to track performance and the process by which the system is monitored to determine overall effectiveness of the model in relation to the objectives stated and the targets set.
- ***Coordination***  
This describes how services will be accessed and coordinated by the individuals and their families, as well as how providers will work with one another to ensure smooth interfaces and transitions for consumers/families.



## Rationale

The data presented is for the 65 plus population and is used for planning purposes only. It must be noted that the system of service delivery will be applicable to those 65 and over, including all seniors whether they are healthy and aging in the community, or have more complex needs. Adults with complex needs are included as they often access similar services with requirements related to complex or multiple conditions. This group is not age restricted. The majority of data presented here pertains to the seniors population, and it is recognized that additional data collection will be required by the Priority Action Teams.

The rationale for the selection of the priority population is evident from the data presented below. Currently the system focuses on delivery of services to seniors, aged 65 plus. We do not have significant utilization data from all parts of the continuum – but enough anecdotal information to recognize that this population utilizes significantly more services, over 50%, even though it represents only 14.4% of the total population.

### What our data tells us

- The South West LHIN is expected to add 42,668 people age 65+ to the population from 2006 to 2016, which will be an increase of 31.1%.
- The 2001 census reflects that at 17.9%, the proportion of North area residents that are seniors (age 65+) is greater than that of the provincial average of 12.9% and greater than the other areas within the South West LHIN. Furthermore, it ranks as one of the highest rates of seniors population in the broader Southwestern Ontario region. At 15.9% and 13.7% respectively, the proportions of Central and South area residents that are seniors (age 65+) are also greater than that of the provincial average.
- Higher percentages of seniors are found in the communities along the shores of Georgian Bay and Lake Huron (including Northern Bruce Peninsula, where 26.7% of the population are 65 and older, and South Bruce Peninsula, where 23.5% are seniors). Communities with the lowest percentage of seniors include Saugeen 29 (8.1%) and Malahide (9.5%).
- Consistent with the high proportion of people aged 65+, the South West LHIN has a dependency ratio above the provincial average. The dependency ratio is defined as the ratio of the combined child and elderly population (0-14 and 65+) to the working population (age 15-64). It is a measure of the number of dependents for every 100 people of working age in the community.<sup>8</sup> In the South West LHIN, the 2006 dependency ratio of 47.8 is higher than that of the province (44.4), and this trend is expected to increase to over 50% by 2016. Consequently, this greater socio-economic dependency placed on working age residents by the young and elderly sectors of the population will likely place increased demands on health services.

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<sup>8</sup> Statistics Canada

- The growth in seniors population will place a tremendous burden on the health care system over the next few decades with the increased prevalence of dementia and other diseases of aging.
- The growth in dementia cases for the South West LHIN is expected to reach 16,912 by 2016, an increase of 24.6%. The percentage increase is expected to be highest for the North (29.0%), while the largest increase in the number of cases will be in the South (2,268).
- The South West LHIN currently provides 6,739 beds for its residents in its 74 long term care homes.
- The South West currently has 74 long term care homes. The occupancy rates for long-stay patients is 100% or close to 100% at all long term care homes, indicating that the facilities are all operating at or near capacity. The South West LHIN ranks 7th and exceeds the provincial average for the median time to placement to a long term care home for individuals residing in the community or an acute care setting.

<b>Seniors Growth Profile by Sub-LHIN Area</b>	<b>Ontario</b>	<b>SW LHIN</b>	<b>North</b>	<b>Central</b>	<b>South</b>
Number of Seniors in 2001	1,472,170	105,840	25,300	21,160	80,540
Number of Seniors in 2006*	1,642,693	137,211	29,822	22,032	85,357
% of Population that are Seniors in 2006*	12.9%	14.7%	18.3%	15.8%	13.7%
Additional Seniors 2006 to 2016*	782,061	42,668	11,489	4,790	26,388
Expected Number of Seniors in 2016*	2,211,794	179,878	41,311	26,822	111,745
% of Population that are Seniors 2016*	15.5%	17.9%	23.6%	18.2%	16.8%

\* Ministry of Finance population projections include portions of Grey and Norfolk counties which shared by neighboring LHINs

- The following are repeated issues/themes that appeared in South West LHIN community support service plans submitted to the regional office of the MOHLTC and relate specifically to seniors:
  - There has been an increase in the number of admissions to long term care homes of young adults and of seniors that could have been prevented if supports were available in the community (referred to as “inappropriate admits” in the data).
  - The clientele are aging, presenting with many secondary symptoms and increasing complexity of needs, but there is no change in funding to meet these expanding needs.

## **Community Engagement**

### ***What we heard to inform the draft priorities:***

Many of the priorities identified during community engagement activities relate to seniors services either directly or indirectly. Suggestions included the need for enhanced care for the elderly, strategies for end-of-life services, and recognition of the importance of rehabilitation services across the continuum. The following additional themes also emerged through the community engagement process:

- Standardization and patient-focused health care pathways will help to achieve improvements in quality across the care continuum.

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- Commitment is needed to a service delivery system that supports individuals to live securely and independently at home.
  - Community Support Services support many people in their homes who would otherwise be institutionalized.
  - Implementation of shared best practices can be facilitated through the development of a quality framework with common indicators and an evaluation system to facilitate benchmarking.
  - A foundation of shared information and knowledge across all providers in the continuum is required.
  - The importance of rehabilitation services across the continuum, from children to seniors and across many disease processes, was highlighted in numerous ways. Geriatric and therapeutic rehabilitation programs were cited specifically for seniors.
  - The need to support navigation across the care continuum with respect to seniors' services, chronic disease management and palliative care was identified.
  - Strategies for end-of-life care services need to be identified.
  - A formal structure should be created for rehabilitation services in Long Term Care for specific target populations (SCI/Acquired Brain Injury/Stroke).
  - A proactive focus on frail and elderly individuals presenting at emergency departments, is needed to avoid admission and reduce acute care utilization.
  - Discharge and home care planning needs to be improved to reduce readmissions and length of stay (LOS) through improved coordination of care across institutions and community care providers.
  - The issue of Alternate Level of Care (ALC) was identified as a significant opportunity for integrated solutions to providing care in an appropriate setting.
  - Regional Office staff emphasized the importance of integrating seniors' services, stressing the lack of long term care beds in many parts of the South West as well as the often inappropriate admissions to long term care because of service gaps for particular populations.
  - A focus on home care strategies and the promotion of healthy aging is required.
  - Strategies need to be identified to enable seniors to remain in the community as they age, including supportive housing, respite care, and support for family care givers. Key issues identified by the group included complexity of the client, rural isolation, and lack of formal support for care givers.
  - Participants taking part in a session on rural health at the South West LHIN May 12, 2006 forum ranked seniors as the population that would most benefit from a more integrated continuum of care.

***What we heard to inform the final priorities:***

The second phase of community engagement includes more than 65 sessions held to gain input from the public, providers, and front line workers, as well as special communities such as Aboriginal and First Nations communities, the Francophone community, people suffering from mental illness, and the deaf. The majority of participants were supportive of the South West LHIN's draft priorities, and many of the same themes emerged from the discussion. Some of the comments and



suggestions made by the participants included:

- The need for better education of providers and clients to enable access to appropriate services.
- Recognition of bed shortages for long term care across the South West LHIN; concern that funding for existing long term care beds may be cut in the north, despite long wait lists.
- Recommendation to include both well seniors and those with more complex needs in the discussion of system navigation and the continuum of care.
- The need to link with Cancer Care Ontario and other provincial networks, and to include current end of life strategies and programs in the solution.
- Recognized that “buy in and trust” among providers and health care professionals could be a major barrier for implementation.
- The need for a common information base; links to e-health needed even though seniors may not be as technology-ready as others.
- Numerous public participants cited transportation challenges, including the need to link with transportation initiatives (e.g., going to see a specialist can take an entire day, and transportation can be difficult to organize).

#### ***Obstacles to Overcome: What We Heard***

- **Challenge of coordinating the flow of information:** coordinating and integrating the flow of information among providers was identified as a significant challenge for implementation of a care continuum
- **Awareness about CCACs:** participants discussed confusion felt by many people trying to access community services, and highlighted differences across different geographic areas
- **Shortage of people providing support in the community:** participants discussed the role of volunteers, care givers, as well as providers in the community and voiced concerns about declining numbers of providers and volunteers
- **Shortage of appropriate care beds:** shortages within appropriate settings (e.g., long term care, acute care, etc.) were identified as a barrier in many communities, particularly in rural areas
- **Transportation issues:** several participants identified barriers to access resulting from travel and transportation requirements, particularly in the northern part of the South West LHIN
- **Mental health issues:** participants highlighted mental health issues among the seniors population as an area which needed particular attention

#### ***Strengths to Build On:***

- **Innovative programs:** examples of successful primary health care programs or initiatives in the South West included:
  - CCAC Seniors scene book and directory
  - Transition units at long term care homes preventing admissions to acute care and facilitating earlier discharge
  - Current case managers who want expanded role as system navigators in the CCACs
  - Hospice volunteer services and local palliative care committees
  - Alzheimer’s Society

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- Public Health Units' work on falls prevention
  - Numerous initiatives in end-of-life care in and around London
  - Cancer care and regional stroke strategy efforts to coordinate services
  - Pathway Group – Grey Bruce Evidence Based Care
- **South West Network Input**
    - **South West End-of Life Network:** Work underway in end-of-life care is a possible focus for a Quick Start Plan or demonstration project. However, implementation would require more aggressive timelines as Ministry funding for the South West End-of-Life Care Network runs only until March 2008.
    - **Regional Cancer Services Alliance:** The RCSA has started the work to better support seniors and adults with complex needs across the cancer prevention and treatment continuum and has suggested that the opportunity to integrate cancer care across the South West be consideration as a quick start for the IHSP. The RCSA has already completed a detailed service needs assessment process and has reported that progress is being made to address service delivery issues back to communities.
    - **Southwestern Ontario Stroke Strategy:** Stroke is the leading cause of adult disability and transfer from hospital to LTC in Ontario. The “Rehabilitation Action Planning Day” is designed to bring health care providers and other stakeholders together to look at the current system for stroke rehabilitation. This initiative addresses the first two objectives outlined under this priority: a detailed environmental scan of stroke rehabilitation services and recommendations on standards. Each Stroke Centre also has committees and working groups that set priorities and work plans for stroke initiatives in their respective jurisdictions.
    - **Specialized Geriatric Services:** SGS is an integrated program of Geriatric Medicine and Geriatric Mental Health within St. Joseph's Health Care London, providing a variety of services for the frail senior. SGS has established easy access for referrals, through a Centralized Intake service for the services offered across London and the Region. A network of specialized geriatric assessment teams, established and located within the CCAC's in LHIN 1 and 2 in the Southwest, form the Southwestern Ontario Geriatric Assessment Network (SWOGAN).

#### **Other Relevant Evidence:**

By 2025, more than 20 per cent of Canada's population will be over the age of 65, double the proportion of this cohort in 1980<sup>9</sup>. Aging populations tend to be the highest users of the health system because they often have more complex health needs. The escalating costs of health care will pose a significant fiscal challenge, and pension plans will also experience increased pressures. These realities will place increased pressure on the fiscal foundations and the remaining workforce.

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<sup>9</sup> Anne Golden - Conference Board of Canada May 2006.

## Overview of Action Planning

To realize an integrated continuum of care, the South West LHIN and its partners will need to better understand the range of services available, and build partnerships that will enhance, coordinate and augment existing initiatives and programs. Those with complex needs interact with multiple systems (e.g., the health care system, social services system, etc.) and therefore linkages will be needed not only among service providers, but also across government ministries and with municipalities.

To address the need for an integrated continuum of care for the target population of seniors and adults with complex needs, three major areas require a plan of action:

1. Develop and implement an integrated continuum of care for all seniors and adults with complex needs which will build a foundation for continuum design for other populations.
2. Focus on rehabilitation across the continuum.
3. Develop a strategy and plan of action to ensure access to long term care services to meet the needs of the South West LHIN.

## Performance Outcomes and Measures

These outcomes and indicators are preliminary and will be discussed and refined by the Priority Action Team. The indicators *italicized* are not represented in the Ontario Local Health System Scorecard and should be viewed as developmental until further work is complete and a determination of their ability to measure is made.

Short Term Outcomes (1 to 3 Years)	Medium Term Outcomes (4 to 5 Years)	Long Term Outcomes (6+ Years)
<ul style="list-style-type: none"> <li>○ Increased consumer and family awareness of the availability for priority population services</li> <li>○ Increased referral to and seamless delivery of seniors services across all providers</li> <li>○ Reduced unnecessary acute care utilization (both ED and hospital utilization)</li> </ul>	<ul style="list-style-type: none"> <li>○ Improved quality of life for priority population</li> <li>○ Earlier detection of conditions of aging</li> <li>○ Increased avoidance of LTC home placement</li> <li>○ Maintain or slow decline in functional capability</li> <li>○ Increased location of choice for end-of-life (EOL)</li> </ul>	<ul style="list-style-type: none"> <li>○ Easier movement along the continuum of care</li> </ul>



Short Term Performance Indicators	Medium Term Performance Indicators	Long Term Performance Indicators
<ul style="list-style-type: none"> <li>○ Number of appropriate referrals and service utilization for seniors programs</li> <li>○ Percentage of ED visits that could be managed elsewhere (Aged 65+)</li>            <li>○ <i>Awareness indicator</i></li> </ul>	<ul style="list-style-type: none"> <li>○ Preventative screening for diseases of aging</li> <li>○ Percentage incidence of falls; adverse events (e.g., overmedications)</li> <li>○ ALOS for ALC awaiting discharge (long term care services)</li> <li>○ Percentage of the priority population reporting having a regular MD</li> <li>○ Percentage of population with functional score decline</li> <li>○ Percentage of palliative population reporting first choice for EOL</li>    <li>○ <i>Quality of life indicator</i></li> <li>○ <i>Proxy for avoidance indicator</i></li> </ul>	<ul style="list-style-type: none"> <li>○ Percentage of priority population reporting unmet health care needs</li>            <li>○ <i>Consumer satisfaction measure</i></li> <li>○ <i>System navigation score/ transition measurement score</i></li> </ul>



## Action Plan #1

### Objective

**Develop and implement an integrated continuum of care for seniors and adults with complex needs which will build a foundation for continuum design for other populations.**

### Description

No one organization can or does provide the entire spectrum of services required by a population. To ensure that consumers move through the system easily, service providers across the continuum must work collaboratively to achieve the optimal health outcomes for that population. Providers must have a shared responsibility for population outcomes, and collectively determine responses for improvement if targets are not achieved. An integrated continuum of care should provide the context for the delivery of comprehensive health and community-based services, and recognize the good work currently initiated by community and provider partners within the South West LHIN.

Care coordination is a key aspect of the service delivery model and reflects a global trend towards increased acknowledgement of the need to support clients/patients in navigating the health system. Therefore, there will be a need to develop an enhanced care coordination role that:

- Enables care management as the consumer moves across the entire continuum of care;
- Focuses on seniors and adults with complex needs; and
- Exhibits passion and depth of knowledge in complex needs and system navigation.

## Deliverables – Years One to Three

### Year 1 Deliverables:

- Establish a cross-sectoral Priority Action Team to provide leadership for:
  - A detailed environmental scan and analysis, including:
    - Needs assessment and analysis of current services to enable leveraging current service excellence
    - Review of existing programs and services to identify duplication and opportunities for improved efficiencies and effectiveness
    - Gap analysis per geographic area
  - The engagement of providers, consumers and the public in order to get a detailed understanding of the strengths, challenges and issues facing this target population and their care givers
  - The development of recommendations for the integrated continuum of care for seniors and adults with complex needs, including:
    - Service delivery across the continuum
    - Best practices in urban-rural integrated service delivery for seniors and adults with complex needs

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- Opportunities for coordination and collaboration between physical and mental health experts
  - Opportunities to build on existing programs and initiatives

### **Year 2 Deliverables:**

- Define a strategy based on the Year 1 recommendations, focused on the following:
  - Core services required within each geographic area
  - Scope of services required at the secondary and tertiary levels within the South West LHIN
- Research best practices in care coordination
- Engage the community to determine consumer views of current case management and care coordination
- Make recommendations for care coordination for seniors and adults with complex needs
- Develop detailed plans for the implementation of the integrated continuum of services – by geographic area
- Establish a team to conduct a detailed review of the transportation implications of the proposed model
- Identify potential “Early Win” opportunities that can be designed and implemented during year 2

### **Year 3 Deliverables:**

- Execute detailed implementation plans as appropriate
- Implement system-wide performance management program

### **Performance Outcomes and Measures**

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary scorecard for the priority and the work of the Seniors and Adults with Complex Needs Expert Panel held on October 2, 2006.



## Action Plan #2

### Objective

**Focus on rehabilitation across the continuum.**

### Description

Rehabilitation for seniors and adults with complex needs is often required as a preventative measure to enhance and maintain an individual's quality of life and as a reactivation measure after an acute episode. The availability of these types of services has a significant impact on the individual's ability to maintain or resume a functioning life style, and can help people to avoid or delay admittance to long term care homes. Thus the focus of this action plan is to enhance rehabilitation services across the continuum of care for the specific target population – seniors and adults with complex needs.

### Deliverables – Years One to Three

#### Year 1 Deliverables:

- Establish a cross-sectoral Priority Action Team to provide leadership for:
  - A detailed environmental scan and analysis, including:
    - Utilization of services by seniors and adults with complex needs across the continuum in both the public and private settings
    - Cost to the system of reduced function through extended length of stay, alternative level of care days, premature admission to long term care homes and frequent utilization of acute services due to chronic conditions
    - An understanding of the impact of the Convalescent Care program (currently in Grey Bruce) that has been recently introduced
  - The engagement of the community and providers to better understand opportunities and barriers to improving rehabilitation services
  - Making recommendations on the minimum standard for rehabilitative services for seniors and adults with complex needs and the associated cost structure of that minimum standard set for rehabilitative services

#### Year 2 Deliverables:

- Develop detailed implementation plans for an integrated continuum of services – by geographic area
- Identify potential “Early Win” opportunities that can be designed and implemented during year 2



### **Year 3 Deliverables:**

- Execute detailed implementation plans as appropriate
- Implement system-wide performance management program

### **Performance Outcomes and Measures**

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary scorecard for the priority and the work of the Seniors and Adults with Complex Needs Expert Panel held on October 2, 2006.



## Action Plan #3

### Objectives

**Develop a strategy and plan of action to ensure access to long term care services to meet the needs of the South West LHIN.**

### Description

An effective integrated health system facilitates the delivery of care to people in the most appropriate setting for their needs. Long Term Care (LTC) services play a unique role in the health system for seniors and adults with complex needs who are no longer able to live independently in their own home. Within the South West LHIN there are significant challenges associated with timely placement in long term care homes and there has been the suggestion that some placements occur because more appropriate alternatives are not available. Thus a full review and analysis is needed to better understand the demand for LTC home placement and any alternative approaches that could enable the system to provide the required services at the appropriate place and time. Strategies would then be developed to implement the recommendations.

### Deliverables – Years One to Three

#### Year 1 Deliverables:

- Establish a cross-sectoral Priority Action Team to provide leadership for:
  - A detailed environmental scan and analysis, including:
    - Utilization of LTC homes and services in both the public and private settings
    - A full understanding of the residents or clients served, programs offered, wait list, linkages to hospitals, CCAC, among others
    - Engagement of the community and providers to better understand opportunities and barriers to improve the spectrum of LTC services
- The development of recommendations on the LTC service needs and opportunities that exist to positively impact the system

#### Year 2 Deliverables:

- Develop detailed implementation plans for an integrated continuum of services – by geographic area
- Identify potential “Early Win” opportunities that can be designed and implemented during year 2

#### Year 3 Deliverables:

- Execute detailed implementation plans as appropriate
- Implement system-wide performance management program

### Performance Outcomes and Measures

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary scorecard for the priority and the work of the Seniors and Adults with Complex Needs Expert Panel held on October 2, 2006.