Commonly Used Abbreviations

ALC – Alternate Level of Care
AFC – Alternate Family Care
CH – Central Health
HS – Home Supports
ILA – Individual Living Arrangement
LOS – Length of Stay
LPN – Licenced Practical Nurse
LTC – Long Term Care
NH – Nursing Home
OT – Occupational Therapist
PCA – Personal Care Attendant
PCH – Personal Care Home
PCR – Protective Community Residence
PCU – Protective Care Unit
PRD – Per Resident Day (Cost)
PT – Physiotherapist
RCU – Restorative Care Unit
RN – Registered Nurse
SLP – Speech Language Pathologist
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The following Report has been developed in response to Central Health’s requirement for a Long Term Care Needs Assessment. The Report includes the following components:

- An analysis of the Long Term Care services being provided across multiple settings in Central Health region identifying the strengths, service gaps and opportunities associated with each area.
- A review of best practices and service models across Canadian and international jurisdictions that meet service gaps similar to those identified in Central Region.
- An analysis of the current population availing of Long Term Care services across multiple care settings and projections for future demand.
- Recommendations of the types of services that Central Health and the Department of Health and Community Services need to invest in to be responsive to the Long Term Care needs in the region.
- Capital infrastructure Class D estimates and operating costing for the recommended residential options taking into consideration the adequacy and challenges associated with the current physical infrastructure.
- The detailed analysis and capital cost estimates pertaining to the Nursing Home sector are included in the Nursing Home Sector Analysis Supplemental Report.
Executive Summary
Approach Overview

- The LTC Needs Assessment includes a review of all Long Term Care services and care settings available across Central Health to both seniors (65+) and adults with disabilities.
- All demand projections are based on 65/65+ population. A comparative analysis for the nursing home sector focusing on the 75+ population is also included, to account for the fact that the average age of admission to Nursing Homes in Central Health is currently 80 years of age.

Outputs:
- Presentation of Results and Validation Sessions
- Nursing Home Sector Analysis Supplemental Report
- Final Report

Demographic Data Analysis:
Sourcing of Demographic data and development of population projections for CH

CH Data Analysis:
Review of available utilization, waitlist, ALC, clinical, cost and budget data from 2010 until 2014

Provincial and RHA Info.:
Review of relevant Strategies (e.g. Close to Home) and Policies

Multi-Jurisdictional Scan:
Review of Canadian and international leading practices, data, literature and stakeholder consultations

Stakeholder Consultations:
In-person and phone interviews with 58 key CH VPs, Directors, Managers, Front line staff including physicians and AHP as well as relevant external and HCS stakeholders.

Site Visits:
6 in-person site visits including Lakeside Homes; Carmelite House, Valley Vista SC, Dr. H. Twomey, North Haven Manor and Notre Dame Bay Memorial HC

Capital Infrastructure Data Analysis:
Review of relevant data and external benchmarking for all 11 Nursing Homes
Executive Summary
Primary Drivers for Change Across the LTC Sector of Central Health

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<tr>
<th>Drivers</th>
<th>Findings</th>
<th>Implications</th>
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| Demographic Trends             | While an 8% decrease is expected in the overall population of Central Health region by 2026, the seniors (65+) population will increase by 39%                                                              | ➢ Increased demand for LTC services for higher acuity clients across all LTC settings  
 ➢ Decreased availability of both formal and informal caregivers |
| Cost of Long Term Care         | The weighted average per resident bed day (PRD) cost for Nursing Home care in Central Health facilities is $347. This represents a 67% higher cost than the Canadian average and a 56% higher cost than the Newfoundland provincial average | ➢ Need for alternate lower cost community based care options to ensure sustainability  
 ➢ Economy of scale considerations should guide new investment in LTC beds |
| Supply of Nursing Home Beds    | Supply of Nursing Home beds varies widely across Canada and is associated with availability of other community based resources. Data from the Health Association of Nova Scotia (2011) indicates that the national median is 43.3 beds per 1000 residents. Central Health currently only has 26.9 NH beds per 1000 residents. | ➢ Nursing Home bed utilization is at capacity  
 ➢ Investment in additional NH beds is required to meet current and future demand |
| Growing Incidence of Dementia  | Consistent with Canadian trends, the number of nursing home residents with dementia is on the rise. 55% of clients in Central Health Nursing Homes have a diagnosis of dementia as do 56% of ALC patients waiting for Nursing Home placement (2014 data) | ➢ Increased need for specialized resources and training across all LTC settings  
 ➢ Increased need for support and care options for clients and formal/informal caregivers |
| Cost of ALC                    | Almost 60% of ALC patients in Central Health acute care facilities are waiting for Nursing Home placement. The bed day cost for ALC is ~$1200, i.e. 3.5 times the cost of a NH bed and 20 times the cost of Home Supports | ➢ As demand for LTC services increases, there will be a sharper focus on timely appropriate placement and quality outcomes |
# Executive Summary

## Overview of Priorities and Expected Outcomes

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<tr>
<th>Client Group</th>
<th>Priorities</th>
<th>Expected Outcomes</th>
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| Seniors                             | - Enhance community based support options for seniors  
- Enhance PCH sector ability to care for clients with higher care needs through more education and training opportunities and improved access to specialized clinical resources  
- Increase the number of Nursing Home Beds in areas of the region where current and projected demand is greatest | - Reduction of community emergency admissions to LTC  
- Reduction of ALC days  
- Reduction of inappropriate placements in LTC  
- Reduction in the rate of LTC transfers  
- Cost Savings  
- Decreased rate of the inappropriate use of chemical and physical restraints  
- Improved quality outcomes |
| Clients with Dementia               | - Increase access to Home Support hours of service for clients  
- Provide enhanced respite care options  
- Provide access to Dementia focused Adult Day Programming  
- Develop a Dementia Care Strategy with a focus on engaging primary care physicians and education/training for LTC resources as well as informal caregivers  
- Provide access to Complex Care beds, additional PCU beds and Assessment beds |                                                                                                                                                                                                                                |                                                                                                                                                                                                                                     |
| ALC Patients waiting for NH placement | - Develop a transitional care option allowing patients who are medically discharged to be followed in an alternate setting with more appropriate supports  
- Provide acute care clinical staff with Older Adult Care and Dementia training  
- Increase PT/OT/SLP coverage for ALC patients |                                                                                                                                                                                                                                |                                                                                                                                                                                                                                     |
| Adults with Intellectual Disabilities| - Develop multiple dwelling options with more specialized resources and access to appropriate recreation  
- Develop additional respite services | - Improved quality outcomes  
- Cost savings |                                                                                                                                                                                                                                |
<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendations</th>
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| **Capital**       | 1. Invest in 34 new Nursing Home Beds at Carmelite House (including a 12 bed Protective Care Unit)  
2. Develop new 158 bed facility to replace Lakeside Homes including:  
   - An investment in 56 new beds including 12 Protective Care beds and 1 Assessment bed  
   - The replacement of 102 current beds at Lakeside Homes  
3. Repurpose 6 beds at Dr. Hugh Twomey to create a Complex Care unit  
4. Reopen 18 residential care beds at Valley Vista Seniors Complex to be used as a transitional care unit |
| **Human Resources**| 5. Expand the Enhanced Pilot to help support higher acuity clients in PCH  
6. Implement a Mobile Dementia Team  
7. Recruit a Geriatric Psychiatrist for the Central Health region |
| **Training**      | 8. Provide better access to training/educational opportunities for PCAs to improve the capacity of Personal Care Homes to care for higher acuity/dementia clients  
9. Provide specialized training for staff who provide care to ALC patients awaiting Nursing Home placement |
| **Planning**      | 10. Develop a Home First Strategy  
11. Perform a comprehensive assessment of Home Support Services across the region  
12. Develop a Dementia Strategy that includes Primary Health Sector Engagement, formal and informal caregivers |
| **Community Programs** | 13. Increase First Link Dementia referral service uptake  
14. Implement Adult Day Programming  
15. Develop Group Living Arrangements for clients with intellectual disabilities |
Executive Summary
Long Term Care Priority Implementation Road Map

Milestones
Immediate tasks addressed
2015 - 2016
2017-2018
2019 - 2020

Capital
#1 Increase the number of NH beds at Carmelite
#2 Replace Lakeside Homes Facility
#4 Transitional Care Unit at Valley Vista
#5 Enhanced Pilot Expansion

Human Resources
#7 Geriatric Psychiatrist
#8 Personal Care Home Staff

Training
#9 Acute Care Staff
#11 Home Supports Assessment
#12 Home First Strategy

Provincial/Regional Planning
Community Programs

Future strategy realized
Completion
#3 Develop 6 bed Complex Care Unit at Dr. H. Twomey
#6 Mobile Dementia Team

Priority Level 1 (within 12 months)
Priority Level 2 (within 24 months)
Priority Level 3 (within 36 months)

#14 Adult Day Programming
#15 Develop Group Living Options for Adults with Intellectual Disabilities

CH LTC Needs Assessment: Final Report – Executive Summary
Central Health Demographics
Number of Residents Aged 65+ is Increasing across Central Health

- Central Health’s total population is decreasing, while the population of seniors aged 65+ is increasing
- From 2014 to 2026 the total Central Health population will decrease by 8%
  - The under 65 population will decrease by 21%
  - The population of seniors (65+) will increase by 28%
  - The population of seniors aged 75+ will increase by 55%
- The number of seniors (65+) availing of LTC services (Including Nursing Homes, Personal Care Homes, and Home Supports) represents approximately 11% of the seniors population overall

The proportion of over 65 in LTC services in 2014 (24%) is applied to the 65+ population projections for 2017, 2022 and 2026 to obtain the projected future number of seniors of 65+ in LTC settings
**Current State**

Globally on Average 70% of Formal Long Term Care is Provided in the Home vs. Under 40% in Central Health Region

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>LTC users as share of population</th>
<th>Home Support as a share of all LTC</th>
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</thead>
<tbody>
<tr>
<td>United States</td>
<td>0.5%</td>
<td>n/a</td>
</tr>
<tr>
<td>Italy</td>
<td>1.4%</td>
<td>57%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2.1%</td>
<td>76%</td>
</tr>
<tr>
<td>Australia</td>
<td>2.3%</td>
<td>70%</td>
</tr>
<tr>
<td>Germany</td>
<td>2.8%</td>
<td>68%</td>
</tr>
<tr>
<td>UK</td>
<td>2.9%</td>
<td>n/a</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3.8%</td>
<td>61%</td>
</tr>
<tr>
<td>Canada</td>
<td>2.0%</td>
<td>n/a</td>
</tr>
<tr>
<td>OECD (23 countries with available data)</td>
<td>2.3%</td>
<td>70%</td>
</tr>
<tr>
<td>Central Health</td>
<td>2.1%</td>
<td>36%</td>
</tr>
</tbody>
</table>

*The global trend is moving towards fewer residential services as home-based services are more cost effective, and have been shown to result in better health outcomes*

*“In nearly all OECD countries, between half and three quarters of all formal LTC is provided in home-care settings…More than half of the care recipients aged 80 years or over receive care at home in most countries.”*

*Source: OECD 2008 Report: Long Term Care: Growing Sector, Multifaceted Systems*
Current State
Client Allocation and Cost Overview by Care Setting (Seniors 65+)

Community Setting
- Home Supports
  - % of total seniors receiving LTC services: 36%
  - Total annual cost (FY13/14): $20M
  - Average PRD Cost (FY 13/14): $60

- Community Programs for Adults with Disabilities
  - Total annual cost (FY13/14): $28M
  - Average PRD Cost Range (FY 13/14): $11 - $634

 36% of Seniors 17% of Cost

Institutional Setting
- ALC patients awaiting NH placement
  - % of total clients: 2%
  - Total annual cost (FY13/14): $28M
  - Average PRD Cost (FY 13/14): $1200

- Personal Care Homes
  - % of total clients: 43%
  - Total annual cost (FY13/14): $6.5M
  - Average PRD Cost (FY 13/14): $65

- Nursing Homes
  - % of total clients: 19%
  - Total annual cost (FY13/14): $64M
  - Average PRD Cost (FY 13/14): $347

64% of Seniors 83% of Cost
Current State
Overview of Strengths, Gaps, Opportunities across the LTC and Community Support Services Program

Strengths
► Strong leadership at the Executive and Director Level
► Active performance monitoring and implementation of process and outcome improvement initiatives
► Recognition of need to change to ensure long term sustainability

Gaps
• Challenges with access to Nursing Home beds in centres with the greatest demand
• Lack of placement options for clients with complex care needs
• Lack of psychiatric resources specializing in the care of older adults
• Inadequate Rehabilitation resources to support LTC clients in the community as well as in residential and acute care settings
• Limited community based supports for seniors
• Limited access to community based respite
• Lack of designated medical leadership for Long Term Care
• Lack of community based resources for clients with dementia and their caregivers

Opportunities
► Leverage existing older adult expertise among medical staff, including at Dr. Twomey, to support and educate key clinical staff across the region
► Consider designating a LTC physician Lead for the Region
► Currently the various service settings operate in silos. There are opportunities to develop better communication, education and training sharing as well as engaging seniors in the community in recreational programs offered by the Nursing Homes and Personal Care Homes
► Volunteer numbers have been declining, in part due to the rigid application and screening process. Developing a strong volunteer base would allow for enhanced recreational activities for clients across multiple LTC settings
There are currently 518 beds (499 LTC, 11 Respite and 8 Palliative) in 11 Nursing Homes across Central Health

In 2013-14, the total cost of those 11 Nursing Homes was approximately $64M

In 2014, Central Health had a total of 495 NH clients and an average utilization rate of 96%

The average waitlist for 2014 was 86 persons

Among the people waiting for placement, 19% were in a Personal Care Homes, 25% in the community and 56% in ALC beds

On average 55% of the NH residents have dementia

The average age of a resident in a NH in Central Health is 82 years old

The average Length of Stay is 2 years

The average wait time for Nursing Home placement is 3.5 months

The four facilities with the longest average wait times are Carmelite House with 7.2 months, Fogo Island with 5.8 months, Baie Verte with 5.4 months and Lakeside Homes with 4.4 months
Current State
Strengths, Gaps, Opportunities – Nursing Homes

Strengths
- Roll out of Specialized education including: Gentle Persuasive Approach and PIECES
- Active Family Councils, but only four out of 11 are in place
- Engaged management and staff, committed to quality outcomes

Gaps
- An inadequate number of Nursing Home beds
- Lack of specialized care beds to accommodate the complex care needs of individuals with neurocognitive disorders and behavioural and psychological symptoms of dementia (BPSD)
- Inadequate access to Protective Care beds
- Resourcing challenges including:
  - Lack of adequate funding as well as recruitment and retention of LPN, Allied Health Professionals (PT/OT/SLP) and PCAs
  - Lack of specialization and training among current resources in the care of older adults and dementia care

Key Indicators
- Central Health has 26.9 beds per 1000 residents aged 65+, compared to an average of 38.2 provincially and a 43.3 national median (2011 data)
- The weighted average cost per resident bed day (PRD) for NH beds across 11 Central Health LTC facilities is $347, with PRD costs for individual facilities ranging from $220 (Carmelite) up to $701 (Fogo).
- There was an average waitlist of 86 people for NH beds in 2014
- 53% of those clients were waiting for placement at Lakeside Homes (Gander) and Carmelite House (Grand Falls)
- Demand for PCU beds is projected to increase by 70% in the next 10 years
- The current skill mix ratio in LTC settings within Central Health is ~26/54/13 (RN/LPN/PCA), compared to <20/<20/<70 for most Canadian jurisdictions

Opportunities
- Respite beds are being underutilized (37% average in 2014), and there is a need for more awareness of the service
- Partnerships with local dental/vision/hearing clinics should be explored to provide on site clinics to residents, and reduce transportation costs
- Central Health should consider, along with the Government of Newfoundland and Labrador, opportunities for private sector collaboration in NH capital and operating activities
- Develop Meals on Wheels Programs and offer access to NH based recreational activities to seniors in the community
The Average PRD Cost in Central Health Nursing Homes is 67% Higher than the National Average

The weighted average Resident Bed Day Cost in Central Health region is $347 which is:

- 67% higher than the national PRD cost
- 56% higher than the provincial average PRD cost across Newfoundland

The PRD cost is highest in remote facilities, with a small number of LTC beds that are co-located with acute care sites:

- 102% higher than the regional average on Fogo Island
- 84% higher than the average in Harbour Breton and 57% higher in Twillingate
- 40% higher than the average in Baie Verte

The PRD cost is lowest in the largest facilities:

- 37% lower than regional and 1% lower than the provincial average at Carmelite
- 27% lower than the regional average at Lakeside

Several Factors contribute to High PRD Costs at some Central Health Nursing Home Facilities including:

- The low number of beds per site makes efficient resourcing challenging – typically sites with 75+ beds are most cost efficient, whereas Central Health currently operates 8 of 11 sites with fewer than 65 beds
- Older construction - 7 of 11 facilities were built prior to 1989
- Co-location with acute care sites means that some resourcing and operating costs are shared
There are currently 1147 PCH beds in 22 Personal Care Homes across Central Health.

In 2013-14, the total cost of subsidies for the 22 Personal Care Homes was approximately $6.5M.

There are currently 878 residents in PCH across Central Health giving an average utilization rate of 77%.

The average wait list for 2014 was 25 persons with Nightingale Manor having the highest wait list with 6 persons followed by Golden Years Estates – Gander and Otterbury Manor with 4 persons.

Significant contributing factors to the emergence of waitlists for PHCs include an increasing preference for single rooms and PCH location.

Approximately 19% of PCH residents are not subsidized.

The average age of a resident in a PCH in Central Health is 83 years old.
Current State
Strengths, Gaps, Opportunities – Personal Care Homes

Strengths
• Availability of PCH beds
• Implementation of the Enhanced Care in Personal Care Homes (PCH) Pilot Project, aimed at supporting clients who require a higher level of care within the PCH environment allowing them to stay closer to home longer

Gaps
• Resource Limitations: In some areas it is difficult to recruit/keep PCAs when higher paying employment options are available. PCHs also find themselves competing for staff with the Home Supports Program where workers typically care for fewer clients as well as with Central Health where higher wages are offered
• Access to specialized training (e.g. Safe Patient Handling, GPA) for PCAs is limited due to costs and issues with backfilling of resources
• PCHs are not licensed for Level 3 care, but there is a growing number of Level 3 clients in the PCH setting waiting for LTC placement
• PCHs need support to better maintain Level 3s while waiting for NH placement in order to avoid ALC days
• No Rehab coverage: Clients coming back from restorative care, or acute care don’t get PT support and can’t maintain higher level of function
• PCHs are not equipped with staff, or systems to manage an increasing number of clients with dementia. Increased demand in certain areas of the region and lack of appropriately trained resources can lead PCHs to “cherry pick” lower acuity clients for admission
• Clients increasingly want single rooms. This is one of the key contributing factors to the emergence of PCH waitlists in some areas of the region. People are willing to wait up to a year for a single room

Opportunities
• Opportunity to extend the Enhanced Pilot to additional Personal Care Homes across the region. An evaluation of the Pilot project is pending, but anecdotally, LPN /PT support and ability to assess clients on site prevents Emergency Room visits and acute care admissions
• Opportunity to extend recreational program access to seniors in the community
There are currently 977 seniors (65+) who avail of the Home Supports Program across Central Health for a total of 3982 Home Support hours provided per month.

38% of the total hours are provided by agencies and 62% are self-managed (2014).

In 2014 clients qualify for up to 5.5 hr/day if they utilize an Agency or 6.5 hr/day through self-managed care.

In 2013-14, it cost approximately $19.7M to provide the Home Support Program to Seniors.

There are 53 clients over the ceiling for a total cost of $0.56M in 2014.

The average age of a client receiving Home Support Program in Central Health is 80 years old.

~60% of seniors who avail of Home Support hours suffer from dementia.

Kittiwake Coast health service area provides 981 Home Support (HS) hours per month, which is the highest followed by Isles of Notre Dame with 660 HS hours per month and Coast of Bays with 434 HS hours per month.
Current State
Strengths, Gaps, Opportunities – Home Supports/Dementia Care

Gaps

- Home Support hour ceilings require review. Increases in worker’s pay rates have increasingly limited the number of Home Support hours that clients can access. Clients have to choose between support for basic needs and respite hours to stay within the allotted ceilings.
- There is limited access to night time support for clients with dementia (up to five hours, but no overnight option). Adding such services would reduce caregiver burnout.
- Clients who only need meal preparation don’t qualify for Home Support Services.
- It is difficult to find Home Support workers due to low hourly rates, especially in larger centres where other employment opportunities exist.
- There is a lack of community based respite options for clients with dementia.
- There is no standardized case management for clients with dementia that would function as a preventative measure and support client’s transitions between care settings. Such an approach, which would require primary care provider engagement, would decrease crisis situations that result in community emergencies.
- There are very limited educational requirements for Home Support workers under the self-managed care option, which limits their ability to care for clients with increasing acuity levels.
- There is inadequate community based PT/OT/SLP/Psychology/Psychiatry support.
- There are limited convalescent care options in the community. The Restorative Care Unit is not centrally located which can be a deterrent for some clients.
- There is a need to develop a Dementia Strategy which would include a focus on the engagement of primary care physicians towards consistent screening, early diagnosis, referrals for services, and informal caregiver support right up to NH admission.
- There are limited Supportive Living options for clients with moderate dementia who can’t cope at home, bridging the gap to protective care. The Protective Community Residence offers services to individual clients, but there are no options for family living arrangements with shared supportive care in the community.

Opportunities

Leverage Home Support Agencies to provide additional services to seniors such as grocery shopping, transport to recreation
Leverage Personal Care Home beds to provide convalescent care on a short term basis
Leverage Behaviour Management Specialists to provide support and education to informal caregivers of clients with dementia who exhibit aggressive behaviours.
Leverage the learnings from the implementation of the community Palliative Care team to develop an operating model for a Dementia Care team.
Develop Meals on Wheels Program to support seniors in the community. Currently this program is very limited and only available through Valley Vista in Springdale.
There are currently 65 ALC patients across the nine Health Centres in Central Health. (Nov 2014 data)

- 56% of the ALC patients are waiting for NH Placement
- In December 2014, James Paton Memorial Regional Health Centre had 31 ALC patients (37% of beds), Central Newfoundland Regional Health Centre had 27 (22% of beds)
Current State
Strengths, Gaps, Opportunities – Alternate Level of Care

**Strengths**
- Co-location of acute and LTC services in some areas of the region, allowing for sharing of specialized resources and can contribute to greater continuity of care

**Gaps**
- Need training for clinical staff in the care of older adults to reduce “over-management” of elderly clients in acute care
- Lack of Adequate Rehabilitation Coverage for ALC patents awaiting NH placement leads to deconditioning
- Lack of access to geriatric psychiatry resources contributes to high incidence of restraint use

**Key Indicators**
- The per resident bed day cost for an ALC bed is $1200
- The total cost of ALC within Central Health for 2012-2013 was $19M and for 2013-2014 it increased to $28M
- The average LOS for ALC Patients across the region is 35 days (2014), while the average LOS for ALC related to dementia is 71 days.
- Central Health has a high rate of administration of anti-psychotics, 63% of ALC patients waiting for NH placement in January 2015 were being prescribed anti-psychotics

**Opportunities**
- A low cost refurbishment of 18 beds in the currently unused Residential Care Unit at Valley Vista Seniors Complex could be used as a transitional care unit for ALC patients awaiting Nursing Home placement
- Community Rapid Response Team (12 month pilot) could be expanded to include follow-up with ALC clients
- Integrated Specialist Palliative Care Team expansion
There are five main community based programs for adults with disabilities in Central Health: Alternate Family Care (AFC), Board and Lodging, Co-operative Apartment, Own Home/Apartment, and Individualized Living Arrangement.

- There are 871 clients who avail of community based program services.
- Board and Lodging is the program with the most clients (447) followed by Own Home/Apartment (315).
- Individualized Living Arrangement program provides service to 34 clients for a total annual cost of approximately $5.6M and the Co-operative Apartment program provides service to 7 clients at a total cost of $1.6M.
- In 2013-14, it cost approximately $28M to provide all of the community based programs in Central Health, 42% of the total cost was spent for the Own Home/Apartment program, followed by 25% on the Individualized Living Arrangement program.
Current State
Strengths, Gaps, Opportunities – Community Programs for Clients with Intellectual Disabilities

Strengths

► The Central Residential Services Board, which administers the Co-op Apartment Program has a paid Executive Director who is active in seeking out more efficient and effective housing and care options for clients

Gaps

• There is a shortage of Alternate Family Care homes. There are few homes in the Gander/Grand Falls area and no homes west of Grand Falls. AFCs tend to exist in smaller communities where clients have limited access to appropriate recreation
• It is difficult to recruit home support workers for clients with intellectual disabilities as the pay is low and access to proper training is not always available
• No appropriate housing options for brain injured/Korsakoff clients as well as dual diagnosis clients with mental health issues
• There are no emergency housing options for clients
• There are limited respite options, enhancing access to such services would allow clients to stay with family longer

Opportunities

• Using multiple unit dwellings for lighter care clients would enable the leveraging of support workers and provide clients with better access to recreational activities in the community. A group home in Grand Falls that is no longer being used could be acquired for this purpose
• The Central Residential Services Board could be leveraged to develop and oversee additional residential options for clients with intellectual disabilities as well as options for clients requiring mental health support
• Leverage Behaviour Management Specialists to provide support to clients placed in Nursing Homes, ALC Beds and Community Based Programs (e.g. AFC)
Leading Practices
Leading Practices
Key Global Trends

**Community Setting**
- Home Supports 65+
  - Flexible high impact programs, volunteer-led
- Community Programs including Home Supports -65
- Leveraging Social Capital

**Institutional Setting**
- Acute Care ALC awaiting LTC placement
- Active case management to limit intake
- Transition beds to facilitate discharge flow

**Nursing Homes**
- Economies of scale for operational efficiency
- Co-location with hospitals to optimize direct care staff mix

**Increasing Proportion of clients and funding**

**70:30 OECD av. clients in community to clients in residential care**

**Decreasing Proportion of clients and funding**
Leading Practices
ALC Bed Day Reduction

Problem Statement

System concern: cost avoidance; ALC setting is by far the costliest
Health outcomes concern: 'last resort' option, high potential for deconditioning of seniors

Strategic Options

Reduce in-flow to ALC
Facilitate waitlist reduction for LTC placement
Ensure sufficient 'downstream' services to avoid recurrence of the bottleneck

Implementation

Early intervention dementia care: the Alzheimer Society Model – 7 components of successful strategy
Transition Care: USA, Australia – 61 days average length of stay in LTC transition
Palliative Care Teams: Edmonton (20,000 annual Acute Care bed savings), Australia, New Zealand
Leading Practices
Dementia Care

- Increasing incidence of dementia is coinciding with an aging population to create rapid increase in demand for dementia care
- Lack of alternative dementia supports in CH region leads to emergency acute care admissions and placement in inappropriate settings

- Integrated care approach to generate a wider range of care options and case-by-case solutions
- Engage in early diagnosis, care planning, and caregiver relief to mitigate sudden emergency care needs
- Use of tele-health approaches for rural areas

- Team-based dementia supports to mitigate inappropriate admissions - DMHSOAP, NW Ontario
- Increased supply of respite care beds (NS)
Leading Practices
Assessment Beds

► ALC rates in CH region rose by 44% over six years to 2014
► ALC bottlenecks most often occur due to outflow placement management issues. Along with ON, NL had the highest proportion of ALC hospitalizations in recent years (CIHI, 2009)

► It is not possible to manage and maintain LTC placement waitlists without effective ‘post-acute care’ programs:
  ► Assessment beds (in LTC facilities) and
  ► Transition Care (home-based)

► Medicare Bed Model – USA – cumulative annual allocation of 100 days in LTC assessment
► Transition Care program, Australia – 61 days average length of stay
Leading Practices
Community Support Models

► Seniors living healthier, longer
► NL demographic profile: among oldest in Canada
► Highly-effective models but challenging to provide consistent and quality programs due to resourcing challenges, especially in rural areas

► Targeted wellness programs
► Engage the volunteer sector
► Leverage social capital in rural isolated areas; seniors helping seniors provides win-win wellness outcomes for carer and recipient

► Enhance Wellness: motivational behaviour change interventions – 72% hospital admission reduction (USA)
► PEARLS – addressing depression (USA)
► Telecare - 38% reduction in care costs (rural UK)
Leading Practices
Low Cost Residential Options

- Need to avoid high-cost acute-care admissions to improve overall health outcomes and reduce ALC bed days
- ALC rates in CH region rose by 44% over six years to 2014

- Provide ‘in place’ integrated team-based care
- Co-location of residences to facilitate access to existing health care resources
- Provide healthy living wellness programs

- PRIME in Manitoba delivers health care, social services and recreation programs – 43% reduction in ER visits
- CHOICE – a full-range (medical, social and supportive services) integrated program in Alberta has enabled a 30% reduction in ER visits

Problem Statement

Strategic Options

Implementation
## Recommendations
There are Five Main Areas of Recommendation

<table>
<thead>
<tr>
<th>#</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nursing Home Capital Development/Redevelopment</td>
</tr>
<tr>
<td>2</td>
<td>Human Resources</td>
</tr>
<tr>
<td>3</td>
<td>Training and Education</td>
</tr>
<tr>
<td>4</td>
<td>Regional Planning</td>
</tr>
<tr>
<td>5</td>
<td>Community Programs</td>
</tr>
</tbody>
</table>
Recommendations
System Overview

**Community Setting**
- Adult Day Programming
- First Link
- Home First Strategy
- Home Support Services Assessment
- Development of Dementia Strategy with Primary Health Sector Engagement
- Mobile Dementia Team
- Development of Group Living Arrangements

**Institutional Setting**
- Investment in 90 new NH beds (per NH Analysis) including:
  - Addition of PCU at Carmelite
  - Specialized Care Unit at Twomey
  - Assessment Beds
  - Replacement of 102 beds at Lakeside Homes
  - Expansion of Enhanced Pilot to help support higher acuity clients in PCH longer
  - Recruitment of Geriatric Psychiatrist for the region
  - Specialized Training for staff (GPA/PIECES etc.)
  - Transitional Care Model Development (Valley Vista)
Recommendations
1. Capital Development and Redevelopment

Demand projections suggest that Central Health will require 118 new Nursing Home beds by 2017:
► 54% of new beds required in the short term would be at Lakeside Homes in Gander and Carmelite House in Grand Falls-Windsor
► 80% of new beds required by 2026 would be within Economic Zones 14 (Gander area) and 12 (Grand Falls-Windsor area)

The following key considerations informed recommendations related to capital investment in the Nursing Home sector across Central Health:
► Highest first choice waitlist (based on current demand for 2014)
► Future demand projections
► Ability to meet specialized needs of an evolving client population
► Alignment, where possible, with the “Close to Home” strategy
► State of current physical infrastructure
► Financial Sustainability
► Ability to achieve maximum efficiency in terms of operating costs
► Ability to recruit and retain staff

► Adding 75% of total projected demand by 2017 through targeted investments at sites that meet all of the above criteria will provide higher confidence that increased capacity will be utilized
► The remaining percentage of the demand will be met through expansion and investment in other LTC settings (Home Supports, Community-based Programming, Personal Care Homes) increasing the ability of seniors to remain independent and in the community longer
► A re-assessment of the need for new Nursing Home beds would be recommended within 5 years to determine additional investment requirements across the region
# Recommendations

## 1. Capital Development and Redevelopment

### Recommendations # 1 and 2: Invest in the Development of New Nursing Home Beds

<table>
<thead>
<tr>
<th>Description</th>
<th>Add 90 new Nursing Home Beds across Central Health Region including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 56 beds at Lakeside Homes</td>
</tr>
<tr>
<td></td>
<td>• 34 beds at Carmelite House</td>
</tr>
</tbody>
</table>

**Replace 102 beds at Lakeside Homes in Gander***

- The current compliment of PCU, Nursing, Respite and Palliative Beds should be maintained
- The additional 56 new beds should be added, making Lakeside a 158 bed facility and capitalizing on economies of scale for cost efficiency

**The recommendation is to build 75% of the total projected demand by 2017 at these two sites**

- The remaining percentage of the demand will be met through expansion and investment in other LTC settings (Home Supports, Community Programs, Personal Care Homes)
- Targeted investments in areas with the greatest need will provide higher confidence that increased capacity will be utilized

<table>
<thead>
<tr>
<th>Staffing</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (Capital)</td>
<td>$76.4M**</td>
</tr>
</tbody>
</table>

*The recommended bed numbers for each site are based strictly on projected future demand. A detailed resourcing analysis would need to be conducted to determine the optimal number of new beds at each site based on staffing requirements to ensure maximal cost efficiency

**Capital investment figures are exclusive of resourcing and operating costs.*
**Recommendations**

1. Capital Development and Redevelopment

**Recommendation # 3: Develop a 6 Bed Complex Care Unit at Dr. Hugh Twomey Health Centre**

<table>
<thead>
<tr>
<th>Description</th>
<th>Residents requiring complex care include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Individuals with neurocognitive disorders and behavioural and psychological symptoms of dementia (BPSD). This includes Lewy Body Dementia, Frontal Temporal Lobe Dementia, Alzheimer Type Dementia, Vascular Dementia, Mixed Dementia and other less common causes. Sometimes these clients may be referred to as having a “dual diagnosis”</td>
</tr>
<tr>
<td></td>
<td>• Currently there are 3 residents at Dr. Hugh Twomey who fit this definition. These residents are housed in the Protective Care Unit which can be disruptive to other PCU residents and challenging for staff</td>
</tr>
<tr>
<td></td>
<td>• Another 9 patients who fit the definition are currently in the hospitals in ALC beds, some for extended periods of time (up to and beyond 1 year) due to the lack of appropriate placement options</td>
</tr>
</tbody>
</table>

| Staffing | TBD |
| Cost     | TBD |

*Capital investment figures are exclusive of resourcing and operating costs*
# Recommendations

## 1. Capital Development and Redevelopment

### Recommendation # 4: Implement a Transitional Care Unit at Valley Vista Seniors Complex

<table>
<thead>
<tr>
<th>Description</th>
<th>A Transitional Care Model will provide a lower cost, more appropriate care setting for ALC clients waiting for Nursing Home placement</th>
</tr>
</thead>
</table>
| The partially unused Residential Care Unit at the Valley Vista Seniors Complex in Springdale has been identified as a potential site for a Transitional Care Unit because: | • It has existing infrastructure that can be reopened at relatively low cost  
• There are currently 18 unutilized beds at the site  
• The site is in relatively close proximity (within ~ 100km) to the Central Newfoundland Regional Health Centre |
| Transitional Care Model Overview:                                           | • The beds would be used for convalescent and transitional care, providing a lower cost option for ALC patients currently awaiting Nursing Home Placement (or discharge to another destination) at Central Newfoundland Regional Health Centre in Grand Falls Windsor as well as those at James Paton Memorial Regional Health Centre  
• The unit could accommodate patients for up to 12 weeks  
• Specific appropriateness criteria would need to be developed to ensure that this setting is utilized for short stay clients whose discharge destination has been identified  
• Rehabilitation and therapeutic support would be provided as well as access to appropriate recreation  
• The objective would be to optimize and strengthen the patient’s condition while they wait for LTC placement |

<table>
<thead>
<tr>
<th>Staffing</th>
<th>TBD</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cost (Capital)</th>
<th>$516K*</th>
</tr>
</thead>
</table>

*Capital investment figures are exclusive of resourcing and operating costs*
## Recommendations

**A Mix of Bed Types for Target Locations will Support More Effective Demand Management**

Attributes of the three facilities inform the types of beds that should be added:

- **Lakeside Homes** - New Build: Longest waitlist, largest population in the region and largest seniors population in the future, PCU, staff trained in dementia care
- **Carmelite House** - Expansion: Second largest waitlist, newer infrastructure conducive to cost effective expansion, second largest future seniors population in the region

<table>
<thead>
<tr>
<th></th>
<th>Recommended investment (Total Number of new Beds)</th>
<th>Nursing Beds</th>
<th>PCU Beds</th>
<th>Specialized Care Beds (Complex Care)</th>
<th>Assessment Beds /Holding Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEW BEDS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakeside Homes</td>
<td>56</td>
<td>43</td>
<td>12</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Carmelite House</td>
<td>34</td>
<td>21</td>
<td>12</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Dr. Hugh Twomey</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>6*</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>90</td>
<td>64</td>
<td>24</td>
<td>6*</td>
<td>2</td>
</tr>
<tr>
<td><strong>REPLACEMENT BEDS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakeside Homes</td>
<td>102</td>
<td>74</td>
<td>28</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>REOPENED BEDS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valley Vista</td>
<td>18</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>18</td>
</tr>
</tbody>
</table>

*The 6 Bed Specialized Care Unit at Dr. Hugh Twomey would not require new beds, but would rather utilize a portion of an existing unit*
# Recommendations

## Overview of Recommended New Investment Options and Associated Capital Costs

<table>
<thead>
<tr>
<th>New 158 Bed Facility</th>
<th>34 Bed Expansion</th>
<th>18 Bed Reopening</th>
<th>6 Bed Repurposing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lakeside Homes</td>
<td>Carmelite House</td>
<td>Valley Vista</td>
<td>Dr. Hugh Twomey</td>
</tr>
</tbody>
</table>

### Summary

- **New 158 Bed Facility**
  - Built in 1970 with FCI of 0.15
  - Requires approximately $1.4 million of future capital needs in the short-term
  - Facility is nearing end of its useful life and will continue to require significant capital costs for repairs unless replaced
  - Topography is sub-optimal and facilitates infrastructure damage

- **34 Bed Expansion**
  - Newer facility built in 2002.
  - No known future capital needs in the short-term.
  - Demand does not warrant a secondary facility
  - Current design likely allows for additional expansion (i.e. infill potential appears to exist)

- **18 Bed Reopening**
  - Older facility built in 1976 with FCI of 0.13
  - 18 vacant Beds on currently unused Residential Care Unit
  - The existing infrastructure could be leveraged with minimal cost to house ALC clients waiting for NH placement in a more appropriate setting.

- **6 Bed Repurposing**
  - Built in 1989 with FCI of 0.17
  - Requires approximately $1.15 million of future capital needs in the short-term
  - Demand does not warrant a secondary facility
  - 6 PCU beds could be repurposed for a Complex Care Unit

### Recommendation

- **New 158 Bed Facility**
  - Expansion of 34 beds
  - $65.6 million

- **34 Bed Expansion**
  - Reopening of 18 beds
  - $10.8 million

- **18 Bed Reopening**
  - Reopening of 18 beds
  - $516K

- **6 Bed Repurposing**
  - Repurposing of 6 beds
  - $TBD

---

The recommended bed numbers for each site are based strictly on projected future demand. A detailed resourcing analysis would need to be conducted to determine the optimal number of new beds at each site based on staffing requirements to ensure maximal cost efficiency.
## Recommendations
### Potential Implementation Timeline for Recommended Options

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Valley Vista Reopen</td>
<td>Pre-planning</td>
<td>Renovation</td>
<td>Occupancy</td>
<td></td>
</tr>
<tr>
<td>Lakeside Homes – Build New</td>
<td>Pre-planning</td>
<td>Development</td>
<td>Occupancy</td>
<td></td>
</tr>
<tr>
<td>Carmelite House - Expand</td>
<td>Pre-planning</td>
<td>Expansion</td>
<td>Occupancy</td>
<td>Remode</td>
</tr>
<tr>
<td>Dr. Hugh Twomey Re-Purposing</td>
<td>Pre-planning</td>
<td></td>
<td></td>
<td>Occupancy</td>
</tr>
</tbody>
</table>

### Implementation Considerations
- Development potential analysis & due-diligence is required on all options (i.e. feasibility studies)
- Labour market availability
- Financial capacity and general contractor to develop (internal vs. external)
- Procurement approach

***Please refer to the Nursing Home Analysis Supplemental Report for a detailed Analysis and Rationale for the Capital Investment Recommendations***
Recommendations

2. Human Resources

Through the consultations and jurisdictional scan, there were three areas of specific staff support required to fill key gaps in assessment and treatment:

Enhanced Care Pilot Project Expansion

- Enhance and expand the role of Personal Care Homes in the provision of seniors’ care in or close to their home communities
- Provide seniors with an opportunity to age in place; and,
- Expand seniors’ choices for residential care by offering a new placement option

Implementation of a Specialized Mobile Dementia Team

- Multi-disciplinary team composition
- Referrals from community physicians
- Provision of support to clients and informal caregivers in the community throughout the progression of the disease

Recruitment of a Geriatric Psychiatrist:

- Development of standards of care and support across care teams in acute and non acute settings
- Early assessment and design of treatment plans that may include medication, support, education and behavioral approaches

Build regional capacity and local expertise that can be effectively managed to extend the reach of assessment and care in Central Health
Recommendations
2. Human Resources

Recommendation # 5: Expand the Enhanced Care in Personal Care Homes (PCH) Pilot Project

| Description                                                                 | While Personal Care Homes in Newfoundland are licensed to care for clients who typically require a lighter level of care (Level 1 and 2), there is an increasing number of clients with higher care needs in PCHs due to: |
|                                                                           | • Long waits for Nursing Home placement (E.g. at Golden Years Estate wait times for NH placement for three Level 3 clients in 2014 ranged from 2 to 8 months) |
|                                                                           | • The average age of entry is progressively higher, currently 83 years of age |
|                                                                           | • There is an increasing incidence of dementia (Golden Years Estate and Hallett’s reported that ~20% of their current residents have a diagnosis of dementia) |
|                                                                           | • In November 2014 there were 14 Level 3 residents in Personal Care Homes across Central Health |
|                                                                           | • Anecdotally, the lack of access to more specialized resources and adequate training within the PCH sector results in preventable emergency room visits and acute care admissions |
|                                                                           | • Clients who come from the Restorative Care Program receive no follow-up due to the lack of access to Physiotherapy and are unable to maintain the increased level of mobility |

The objectives of the Enhanced Pilot are to:
• Enhance and expand the role of Personal Care Homes in the provision of seniors’ care in or close to their home communities
• Provide seniors with an opportunity to age in place; and,
• Expand seniors’ choices for residential care by offering a new placement option

Expected Outcomes
• Increased access to LPNs and Allied Health Resources (PT/OT) in Personal Care Homes would contribute to their ability to assess residents on site, and to maintain clients with mild medical conditions or mobility issues longer or until a Nursing Home bed becomes available
• Increase access to specialized training such as GPA, PIECES would allow PCH staff to care for clients with mild to moderate dementia and MSD

<table>
<thead>
<tr>
<th>Staffing</th>
<th>LPN/PT/OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (Recurring)</td>
<td>TBD</td>
</tr>
</tbody>
</table>
## Recommendation # 6: Implement a Multi-Disciplinary Specialist Mobile Dementia Team

<table>
<thead>
<tr>
<th>Description</th>
<th>Proposed Team Overview:</th>
</tr>
</thead>
</table>
|             | • Multi-disciplinary team composition including Social Workers, RNs (Specialized Clinical Leads and Case Managers), Occupational Therapists  
|             | • Referrals from community physicians and from Acute Care (Discharge Liaison Nurses/Physicians)  
|             | • Provision of support to clients and families in the community throughout the progression of the disease |

### Strategic approach to service delivery with a focus on:

- Supporting clients with dementia living at home through enhanced case management from diagnosis until admission to a Nursing Home  
- Supporting the informal caregivers of client with dementia living at home through early education and support throughout the progression of the disease  
- Providing education and training to primary health workers based in the community  
- Integration across the health care continuum through building relationships with both internal and external stakeholder groups

### The expected outcomes of implementing a Mobile Dementia Team include:

- Increased length of time that clients are able to live in their home  
- Reduced Emergency Department utilization due to caregiver burnout  
- Reduced Acute Care Admissions and ALC days

<table>
<thead>
<tr>
<th>Staffing</th>
<th>SW/RN/OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (Recurring)</td>
<td>TBD</td>
</tr>
</tbody>
</table>
## Recommendations

### 2. Human Resources

#### Recommendation # 7: Recruit a Geriatric Psychiatrist

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Central Health has a very high rate of the use of chemical restraints in ALC patients waiting for Nursing Home Placement as well as in Nursing Homes which is largely attributed to the lack of appropriate geriatric psychiatry expertise and support in Central Health region</td>
</tr>
<tr>
<td>• The need for a geriatric psychiatrist for the region was identified in all LTC site consultations</td>
</tr>
<tr>
<td>• With one recent retirement, Eastern Health currently has four full time Geriatric Psychiatrists serving a population that is more than three times that of CH</td>
</tr>
<tr>
<td>• Implementing this position would facilitate the maintenance of the standards of care and support across care teams in acute and non acute settings including early assessment and design of treatment plans that may include medication, support, education and behavioral approaches</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Psychiatrist with regional coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost (Recurring)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
</tr>
</tbody>
</table>
Recommendations

3. Training and Education

Increased access and availability of continuing and topic specific education and training can enhance the skills and confidence of clinical and non-clinical staff with resident/patient care.

► The greatest need across long term care settings for both clinical and non-clinical staff is for education and training relating to both the care of older adults as well as dementia care
► There are a number of on line programs for care staff at all levels that are available at minimal cost
► The advantage of many on line courses is the breadth of programs and the availability of access to programs at convenient times and for a variety of learning needs
► With the growing interest in care for seniors and those with special needs, online collaborations are growing
► Key to program development is to:
  ► Assess learning needs of staff
  ► Scan provincial and other interest groups
  ► Address challenges to providing continuing education programs
  ► Incorporate into business planning measures of ensuring continuing education as a basis for the ongoing competence and development of staff

Collaboration between long-term care settings and other organizations across the region, such as the Alzheimer’s Society, to develop strategies to operationalize an action plan for learning as a basis for the provision of optimal care to residents
Recommendations

3. Training and Education

| Recommendation # 8: Additional Education for Personal Care Home Staff |
| Recommendation # 9: Additional Education for Acute Care Staff Caring for ALC Seniors |

**Description**

There is generally a lack of consistent education and training for staff who care for seniors in the following areas:
- Care of Older Adults
- Dementia Care
- Behaviour Management
- Safe Patient Handling

Central Health requires a Comprehensive Education Strategy and Plan to support staff within its facilities and to offer access to appropriate training for PCH staff as the acuity level of clients increases and the incidence of dementia rises.

Gentle Persuasive Approach and PIECES training should be a requirement for all CH staff who care for older adults.

Education related to Dementia Care being offered online, or in person by the Alzheimer’s Society should also be made available and promoted with both formal and informal caregivers.

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Recommendations
4. Regional Planning

- Facilitating a shared vision and targeted investments across the region to provide a comprehensive and integrated plan to meet the needs of citizens who have multiple and complex needs
- Integrating concepts such as access, equity, choice, value and quality to guide proposed policies, programs, and services

Dementia Care Strategy
- Ensure that significant improvements are made to dementia services with a focus on access to respite services close to home and residential options in the community
- Includes improved awareness, earlier diagnosis and intervention

Home Supports Services Assessment
- Perform a comprehensive assessment of Home Support Services and Utilization across the region to inform a business case for the requirement to increase the Home Support Subsidy Ceilings

Home First Strategy
- Setting priorities with a focus on wellness, health, social services, integration and developing age friendly communities and investment to enable seniors to continue living in their own homes and communities for as long as possible
- Includes the identification of the role of research and the implementation of required education and partnerships

Define and shape the vision and set priorities for investment and quality
Recommendations
4. Regional Planning

Recommendation # 10: Develop a Dementia Care Strategy

Description
- A comprehensive Strategy would ensure that significant improvements are made to dementia care services with a focus on access to respite services close to home and residential options in the community
- Include improved awareness, earlier diagnosis and intervention
- The Alzheimer Society has evaluated Canadian and leading international approaches and concluded that a number of key components are required for a comprehensive dementia strategy
- While Central Health does not currently have a Dementia Care Strategy, there are opportunities available through the Alzheimer’s Society that could be leveraged to provide greater support to clients with dementia and caregivers throughout the region

Cost (One Time)
TBD

<table>
<thead>
<tr>
<th>#</th>
<th>Key Element from International Dementia Care Models</th>
<th>Available in CH Yes/No</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Public information to facilitate early intervention</td>
<td>No</td>
<td>• Central Health is currently rolling out training including Gentle Persuasive Approach and PIECES in Nursing Homes. It would be beneficial to offer this training to PCH staff, as well as informal caregivers in the community</td>
</tr>
<tr>
<td>2</td>
<td>Information to promote recognition and awareness of dementia for carers</td>
<td>No</td>
<td>• The NL Chapter of the Alzheimer’s Society is planning to promote First Link in Central region in early Spring of 2015. Central Health should partner with AS in the promotion of the dementia referral service and the engagement of potential referring partners across CH</td>
</tr>
<tr>
<td>3</td>
<td>Information on appropriate treatments and care strategies for professionals</td>
<td>Some</td>
<td>• AS also offers a free 16 week online Learning Series on Dementia for informal caregivers and a 7 week Care at Home course for PCAs</td>
</tr>
<tr>
<td>4</td>
<td>Reduced financial disincentives and increased respite and training for caregivers</td>
<td>No</td>
<td>• There is an opportunity to form a stronger partnership between CH and AS to enhance access to information, education and support for clients with dementia in the community</td>
</tr>
<tr>
<td>5</td>
<td>Case management and system navigation</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Alignment of services along existing chronic disease prevention and management models</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Ongoing research investment</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
**Recommendation # 11: Perform a Comprehensive Home Support Services Assessment**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demand for Home Supports has grown significantly over the past 5 years but</td>
</tr>
<tr>
<td>• The number of Home Support hours that clients can access has decreased due to rising wages for home care workers</td>
</tr>
<tr>
<td>• While ~60% of seniors who avail of home support services have dementia, certain key services for that client group such as overnight care are not available</td>
</tr>
<tr>
<td>• About 70% of home support clients across Central Health choose self-managed care instead of Agency workers in order to be able to obtain more hours of care within the subsidized ceiling</td>
</tr>
<tr>
<td>• A more responsive home support program able to meet the needs of an evolving client base would alleviate the pressure on LTC institutional settings and ALC beds and produce better quality outcomes for clients</td>
</tr>
</tbody>
</table>

**A comprehensive review of the Home Supports Program should include:**

- A review of current eligibility criteria
- A review of the assessment process
- A detailed analysis of the reasons for growth trends over the past 5 years, and projections for future demand
- A review of current staffing model as well as education requirements of support workers
- A review of the current service delivery model including both Agency and self-managed care
- Review of current funding model
- Development of standard Key Performance Indicators

| Staffing | TBD |
| Cost (One Time) | TBD |
# Recommendations

## 4. Regional Planning

<table>
<thead>
<tr>
<th>Recommendation # 12: Develop a Home First Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>- The primary objective of a Home First Strategy is enabling seniors to live independently in their own home for as long as possible by implementing a range of support options in the community and using admission to a Nursing Home bed as an option of last resort</td>
</tr>
<tr>
<td>- Central Health region would benefit from the development of a Home First strategy focused on improving wellness, health and social service integration for seniors age 65 and over with the objective of creating a responsive, integrated and sustainable system that enables:</td>
</tr>
<tr>
<td>- Healthy aging for seniors that is achieved through a focus on healthy living and wellness in a supportive and age friendly community</td>
</tr>
<tr>
<td>- The provision of appropriate supports and care in a person-centred manner by both formal and informal caregivers who are supported to meet the needs of seniors</td>
</tr>
<tr>
<td>- A continuum of care that is accessible for seniors and bridges the gap between health and social services and that has a central philosophy of rehabilitation and reablement</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
</tr>
<tr>
<td><strong>Cost (One Time)</strong></td>
</tr>
</tbody>
</table>
Recommendations
5. Community Programs

Building community capacity is key to the enhancement of programs and enablement of communities
Includes engagement and mobilization of professionals, organization, families and volunteers

First Link
► Early referrals and technology enabled remote support for clients with dementia

Adult Day Programming for Clients with Dementia
► Provides respite to informal caregivers and assists seniors with dementia to continue to live in their own homes
  by providing supportive group programs and activities in the community

Group Living
► This community housing option can help adults with intellectual disabilities have better access to quality care as well as appropriate community resources, significantly improving the client’s quality of life and reducing costs

Creating a range of community based options for care
Recommendation # 13: Support Access to First Link Dementia Referral System

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Through First Link, people with dementia are linked to local health services and resources that best suit individual situations. Clients are able to access Alzheimer Society programs and services to help them and their families learn about dementia, talk about their concerns and live well with the disease</td>
</tr>
<tr>
<td>• The progression of dementia brings with it new challenges. First Link provides support and connects clients to informative workshops to help them better understand and respond to each phase of the disease with practical tips and strategies</td>
</tr>
<tr>
<td>• First Link clients are consistently tracked and supported throughout the progression of their disease and transition to different care settings as required</td>
</tr>
</tbody>
</table>
| • Connecting with First Link allows clients to:  
  • Receive one-on-one or group support  
  • Be referred to local healthcare providers and community services  
  • Meet other people in similar circumstances and exchange experiences  
  • Get help to plan the future |
| • The Newfoundland chapter of the Alzheimer’s Society currently has 90 referring partners across the province, with the vast majority located in Eastern Health Region. The Chapter is planning to come to Central Health region and present information related to First Link in the early Spring of 2015. This is an excellent opportunity for Central Health to get involved and support the growth of the First Link service through the engagement of physicians, nurses, social workers and others who could become referring partners |

| Staffing | N/A |
| Cost | N/A |
### Recommendation # 14: Develop Adult Day Programming for Clients with Dementia

| Description | The lack of respite services for clients with dementia has been identified as a significant gap across Central Health.
|            | The implementation of an adult day program tailored for clients living in the community with dementia would provide support to both the patients and respite to their informal caregivers.
|            | Clients receiving adult day services would travel to a location in their community usually 1-3 and up to 5 days per week where they may receive a variety of services, including:
|            | • An organized program of therapeutic social and recreational activities in a protective group setting
|            | • Caregiver support groups, information and education programs
| Staffing   | RN/SW required to administer and oversee
|            | Volunteers can support activities
| Cost (Recurring) | TBD |
### Recommendation # 15: Group Living Options for Clients with Intellectual Disabilities

**Description**

Supportive Living for Clients with intellectual disabilities that would include access to:

- Appropriately trained staff such as group home counsellors currently used by the Co-op apartment program. Workers in these positions have two years of specialized post-secondary training, are paid by the Central Residential Services Board and Central Health.

- Ability to socialize with other clients in group living arrangement.

- Enhanced recreational activities and improved quality outcomes.

- Housing in more urban locations.

- Access to mental health professionals.

**Staffing**

- Group Home Counsellors
- SW/Mental Health Coverage
- Behavioural Management Specialist Coverage

**Cost (Recurring)**

TBD
Recommendations
Developing Additional Services in the Community Could Shift 10% of Seniors Care Away from Institutional Settings by 2026

Current State Client Allocation between Long Term Care Service Options (Seniors 65+)

- Nursing Homes: 2%
- Home Supports: 19%
- Personal Care Homes: 36%
- ALC: 43%

Target 2026 Client Allocation between Long Term Care Service Options (Seniors 65+)

- Nursing Homes: 49%
- Home Supports: 17%
- Personal Care Homes: 22%
- ALC: 33%

- At the current rate of growth, and assuming that current allocation rates by setting persist, by 2026 utilization of institutional options by seniors will decrease by 3%, overall while Home Supports will increase by the same amount.
- Most of the decline will occur in the PCH sector while the number of Nursing Home residents will experience a growth of 3%
- By developing additional supports and capacity in the community, Central Health should be able to reduce the utilization of Nursing Home beds by 5 %, ALC bed utilization by 1.8% and PCH usage by ~3%
- This represents a cumulative potential savings of $38M
## Recommendations

### Context for Assuming a 10% Decrease in Residential Care Over a 10 Year Period

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Change Driver</th>
<th>Outcomes and Enabling Factors</th>
<th>Relative Constraints for Central Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>Home First assumed 37% of seniors on the waitlist could be diverted to non-residential services</td>
<td>(Mississauga Halton LHIN) the monthly average number of ALC patients was reduced by 56%, and the percentage of ALC patients deemed eligible for residential care was reduced by 76% over three years</td>
<td>Relative rurality: Central 60% versus 15% in Ontario Rising dementia care demand: estimate up to 13,500 people in NL requiring dementia care by 2038</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Home First: assumed 25% potential diversion to non-residential services</td>
<td>Centralized Department led Province-wide effort</td>
<td>Potentially less efficient governance structure at RHA level</td>
</tr>
<tr>
<td>BC</td>
<td>Change program to reduce reliance on LTC facilities since 1985</td>
<td>BC 13% shift over a 10-year period to 1995; proportion of home supports to facility-based services increased from 56:44 to 69:31. More than 2,500, non-profit, LTC beds were closed between 2002 and 2004 with additional closures since that time. Since then, most new residential services are assisted living (AL) or supportive living (SL) housing services, with lower levels of care.</td>
<td>System-wide change implemented over a 20 year period. Shorter timeframes under consideration for Central Health</td>
</tr>
<tr>
<td>Leeds UK</td>
<td>LTC budget unsustainable</td>
<td>19% ratio change achieved over 5-6 years.</td>
<td>Budget constraints not as apparent</td>
</tr>
<tr>
<td>Italy</td>
<td>Home support accounts for 57% of all LTC</td>
<td>Work-force supply: 72% of all LTC workers are foreign-born</td>
<td>Resource constraints: little immigration in rural NL</td>
</tr>
<tr>
<td>Australia and NZ</td>
<td>Home support accounts for 70% and 76% of all LTC, respectively</td>
<td>Work-force supply: Australia and New Zealand (25-30) LTC workforce supply (25-30 per 100 persons over 80 years)</td>
<td>Canada’s LTC workforce supply (20 per 100 persons over 80 years) is roughly average but lower than Australia and New Zealand</td>
</tr>
</tbody>
</table>
Central Health’s total population is decreasing

The increase in aged 65+ is a trend consistent across all Canadian provinces

From 2014 to 2026 the total Central Health population will decrease by 8%

- Under 65 population will decrease by 21%
- Over 65 population will increase by 39%

The number of seniors (65+) availing of LTC services represents approximately 11% of the seniors population overall

The proportion of seniors in LTC services in 2014 (11%) is applied to the 65+ population projections for 2017, 2022 and 2026 to obtain the projected future number of seniors in LTC settings
Demographic Analysis Approach
Economic Zones Were Used as a Proxy for Determining Population Trends Within Health Services Areas

- Population trend data is not currently available specifically by Health Services Area; Economic Zones used as a proxy measure
- Zones 11, 12, 13 and 14 are within the Central Health Region and represent nearly 100% of the population covered by Central Health
  - Very small areas of Zones 8, 9, 15 and 16 could also be considered within Central Health; statistically insignificant
Demographic Analysis Approach Cont’d.
Central Health’s Ten Health Services Areas are Contained within Economic Zones 11-14

Zone 11: Baie Verte
- Baie Verte
- Green Bay

Zone 12: Grand Falls-Windsor
- Exploits
- Grand Falls-Windsor
- Buchans

Zone 13: Harbour Breton
- Coast of Bays

Zone 14: Gander
- Isles of Notre Dame
- Lewisporte
- Kittiwake Coast
- Gander & Area
Demographic Trends by Economic Zone
The Decline of the Overall Population and the Growth of the 65+ Cohort in the Economic zones is Consistent with Trends across the Region as a Whole

Economic Zone 14 (Gander) has the largest population - 50% of the total population in 2014, followed by the Economic Zone 12 (Grand Falls Windsor) with 28% of the total population in 2014 and Economic Zone 11 (Baie Verte) with 14% of the total population in 2014. Economic Zone 13 (Harbour Breton) is the smallest with 8% of the total population in 2014.
Central Health LTC Continuum Overview

Community
Home Supports: 977 Clients 65+
Community Residential Programs (AFC, ILA, Co-op Apt., B&L):
871 clients including 597 also receiving Home Supports

Personal Care Homes
22 Homes, 1147 Beds, 867 clients

Acute Care ALC
285 AC beds, 62* ALC patients, 46* waiting for NH placement as of Dec 2014
Average ALC LOS in 2014: 35* days

Nursing Homes
11 Homes, 518 beds incl. R&P beds, 495 clients
Average LOS 2 years

*ALC data may be incomplete due to lack of consistent coding of ALC patients

*Vacancy rate represents short term bed closures and client transfer turn around times. Actual vacancy rate in NHs is 0%

ER

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CH LTC Needs Assessment: Final Report – Appendix A
Current State
Overview of LTC Skill Mix by Facility

Average Skill Mix across Central Health LTC Facilities:

- RN 26%
- LPN 54%
- PCA 13%
APPENDIX B – Leading Practices
St. Joseph’s Health Care (London, Ontario) Transitional Care Unit is a 15-bed unit for alternate level of care (ALC) patients in London who no longer require acute care hospitalization and who would receive a more appropriate level of care in the TCU. This model of care provides restorative care to promote independence and maximize a patients’ potential to be cared for in retirement homes, long-term care homes, supportive housing or in their own homes with Community Care Access Centre (CCAC) supports. Patients awaiting rehabilitation may receive transitional/convalescent care in the Transitional Care Unit. Patients are expected to take part in their therapy program. Patients come together for their lunch and evening meals in the dining room. They also have the opportunity to participate in the many social and recreational opportunities offered at Parkwood Institute.

**Admission Criteria**
- Medically Stable adult (no daily diagnostic or monitoring);
- Resident of London/Middlesex;
- Cognitively able to follow and retain instructions;
- Able and willing to participate in individual and group programs;
- Potential to improve functional activities and live in community supported living;
- Estimated length of stay of 8-12 weeks;
- Investigations completed (e.g. swallowing);
- Waiting for convalescent or rehab bed;
- Potential discharge destination identified;
- Failure to thrive from emergency (investigations completed)

**Objectives**
- Promote independence and enable individuals to return to an alternative level of care in the community including retirement home, supportive housing, or their own home with CCAC supports;
- Provide short term restoration care in an inpatient environment following an acute medical crisis to maximize an individual's potential for remaining in the community;
- Provide transitional/convalescent care for patients waiting for a rehabilitation bed;
- Facilitate discharge from an acute care admission, thus reducing the pressure on the acute care bed system in London;
Leading Practices

ALC Bed Day Reduction: Palliative Care Teams Integrated with Primary Care

Coordination of palliative care in the community can have significant improvement on reducing hospitalized deaths and therefore saving acute care bed days. Education for primary care providers on palliative care practices and access to palliative care experts 24/7 in the community are common characteristics that support this model.

Select Leading Practice Examples

Silver Chain Group (not-for-profit) in Australia has focused on providing palliative care in the community. They train family physicians and nurse consultants in palliative care to be community champions. Electronic information systems on handheld devices link all care givers and enable interdisciplinary care planning. Hospice services and 24/7 access is available.

The Edmonton integrated palliative care service model is designed to integrate services from home to hospice and acute settings. The program has an annual scorecard to report on performance targets. Evidence based assessment and monitoring tools have been implemented. There is a single point of entry and access to community based care is 24/7.

In New Zealand the Arihauni Hospice has developed a program to reskill primary care providers in palliative care. Education and training is evidence based and includes approaches to culturally sensitive care to reflect the diversity of the Aboriginal population. The hospice staff work in both urban and rural regions and supports patients in long term care and nursing homes.

Outcomes / key features

► Approximately 60% of Silver Chain patients die at home compared to national average of 25%
► Satisfaction rates at 98%
► Region served has 36% fewer hospital-based palliative care beds than other Australian states
► Single point of referral and access

► Program saves approximately 20,000 acute care beds per fiscal year
► Has 100% 24/7 palliative home care coverage
► Adherence rate of 94% of assessment tool in home based setting
► Training provided for program staff and support workers

► Patients receive a visit from a hospice care coordinator within 48 hours of discharge from the hospice
► Hospice has both inpatient and outpatient services
► 90% of GPs have received education and are partnered with the hospice
► Centralized triage and 24/7 access in the community
Leading Practices
ALC Day Reduction: Managing Chronic Conditions

Focus on the Drivers of LTC Facility Admission

► A strategic focus on the drivers for admission to facility-based care may help keep more seniors in good health and in their own homes for longer. The most prevalent factors leading to admission in a LTC facility are:

<table>
<thead>
<tr>
<th></th>
<th>Chronic Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cognitive Impairment</td>
<td>Dementia is the most common cause of impairment and the most prevalent disorder within LTC</td>
</tr>
<tr>
<td>2</td>
<td>Incontinence</td>
<td>Closely associated with functional decline and “often the critical factor that determines relocation to a long-term care home”</td>
</tr>
<tr>
<td>3</td>
<td>Falls</td>
<td>Particularly when resulting in fractures</td>
</tr>
<tr>
<td>4</td>
<td>Stroke</td>
<td>Impairments as the result of stroke</td>
</tr>
</tbody>
</table>

► For seniors in Canada living at home, neither incontinence or dementia are reported among the most prevalent chronic conditions.

► The prevalence rates of both conditions rise dramatically with age:
  ► Dementia rates increase from 8% of seniors at 65 years of age, to 35% of those 85 and older
  ► Incontinence impacts 10% of the population as a whole

Source: Canadian Healthcare Association, 2009
The role of support planning and brokerage for people with dementia is crucial. It helps people navigate the care system and promotes the benefits of maintaining connections with friends, family and the wider community and supports them to do this. The Alzheimer’s Society in the UK has developed a dementia adviser service which has been piloted in 22 areas across England. The service was set up following the publication of the National Dementia Strategy (DH 2009), which recommended that all people with dementia should have access to a dementia adviser following their diagnosis.

St David’s Care Home in Norfolk (UK) is using its communal areas as ‘brokerage hubs’ for people in the local community. Sheringham is a rural area with many isolated older people. This initiative helps to bring them together in one place so they can get support from peers and access information and advice about self-directed support, personal budgets and other social care, household and leisure services. They have also held open days and tea parties, which have attracted people from the local community. By providing a useful local information service, the initiative also helps to link up the people living there and the activities happening outside. Other care homes around the country also offer free meeting rooms to local groups to encourage more interaction with the local community.

Sherbrooke Community Centre, Saskatoon developed the “Eden Alternative” approach, which sets out to counter loneliness, helplessness and boredom. One of six homes in Canada recognized by the Alzheimer Society of Canada for their person-centric approach to dementia care. Groups of 9-10 residents live with 2 staff in each ‘village’ house, with kitchens and communal living rooms in each, allow for flexible and personalized living arrangements. Aims to integrate nature, animals, children and the arts with everyday living for those with dementia.

Centre of Innovative Excellence for Alzheimer’s Care. B’nai Brith (Toronto) developed an innovation Laboratory; 45 bed retirement home for people living with dementia. Leverage innovations to create personalized models of care and supportive environments for quality of life, such as: Sensor surveillance and personal communication systems; Electronic access to social network; Agitation prediction sensors; and Caregiver training protocols. They received $5.4M Federal funding in 2012.
Leading Practices
The Alzheimer Society Model

The Alzheimer Society has evaluated Canadian and leading international approaches and conclude that the following are key components of a comprehensive dementia strategy:

► Public information to facilitate early intervention
► Information to promote recognition and awareness of dementia for carers
► Information on appropriate treatments and care strategies for professionals
► Reduced financial disincentives, and increased respite and training for care givers
► Case management and system navigation
► Aligning services along existing chronic disease prevention and management models, and
► Ongoing research investment
Leading Practices
Team-based Dementia Care in Canada

District Mental Health Services for Older Adults Program (DMHSOAP)

- A program of the Canadian Mental Health Association
- Launched in 2000, DMHSOAP covers six different communities within a 1,200-kilometre radius in North West Ontario
- The program provides services to older adults (60+) living with a serious mental illness and/or dementia (including Alzheimer’s disease) both in the community and in care facilities
- Diverse staff backgrounds allow service delivery variety ranging from nursing to social work to psychology
- Direct services may include counselling or clinical intervention, assessment and cognitive screening, care and treatment planning, referral and advocacy, and monitoring and follow-up. DMHSOAP also provides support services to caregivers and assists caregivers by offering a much-needed planned break each week. Other services include case management, as well as education for the community and care providers
- DMHSOAP delivers service, developing partnerships to meet the unique needs of rural, remote communities. The use of telehealth technology, for example, provides access to scarce specialty resources. The staff meet through teleconference with geriatric psychiatrist Dr. David Conn, working out of Baycrest Hospital in Toronto, for client assessments, consultation and education
- DMHSOAP provided services to 311 individuals in 2003/04, 533 people in 2004/05, and 633 in 2005/06
- [http://cmhaff.ca/district-mental-health-services-older-adults](http://cmhaff.ca/district-mental-health-services-older-adults)
Leading Practices
Early Intervention Dementia Care

The Case for Early Intervention
► In NB, a study conducted in 2009 in two hospitals revealed that 33% of all beds were occupied by ALC patients, and of those, 63% had a diagnosis of dementia. Many of these patients were already receiving the maximum level of home care supports in their community. Researchers concluded that other interventions such as early diagnosis and informal care programs may be needed to help curtail the number of people with dementia in the community who become ALC patients in the hospital system. (McCloskey et al. 2014)

Prevalence in Canada
► The prevalence of dementia in Canada in 2008 was 1.5% of the Canadian population. The Alzheimer Society projects this rate will increase to 2.8% by 2038. (2010 study, Rising Tide)

Increasing need for respite beds
► As the incidence of dementia increases across Canada, respite beds may become increasingly important as one of the tools that could enable more seniors with early-stage dementia to remain in their own homes longer
► NB has 38 in total (1.5% of beds). Largest NHs over 200 beds have 3; most have 0 or 1 respite bed. NB also holds beds for residents on short term hospital stays, eg up to 30 days
► NS announced in October 2012 the conversion of 44 beds in 8 existing nursing homes to respite care. Beds are available to each client for a maximum of 60 days per year, at a cost of $33 per day
► Central NL: Currently a low take up of available respite beds which may indicate a shift in perception and culture among clients may be required
Leading Practices
Dementia Care – Community Models in Canada and UK

Sherbrooke Community Centre, Saskatoon (SK).
► “Eden Alternative” approach, sets out to counter loneliness, helplessness and boredom.
► One of six homes in Canada recognized by the Alzheimer Society of Canada for their person-centric approach to dementia care.
► Groups of 9-10 residents live with 2 staff in each ‘village’ house, with kitchens and communal living rooms in each, allow for flexible and personalized living arrangements.
► Aims to integrate nature, animals, children and the arts with everyday living for those with dementia

Centre of Innovative Excellence for Alzheimer’s Care, housed within the B’nai Brith (Toronto)
► Innovation Laboratory; 45 bed retirement home for people living with dementia
► Leverage innovations to create personalized models of care and supportive environments for quality of life:
  ► Sensor surveillance and personal communication systems
  ► Electronic access to social network
  ► Agitation prediction sensors
  ► Caregiver training protocols
► $5.4M Federal funding in 2012

UK Community-based Approaches
► Dementia Advisors:
  ► The role of support planning and brokerage for people with dementia is crucial. It helps people navigate the care system and promotes the benefits of maintaining connections with friends, family and the wider community and supports them to do this.
  ► The Alzheimer’s Society has developed a dementia adviser service which has been piloted in 22 areas across England. The service was set up following the publication of the National Dementia Strategy (DH 2009), which recommended that all people with dementia should have access to a dementia adviser following their diagnosis.

UK CASE STUDY:
► St David’s Care Home in Norfolk is using its communal areas as ‘brokerage hubs’ for people in the local community. Sheringham is a rural area with many isolated older people.
  ► This initiative helps to bring them together in one place so they can get support from peers and access information and advice about self-directed support, personal budgets and other social care, household and leisure services. They have also held open days and tea parties, which have attracted people from the local community. By providing a useful local information service, the initiative also helps to link up the people living there and the activities happening outside.
  ► Other care homes around the country also offer free meeting rooms to local groups to encourage more interaction with the local community.
Leading Practices
Assessment Beds: Post-hospital Stay Models of Care

Canada
► Transition care or assessment beds not widespread in residential facilities anywhere in Canada

USA
► Medicare bed model: utilizes transition beds between ALC and either placement in a LTC facility or return home depending on outcome. Criteria: minimum hospital stay of 3 days, over 65 years of age; each client is provided a cumulative 100 days annually to use over multiple hospital stays.
  ► Sliding scale fees kick in after 77 days
  ► Each NH would typically have a unit of 30 such beds; operators have incentive to fill them as they are funded by Government at a higher rate

Australia
► Transition Care: aims to improve older people’s independence and confidence after a hospital stay. It allows them to return home rather than prematurely enter residential care. Program guidelines were recently revised to increase the provision of transition care in rural and remote areas by allowing services to be provided in hospitals where appropriate.
  ► Jointly funded by federal and state governments; states have flexibility over program delivery to adapt to local needs
  ► All states partner with NGOs to deliver transition care
  ► Time-limited, goal-oriented and therapy-focused packages of services to older people after a hospital stay; including low intensity therapy (such as physiotherapy and occupational therapy), social work and nursing support or personal care. Care provided for up to 12 weeks (with a possible extension of another six weeks) in either a home-like residential setting or in the community. In 2012–13, the average length of stay was 61 days.
Leading Practices
Community Support Models

► Demand for more innovative delivery of community-based supports is increasing and will continue to challenge LTC planning efforts, particularly in rural areas.
► We must plan for an increasing number of seniors “who will be healthier than previous generations. The next cohort of seniors will live longer, are predicted to experience a compressed period of morbidity at the end of life and will have definite ideas on the types of services they require and the methods of delivery.” Canadian Healthcare Association, 2009
Targeted wellness programs for seniors with chronic conditions and depression have been shown to have significant improvements in hospitalization and overall health and wellness outcomes. Utilizing technology to deliver services in the home can result in a significant cost avoidance and savings opportunity.

### Select Leading Practice Examples

**PEARLS** is an evidence-based treatment program designed to address symptoms of depression and enhance quality of life in the US. Integrated team of nursing and psychologists are linked to the clients primary care physician coordinating treatment. The program is delivered in the home and is designed to be delivered in conjunction with existing community home services.

- Telecare in North Yorkshire County Council in the UK introduced four dedicated Telecare co-ordinators, who are responsible for ensuring processes and performance monitoring systems are in place, to assist Social Care Assessors and to raise awareness around Telecare among key stakeholders. Extensive training is provided to ensure proper use of the tools.

- Enhance Wellness is an evidence-based community-based health program delivered across the US. The program is adaptable and can be delivered in hospitals and nursing homes as well. The program uses motivational behaviour change interventions to target seniors with chronic conditions. The program is supported by on-going evaluation and innovations.

### Outcomes / key features

- **PEARLS** program significantly improves depression and quality of life in older people
- Both functional well-being and emotional well-being improved for patients that were enrolled in the PEARLS program

- 95% of patients in North Yorkshire say that the Telecare equipment has given them more confidence/peace of mind to continue to live independently at home
- Telecare was estimated to contribute to a 38% reduction in care costs
- Telecare has become a ‘mandatory’ service

- Enhance Wellness program participants have shown a:
  - 72% decrease in hospital days
  - 35% decrease in use of psychoactive drugs
  - 11% decrease in depressive symptoms
Leading Practices
Community Support Models: Home Care in Australia

In Australia, in 2010/11 about 6% of seniors requiring care received Community Care, designed to meet the needs of those clients eligible for residential care but who prefer to remain in their own homes and are safely capable of doing so.

► Community Care packages:
  ► a number of programmes are available including Community Aged Care Packages (CACP); Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D).

► Extended Aged Care at Home Dementia: (Home Care Level 4)
  ► A range of services may be provided under a Home Care Level 4 Package, including:
    ► personal services – such as help with showering or bathing, dressing and mobility
    ► support services – such as help with washing and ironing, house cleaning, gardening, basic home maintenance, home modifications related to your care needs, and transport to help you do shopping, visit your doctor or attend social activities
    ► clinical care – such as nursing and other health support including physiotherapy (exercise, mobility, strength and balance), services of a dietitian (nutrition assessment, food and nutrition advice, dietary changes) and hearing and vision services
  ► Home Care Package recipients may also be eligible to access social support such as the Community Visitors Scheme. For those who do not benefit from regular contact with family or friends, the Community Visitors Scheme (CVS) can provide an opportunity for social interaction, friendship and companionship through regular volunteer visits

Leading Practices
Community Support Models: Multi-Purpose Services in Rural Australia

► The Multi-Purpose Service Program is a joint initiative between the Australian federal and state governments. The program recognises that the delivery of some health and aged care services may not be viable in rural and remote communities if provided separately. By bringing the services together, economies of scale are achieved to support the services.

► Multi-Purpose Services operate under the Act and deliver a mix of aged care, health and community services in rural and remote communities. In general, they are operated by state, territory and local governments, and are primarily located in hospital settings.

► As of 2013, there were 143 Multi-Purpose Services in operation with a total of 3,483 flexible care places.

Leading Practices
Community Support Models: Paid Informal / Family Care

Cash for Care:

► Most OECD countries provide benefits to seniors for home-based care support. These supports include in-kind services, cash benefits, carer respite or voucher models as well. For example:
  ► England: carers providing over 35 hours per week of care are legally entitled to financial support, provided the recipient is in need of care and is receiving a social allowance to cover the care
  ► France: informal caregivers for Alzheimer’s patients can receive financial support; however, only 9% of families are paid
  ► Spain: allowance for receiving informal care to compensate informal care giver; EUR 300-519 per month (2009), income-tested and tax free. Eligibility: carer must be a relative but in rural areas a neighbour may also be eligible
  ► Netherlands: informal carers providing at least one year of support receive a token annual sum of €250
  ► Austria and Italy: a significant degree of informal care for seniors is provided by rising number of migrant workers
Leading Practices
Community Support Models: Maximising Social Capital

Volunteer management and social supports:
► Slivers-of-Time provides technology that helps organisations and service users access a talent pool of workers or volunteers that can be booked instantly for the time required. UK case studies:
  ► Hertfordshire County Council Adult Care Services coordinate respite care in care homes as a vital service in allowing carers to have a break. Slivers-of-Time created Resbed, a bespoke website solution for the booking of short stay beds. Before Resbed, residential respite care was arranged through a spreadsheet. This relied on administrators allocating accommodation by phoning around the care homes. It was extremely time consuming finding the right home. The Local authority were frequently paying for beds through block contracts that were being unused
  ► ResBed enables social care service users to book residential respite beds in approved care homes online at any time. There is now an instant view on Connect ‘24/7’ 365 days of the year, of all vacancies across 27 care homes in Hertfordshire and an on-line request form for immediate booking via the system
  ► Breakaway is another Hertfordshire County Council project. It enables carers to have breaks from caring by connecting them with local volunteer sitters whose time they can book online
► http://www.sliversoftime.com/sectors/social-care/

Family Councils:
► Opportunities to engage communities and foster social capital in rural areas through ensuring Resident and Family Councils are active and are able to contribute to the operation of LTC facilities in meaningful ways. Need to ensure that appropriate supports and governance models are in place to facilitate their growth. Potential benefits include:
  ► Increased well-being for residents resulting from being able to contribute to and control aspects of the residential environment
  ► Mitigation of families’ concerns about quality through direct engagement
Village Agents (Gloucester, UK)

► Village and Community Agents work with the over 50's in Gloucestershire, providing easy access to a wide range of information that will enable them to make informed choices about their present and future needs. The aim is to help older people feel more independent, secure, and cared for, and to have a better quality of life.

► All agents are volunteers and are over 50 years of age themselves.

► Village Agents began as part of the LinkAge Plus scheme funded by the Department for Work and Pensions in 2006, with the selection of 96 of the most isolated rural parishes. The aim was to provide older people in the county's rural communities with easier access to information and services.

► The Village and Community Agents Service have trained a team of Specialist Agents to support cancer patients aged 18 and over and their families. They assist with information, support, and practical help from diagnosis onwards.

http://www.villageagents.org.uk/
Partnerships for Older People Projects (UK, Ministry of Health)
► Community facing and hospital-facing models; £60M in funding for 29 projects in total
► Objective of emergency hospital bed days reduction
► Older people working as volunteers contributed to almost 30% of projects.
► All services were designed to be person-centric and integrated
► Projects served over 260,000 clients over three years
► High probability of cost effectiveness: for projects focused on low-level care through the provision of practical help: for a weekly cost of £96 per person, there is a 98% probability of cost effectiveness compared with usual care.
► Overall Results:
  ► Reduction in overnight hospital stays: 47%
  ► Reduction in use of Emergency Departments: 29%
  ► Overall cost savings estimate of 120%
► Highlighted results: Pro-Active case Coordination Services
  ► Reduction in overnight hospital stays: 48%
  ► Reduction in use of Emergency Departments: 60%
  ► Reduced Phone calls to GPs: 28%
  ► Reduced visits to Nurse Practitioners: 25%
  ► Reduced GP appointments: 10%

http://www.pssru.ac.uk/pdf/rs053.pdf
Leading Practices
Community Support Models: “That Little Bit of Help” aka Low-level Services

Joseph Rowntree Foundation (UK, 2006), Report of the Older People’s Inquiry

► “With a little bit more help upstream, the need for high dependency help downstream can be delayed”
► The 13 best schemes to potentially help the lives of older people include:

Welcome Home

• Provided by the Cotswold Council for Voluntary Service; volunteers help people return home from hospital. Volunteers get any shopping required and can give people a lift home. They also help the user to settle back at home by cleaning etc. The volunteer also visits on the second day to check everything is all right, then hands on to social services. The hospital social worker or home care organiser makes referrals to Welcome Home for people who do not have anyone to help them immediately on discharge. No charge is made for the service.
• The scheme has been running for about five years and they find that four volunteers are able to cover Cirencester with a population of 20,000. Volunteers are specially recruited. They are checked with the Criminal Records Bureau (CRB) and references are taken up. Their training includes issues relating to client choice as to where food is purchased, disability awareness, personal and household safety, listening and communication skills, and the importance of confidentiality, responsibility and reliability. All volunteers carry identity cards.
• The co-ordinator is a volunteer who works from home for four hours a week. If need be, the replacement costs for a volunteer, could be assumed to be equivalent to a social worker.
• **No client has returned to hospital during the 48-hour period covered by the scheme.**
• Cost: the scheme is mainly funded by social services, with income covering costs. In 2004, there were 11 volunteers who helped 49 clients. Volunteers made 149 visits to clients at hospital and at home. The unit cost is £3,790 p.a./49 clients = £78 per client helped home.
Leading Practices
Community Support Models: “That Little Bit of Help” aka Low-level Services

- Top-rated services in terms of outcomes and costs:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Unit cost</th>
<th>User charge</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handy Help</td>
<td>£54 per visit</td>
<td>£10 per visit plus materials</td>
<td>Small home maintenance and repairs, such as fixing dripping taps or mending windows. Usually completed in one visit</td>
</tr>
<tr>
<td>Welcome Home</td>
<td>£78 per client</td>
<td>No charge made</td>
<td>Volunteer transports people from hospital and helps them settle at home by tidying up, shopping, sorting post etc.</td>
</tr>
<tr>
<td>Help at Home</td>
<td>£10.70 per hour</td>
<td>£8.25 per hour</td>
<td>Paid workers clean, change bed linen, iron, (accompanied) shop, and collect prescriptions and pensions</td>
</tr>
<tr>
<td>Primary Night Care</td>
<td>£21 per visit</td>
<td>Estimated at £8.50</td>
<td>Paid care workers make home visits at night</td>
</tr>
<tr>
<td>Befriending service</td>
<td>£5.35 per hour</td>
<td>No charge made</td>
<td>Volunteers provide weekly social visits to isolated people and those in need of support</td>
</tr>
<tr>
<td>Sole Mates</td>
<td>£13.50 per hour</td>
<td>£3.50 per visit</td>
<td>Regular visits to give footbath and foot massage and to cut toenails. There is also a one-off £10 charge for nail clippers</td>
</tr>
<tr>
<td>Cinnamon Trust</td>
<td>£35 per person p.a.</td>
<td>No charge noted</td>
<td>Provides help with pet care in the older person’s home and some foster care</td>
</tr>
<tr>
<td>Digging Deep</td>
<td>Six schools in one area: £7,050</td>
<td>No charge made</td>
<td>Allotments developed in primary schools led by older volunteers. Part of the 5-a-day healthy eating initiative</td>
</tr>
<tr>
<td>RISE</td>
<td>£8.30 per day</td>
<td>£3 for lunch; contribution to outings</td>
<td>Provides visits to isolated older people, transport to lunch club, activities and outings. £10 optional membership fee</td>
</tr>
<tr>
<td>SMILE</td>
<td>£144 per user p.a.</td>
<td>20p–£2.90 per session</td>
<td>A major component of this programme is monitored exercise clubs for beginners</td>
</tr>
</tbody>
</table>
Integrated care homes provide effective transitional care setting and are able to manage care with a focus of keeping seniors at home. With 24/7 alternatives to the emergency department and a variety of health and social programs these care homes can result in reductions in ED visits, hospitalization, admissions to long term care homes and lower end of life costs.

### Select Leading Practice Examples

**The Program of Integrated Managed-care of the Elderly or PRIME** program in Manitoba delivers an integrated range of services in health care, social services and recreation. PRIME is focused on prevention of hospitalization and maintaining care at home and offers case management, day services, primary health clinics and after hours support.

**CHOICE**

CHOICE is an integrated care program in Alberta which works to keep older people healthy and living at home. CHOICE provides a full range of medical, social and supportive services including rehabilitation, home care, medication management and 24/7 access. There are speciality programs for seniors with dementia and multiple chronic health issues.

**On Lok**

On Lok is a centre in San Francisco that is one of the most successful of the US PACE program. The PACE program is a proven model of vertically integrated care focused on servicing seniors who wish to age at home. The program serves frail elderly who are almost exclusively Medicare/Medicaid patients. Patients are eligible for nursing home but are managed at home.

### Outcomes / key features

- Participants had a 14% increase in home support visits
- Participants had a 43% reduction in ER visits, 33% reduction in hospital admissions and 16% decrease in hospital days
- Admissions to personal care homes were 26% lower for PRIME participants vs. control group
- Emergency department visits reduced by 30%
- Sites treat on average 45 to 50 patients per day
- In-home care and after-hours emergency access are also provided.
- End of life costs 26% lower than national average
- ER visits 16% lower than national average
- Hospitalization rates overall lower than national average with ALOS 23% lower than national average

1. Comprehensive Home Option of Integrated Care for the Elderly
2. Program of All Inclusive Care for the Elderly
Leading Practices
Behavior Support Services in Long Term Care: Behavioural Supports Ontario Initiative (BSO)

Waterloo Wellington LHIN success story: “Helen was diagnosed with Alzheimer’s Dementia and came here to live in 2009. As time progressed Helen noticeably lost most of her short term memory. Especially in the evening hours, Helen would start to get anxious. At these times she was often seen walking around with her walker telling anyone she saw that she was looking for the children. “Have you seen the children? Do you know where the children are? I’ve lost the children”. At first staff tried reality orientation, assuring Helen that there were no children here and that she lived in long term care. As Helen’s dementia progressed the search for the children became a great source of distress; staff were frustrated and other residents often became unsettled. It was at this time that the BSO team was asked to get involved. The BSO Team thought that perhaps they would try giving Helen a doll and see how she responded. It soon became her constant companion and her “responsive behaviors” were no longer present. She even took the doll home with her for a Christmas visit. It was after Helen passed away that staff learned that over the course of Helen’s life, she had been a foster mom to 72 children. This was the reason that this doll had brought such a great comfort to Helen in the last months of her life.”

Background and Structure
The Behavioural Supports Ontario Initiative was formed in 2011. The objective of the initiative is to enhance services for older adults with complex and predictable responsive behaviors associated with cognitive impairments such as dementia, or other neurological conditions, mental health and addictions, wherever they live – at home, in long-term care, or elsewhere.

LHIN funding is provided to each of the LTC Homes for specialized Behavioral Support positions for Nurses (Registered Nurse or Registered Practical Nurses) as well as Personal Support Workers. Funding is distributed across the LTC Homes for these positions, proportional to the number of beds.

The BSO initiative is recognized as a leading program in behavior support services in long term care. This model is unique in that it is a decentralized service; supporting each of the long term care homes in building capacity and supports to meet the unique needs of each of their residents.

Outcomes / key features
► Service is provided in the individual’s place of residence, community and long term care homes, and includes transitions within/between acute care settings to place of residence
► Use of intersectoral, interdisciplinary care teams

► Initial Provincial investment of $40M to establish the BSO Initiative
► Annual operating budget: for example, the Waterloo Wellington base budget for BSO (2014) was $1.85M for services over 3,822 LTC beds in the LHIN; an annual per bed cost of $483

► Outcomes being evaluated include:
  • Reduced resident transfers from Long-Term Care Homes (LTCHs) to acute or specialized unit for behaviours
  • Delayed need for more intensive services, reducing admissions and risk of Alternate Level of Care (ALC)
  • Reduced length of stay for person
Leading Practices
Stella Burry Centre: Programs for Adults with Intellectual Disabilities

Mission: Stella’s Circle offers services for adults who have faced challenges that prevent them from full participation in our community. These challenges are often combined and include: mental and/or physical health concerns, illiteracy, interrupted education and learning disabilities, among others. Stella’s Circle support people in changing their lives for the better by giving them opportunities to learn, to work, to recover, and to have secure homes and stable jobs. We also offer opportunities for social interaction and fellowship so that people can become active members of their community.

Selected programs:

**Community Support Program**

The Community Support Program (CSP) provides intensive assistance to people with complex mental health needs. The goal of the program is to improve the overall quality of participants’ lives, and to reduce the length and number of admissions to hospitals and prisons.

The program serves men and women over the age of 18 who reside within the St. John’s region, have a diagnosed mental illness, and meet three or more of the following criteria:

- a significant involvement with the mental health system
- a developmental disability
- a significant involvement with the justice system
- an unstable housing history
- behaviour that has resulted in harm to self or others, or is likely to place others at risk

**CanDo! Enterprises**

CanDo! Enterprises offers flexible, hands-on work experience in a supportive environment. We use a social enterprise approach to generate business and provide work opportunities for people. Participants can engage in a variety of activities such as landscaping, rag recycling, garden box installation, painting, and building maintenance.

The program is designed for adults who have experienced serious mental health issues or have other significant barriers to employment; they may have a very limited or broken work history and are not ready for a full-time job or classroom instruction.

- Participants may work between 1 and 15 hours per week on a variety of group and individual projects, depending on their interests and abilities.
- People are paid minimum wage for the hours worked. Individual support and counselling is offered to help participants complete their work and achieve their goals.
Leading Practices
Community Based Programs (Adults with Disabilities): L’Arche

► Founded in 1964 by Jean Vanier, L’Arche is an international organization of faith-based communities creating homes and day programs with people who have intellectual disabilities. L’Arche communities exist as an International Federation of 145 communities in over 40 countries. L’Arche communities were first established in Canada in 1969 and now exist in 29 locations across all Canadian provinces except PEI and NL.

► In L’Arche, people who have intellectual disabilities and those who come to assist share life and daytime activities together in family-like settings that are integrated into local neighbourhoods. L’Arche in Canada has nearly 200 homes and workshops or day programs. These are grouped into what L’Arche calls “communities”. There are 29 communities of L'Arche located across Canada from Cape Breton to Vancouver Island.

► As a service organization, L’Arche espouses a "community model" of living, rather than a medical or social service model of care. As a faith-based organization L’Arche recognizes the spiritual and religious needs and aspirations of its members, and respects those who have no spiritual or religious affiliation. Our community and faith life inspire us to be open to people of differing intellectual capacity, social origin, religion, race, and culture. At L’Arche, people with disabilities and those who assist them, live together and are equally responsible for the life of their home and community.

Jean Vanier

► Jean Vanier is a Canadian humanitarian, spiritual leader, and internationally esteemed pioneer in the field of care for people with intellectual disabilities.

► Born in 1928, he joined the Royal Navy at age 13 and left it at 21 to begin a spiritual quest and to study for his PhD.

► Appalled by conditions of institutions where people with intellectual disabilities lived, in 1964 he welcomed two men to share a home with him. Thus began what has become the worldwide movement of L’Arche.

L’Arche Communities

► L’Arche communities are open and welcoming of neighbours and friends and often engage in various collaborations at the local level.

► Each L’Arche community consists of a small number of households where people share in decision-making and each person contributes as they are able. L’Arche believes that meaningful work or day-time activities are very important to a person's dignity. Many communities of L'Arche have day projects of various types. Some people in L’Arche may have regular jobs in the wider community, but most of the people with intellectual disabilities who come to live in L’Arche need considerable support and find competitive employment is not an option.

► L’Arche seeks to provide environments where people can reach their full potential, lead lives rich in relationships of mutuality, and have a valid place in society where they can contribute.
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APPENDIX C – Nursing Home Sector Analysis
Please Refer to the Nursing Home Analysis Supplemental Report
APPENDIX D – Personal Care Home Sector Analysis
Of the 1,147 Personal Care Home beds in Central Region, 878 were occupied at the time of the data request (Nov 2014)

25 clients were on the waitlist for Personal Care Home placement with:
- 18 (72%) in Zone 14
- 6 (24%) in Zone 12
- 1 (4%) in Zone 11
Golden Years Estate was the site selected for the Enhanced Care Pilot.
PCH Demand Projections

Based on the demand projection, there is currently an over capacity of 244 beds across Central Health.

Based on projections taking into account the population growth and current waitlist size Central Health will require:

- 16 PCH beds by 2022
- 110 PCH beds by 2026

Assumptions made in calculating PCH bed demand

- The demand is calculated by projecting the proportion of clients in the PCH setting by age group vs. the total population in 2014 to the population projection for the years 2017, 2022, 2026
- The demand projection was calculated based on the medium scenario of the population projection
- We have included the current average waitlist for PCH beds for 2014 in our calculations

2017 over 65 = \{(2014 over 65 / 2014 population over 65) \times 2017 population over 65\} + \{(2014 wait list over 65 / 2014 population over 65) \times 2017 population over 65\}

2017 under 65 = \{(2014 under 65 / 2014 population under 65) \times 2017 population under 65\} + \{(2014 wait list under 65 / 2014 population under 65) \times 2017 population under 65\}
Overview of Demand Projections
By 2026 Personal Care Homes in Zone 11 will Require 43 Additional PCH Beds

Economic zone 11 PCH demand projection by age (medium scenario)

<table>
<thead>
<tr>
<th>Economic zone 11</th>
<th>2014</th>
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<th>2022</th>
<th>2026</th>
<th>Total (from 2017-2026)</th>
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</thead>
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<tr>
<td></td>
<td>Client under 65</td>
<td>Client over 65</td>
<td>Wait list</td>
<td>Total demand</td>
<td>New demand under 65</td>
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<tr>
<td>Bay View Manor</td>
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<tr>
<td>Springdale Retirement Home</td>
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<td>95</td>
<td>1</td>
<td>97</td>
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<td>Total</td>
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<td>119</td>
<td>1</td>
<td>122</td>
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Overview of Demand Projections
By 2026 Personal Care Homes in Zone 12 will have Over Capacity of 54 PCH Beds

Economic zone 12 PCH demand projection by age
(medium scenario)

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<th>Economic zone 12</th>
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<th>2026</th>
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<tbody>
<tr>
<td></td>
<td>Client under 65</td>
<td>Client over 65</td>
<td>Wait list</td>
<td>Total demand</td>
<td>New demand under 65</td>
</tr>
<tr>
<td>Exploits Manor</td>
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<td>4</td>
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<td>14</td>
<td>0</td>
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<tr>
<td>Islandside Manor</td>
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<tr>
<td>Killick Retirement Home</td>
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<td>42</td>
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<tr>
<td>Golden Years Estates</td>
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<td>Hollett's Retirement Centre</td>
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<td>Total</td>
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</table>

- Wait list
- Over 65
- Under 65
- Total
- Current capacity

Exploits Manor
Islandside Manor
Killick Retirement Home
Golden Years Estates
Hollett's Retirement Centre
Twin Town Manor
Total
Overview of Demand Projections
By 2026 Personal Care Homes in Zone 14 will Require 56 Additional PCH Beds

Economic zone 14 PCH demand projection by age
(medium scenario)
Overview of Demand Projections
By 2026 Personal Care Homes in Zone 14 will Require 56 Additional PCH Beds (cont.)

<table>
<thead>
<tr>
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<td>------</td>
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APPENDIX E - Home Support Sector Analysis
Home Support 65+ Utilization Overview

Home support clients and cost by health service area

- Number of clients: Baie Verte (95), Green Bay (66), Buchans (20), Exploits (86), Grand Falls-Windsor (92), Coast of Bays (103), Gander & Area (78), Isles of Notre Dame (155), Kittiwake Coast (205), Lewisporte (76)
- Average monthly cost: Baie Verte ($1,598), Green Bay ($1,649), Buchans ($1,792), Exploits ($1,929), Grand Falls-Windsor ($1,739), Coast of Bays ($1,885), Gander & Area ($1,935), Isles of Notre Dame ($2,066), Kittiwake Coast ($1,822), Lewisporte ($1,353)
Among the 976 clients who received Home Support 65+ services, 68 were over the ceiling and for a total additional cost of $46,500 monthly.

Based on projections taking into account the population growth Central Health will require:

- $1.6M more in the Home Support 65+ regional budget allocation by 2017
- $5.1M more in the Home Support 65+ regional budget allocation by 2022
- $7.4M more in the Home Support 65+ regional budget allocation by 2026

The additional budget is based on the 2014 average monthly cost per client.

*Capacity was estimate by using the 2014 average monthly cost per client and the 2014 budget for the program.
Overview of Demand Projections by Economic Zone

Economic zone 11 HSS demand projection by age (medium scenario)

Economic zone 12 HSS demand projection by age (medium scenario)

Economic zone 13 HSS demand projection by age (medium scenario)

Economic zone 14 HSS demand projection by age (medium scenario)
Current State
Community Programs for Adults with Disabilities

Community programs current utilization
(Total number of clients, 2014)

- Alternate Family Care: 68
- Board and Lodging: 7
- Co-operative Apartment: 315
- Own Home/Apartment: 34
- Individualized Living Arrangement: 447

Community programs current annual cost ($000s)

- Alternate Family Care: $3,954
- Board and Lodging: $1,824
- Co-operative Apartment: $1,620
- Own Home/Apartment: $9,470
- Individualized Living Arrangement: $5,662
Current State
Community Programs Overview (2014)

Board and Lodging current utilization

Alternate family care current utilization

Own Home/ Apartment current utilization

Other community programs current utilization

Co-operative Apartment
Individualized living arrangement

EZ 11
EZ 12
EZ 13
EZ 14

Baie Verte
Green Bay
Buchans
Exploits
Grand Falls-Windsor
Coast of Bays
Gander & Area
Isles of Notre Dame
Kittiwake Coast
Lewisporte
Community Programs Utilization Overview

### Community programs client by health service area

- **Baie Verte**: 29, 32
- **Buchans**: 6, 21
- **Coast of Bays**: 47
- **Exploits**: 25, 25
- **Gander & Area**: 57, 55
- **Grand Falls-Windsor**: 64, 74
- **Green Bay**: 11, 6
- **Isles of Notre Dame**: 39
- **Kittiwake Coast**: 34, 44
- **Lewisporte**: 6, 7

### Community programs annual cost by health service area (‘000s)

- **Alternate family care**
- **Board and Lodging**
- **Co-operative Apartment**
- **Own home/Apartment**
- **Individualized living arrangement**

- **Baie Verte**: $0
- **Buchans**: $0
- **Coast of Bays**: $0
- **Exploits**: $0
- **Gander & Area**: $0
- **Grand Falls-Windsor**: $0
- **Green Bay**: $0
- **Isles of Notre Dame**: $0
- **Kittiwake Coast**: $0
- **Lewisporte**: $0

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CH LTC Needs Assessment: Final Report – Appendix F
APPENDIX G - ALC Analysis
ALC Data Overview

ALC Days Related to Dementia are 53% Higher than ALC Days Related to Other Conditions

- Connaigre Peninsula Health Centre has the highest average ALC days of 87 days followed by Fogo Island Health Centre with 57 average ALC days.

- The average ALC days for patients with dementia are higher than the average ALC days.

- Fogo Island Health Centre has the highest average ALC days related to dementia, 161 days, followed by Central Newfoundland Regional Health Centre with 110 days.
Dementia is the Top Driver of ALC Days by CMG

Breaking down the ALC patient into case mix groups (CMGs), the top ten CMGs for ALC days represent approximately 48% of all the ALC days of the Central Health region among which 21% of ALC days are driven by dementia.

While the average number of ALC days across the region is 35, the average number of ALC days related to dementia is more than twice as high.
APPENDIX H – Engagement Summary
Background

Long Term Care and Community Support demands are continuously expanding as the average age of residents across Central Health region increases.

By 2026, 50% of the population of Central Region will be over the age of 55.

The current occupancy rate at all Long Term Care sites ranges between 95% to 100%, and the number of seniors availing of home support services has grown by 250% since March 2006. The waitlist for Long Term Care placement has grown by 82% since 2007 and the number of ALC days per year has almost doubled over the past 7 years.

Central Health has the objectives to meet the current demand and anticipated future needs of LTC clients. Therefore, it requests an assessment of existing long term care and community support services and population as well as future state recommendations addressing service needs and residential gaps, with a focus on maintaining clients at the highest level of independence and as close to home as possible.
Project Objective and Scope

Objective
► Engage key Central Health stakeholders, external experts in the field
► Perform relevant data analysis and literature reviews to inform Central Health’s planning and development of sustainable future state options for LTC services

Scope
► Central Health Region long term care current state analysis identifying strengths, service gaps and areas requiring improvement in order to be responsive to the needs of clients and families
► Jurisdictional scan
► Analysis of the current population residing in LTC to identify potential for more appropriate placement of individuals if other residential options were available
► Recommendations about the types of services and location Central Health and the DHCS needs to invest in to be responsive to the long term care needs in the region
► Capital infrastructure Class D estimates and operating costing for the recommended residential options taking into consideration the adequacy and challenges associated with the current physical infrastructure. The availability of the required workforce will also be considered as part of the analysis of the feasibility of the recommended options

Out of scope
► Development of Detailed Design or Implementation Plan to support Future State Recommendations
► Operational Review of Central Health Long Term Care Facilities
► Children’s Services
► Mental Health Services
Project Approach

**Weeks 1-2**
- **Project Initiation**
  - Project kick-off
  - Project charter sign-off
  - Identification of key stakeholders and consultation approach
  - Data requirements identification and request submission

**Weeks 3-6**
- **Current State and Needs Assessment**
  - Review of currently available reports
  - Collection and analysis of relevant data
  - Stakeholder consultations
  - LTC Population Analysis and Needs Assessment
  - Review of current service offerings
  - Perform multi-jurisdictional scan

**Week 6-9**
- **Future State Options and Recommendations Development**
  - Development of Future State Options and Recommendations including:
    - Future state LTC population needs
    - Proposed service delivery models
    - Risks and impacts
    - Development of supporting capital infrastructure and operating cost estimates

**Week 10-11**
- **Project Close**
  - Incorporation of feedback from draft report and edits as required
  - Final presentation to the Steering Committee
  - Final report submission
  - Knowledge transfer

**Weekly Status Reporting**

**Knowledge Transfer Throughout**

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CH LTC Needs Assessment: Final Report – Appendix H
Consultations
The Project Team Conducted Six Site Visits

The following stakeholders were interviewed during the site visits:

- **Notre Dame Bay Memorial Health Centre, Twillingate**: Gloria Bath, Mgr Primary Health Care Services; Paula Mitchell, Care Facilitator; Angela Roberts, Unit Coordinator; Catherine Samson, Mgr Client Care Services

- **North Haven Manor, Lewisporte**: Cheryl Peckford, Mgr Primary Health Care Services; Joanne Ginn, Mgr Client Care Services; Rhonda Luscombe Social Worker; Karen Pond, Care Facilitator

- **Valley Vista Seniors Complex, Springdale**: Melinda Noel, Director of Services; Wayne Wellman, Client Service Manager; Lisa Goudie, Care Facilitator; Theresa Short, Clinical Educator; Phyllis Bowers, Social Worker

- **Carmelite House, Grand Falls – Windsor**: Sean Tulk, COO CNRHC; Krista Toms, Facility Mgr. Carmelite; Joanne Parsons, Liaison Nurse; Dana Ledrew, Nurse Mgr; MaryLou Ryan, Social Worker; Anne Blackmore, Nurse Educator

- **Lakeside Homes, Gander**: Kerry Small, Nurse Mgr; Debbie O’Brien, Social Worker; Scott Bartlett, Care Facilitator; Sean Roberts, Physiotherapy Aid; Steve Slade, Recreation Therapist; Mimie Carroll, Director LTC and Community Supports; Tina Luter, Care Facilitator

- **Dr. Hugh Twomey Health Centre, Botwood**: Doug Prince, Director of Health Services; Allison Champion, Client Service Mgr; Golda Mullins, Social Worker; Heather Parsons, Care Facilitator; Tonya Murray, Recreation Therapist
Consultations cont’d.

The following stakeholders were consulted on one or more occasions throughout the project:

- Heather Brown, VP LTC and Community Support Services
- Mimie Carroll, Director LTC and Community Support Services
- Sherry Freake, VP Acute Care and COO JPMRHC
- Dr. Jody Woolfrey, Senior Staff Physician, Twomey Center
- Dr. Carmel Casey, Family Physician
- Karen Ropson, Regional Manager Community Support Services
- Florence Sentner, Marlene Steiner, Robert Dixon, Coordinators
- Treena Stead, Manager Client Financial Services
- Stephanie Doucey, Bev Little, Tracey Waterman, Greg McGrath, Placement Coordinators
- Wendy Sutton, LTC Placement Coordinator
- Angela Batstone, Director Long Term Care and Community Supports, Dept. of Health and Community Services
- Deena Waddleton, Consultant Long Term Care and Community Supports, Dept. of Health and Community Services
- Amy Coley, Operator Hallett’s PCH
- Ursula Parsons, Operator Golden Years PCH
- Deanna Oates, Glenda Cokes, Sonja Hoskins, Doug Keough (AHP)
- Corinne Shea, Regional Manager Palliative Care Services
- Dr. John Trend, Consumer and Patient Advocate
- Lori Moulton, Executive Director Central Residential Services Board
- Shirley Lucas, Executive Director Alzheimer’s Society, Newfoundland Chapter