Ontario Long-Term Care COVID-19 Commission

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Canadian Institute for Health Information

About the Canadian Institute for Health Information (CIHI)

Better data.
Better decisions.
Healthier Canadians.

Be a trusted source of standards and quality data

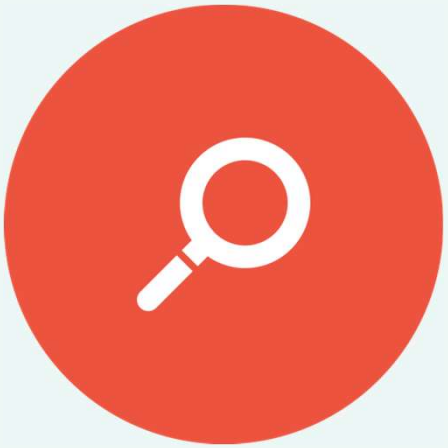
Expand analytical tools to support measurement of health systems

Produce actionable analysis and accelerate its adoption

- Independent, not-for-profit organization that provides creditable, comparable information on Canada's health systems
- Established in 1994 through an agreement between the federal, provincial and territorial governments to forge a common approach to addressing the "deplorable state of health information"

Presentation overview

- What we know about Ontario’s long-term care sector
- CIHI's Framework for assessing and evaluating health system performance
- Observations on data availability and quality
- Opportunities to address data and information gaps



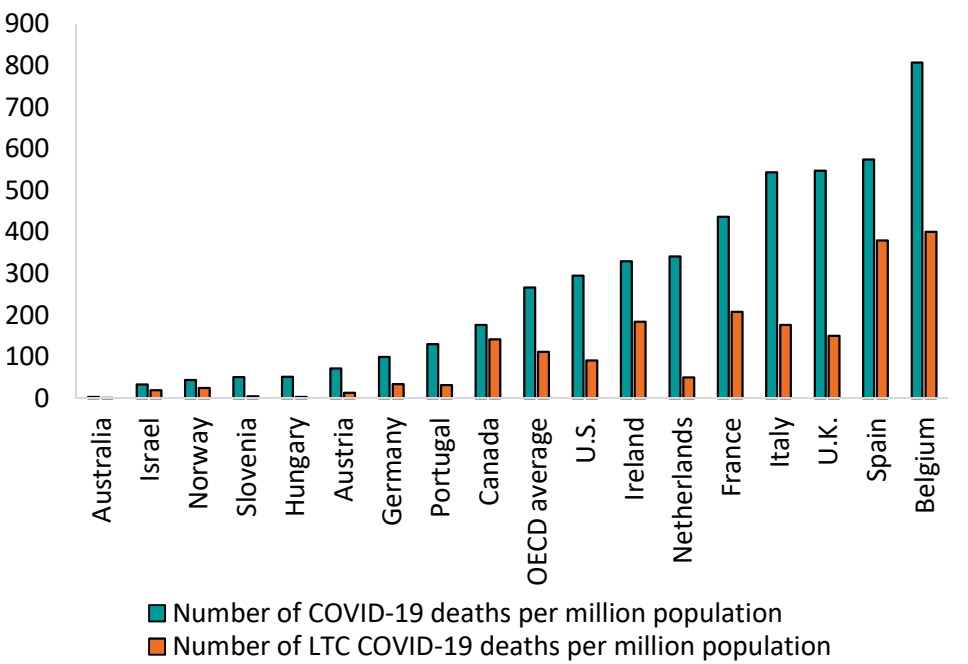
Background

Long-term care (LTC) in Ontario

- Ontario has a total of 626 long-term care homes; Demand for residential long-term care is high in Ontario and across Canada and continues to outpace the number of available beds.
- The care needs of today's long-term care residents are also becoming more complex and more resource intensive over time.
- A CIHI analysis found that 1 in 12 (8%) newly admitted long-term care residents in Ontario could potentially have been cared for at home with the right supports in place.
- The majority of Ontario long-term care homes are owned by private for-profit organizations, followed by private not-for-profit organizations and finally, publicly owned.

International comparison of COVID-19 in LTC

Figure 1. COVID-19 deaths as of May 25, 2020, at 9 p.m.



Canada had a lower COVID-19 mortality rate than the average of 17 OECD countries

Canada had the highest proportion of deaths due to COVID-19 in long-term care and retirement homes

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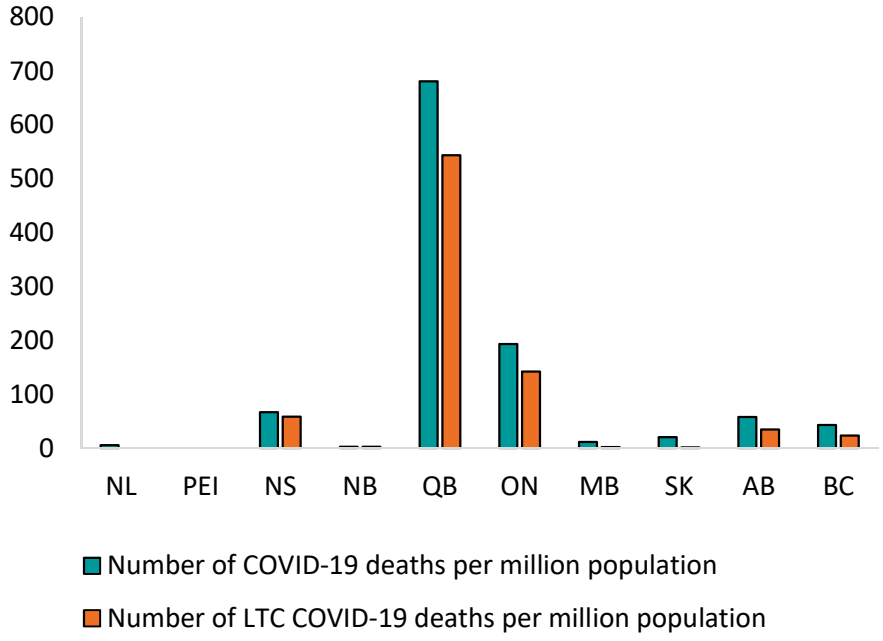
COVID-19 & LTC snapshot in Ontario

Figure 2. COVID-19 deaths as of Sept 15th, 2020, at 9 p.m.



76% of all COVID-19 deaths in Ontario occurred in long-term care

Long-term care workers were disproportionately affected by COVID-19 with 3,486 cases and 8 deaths

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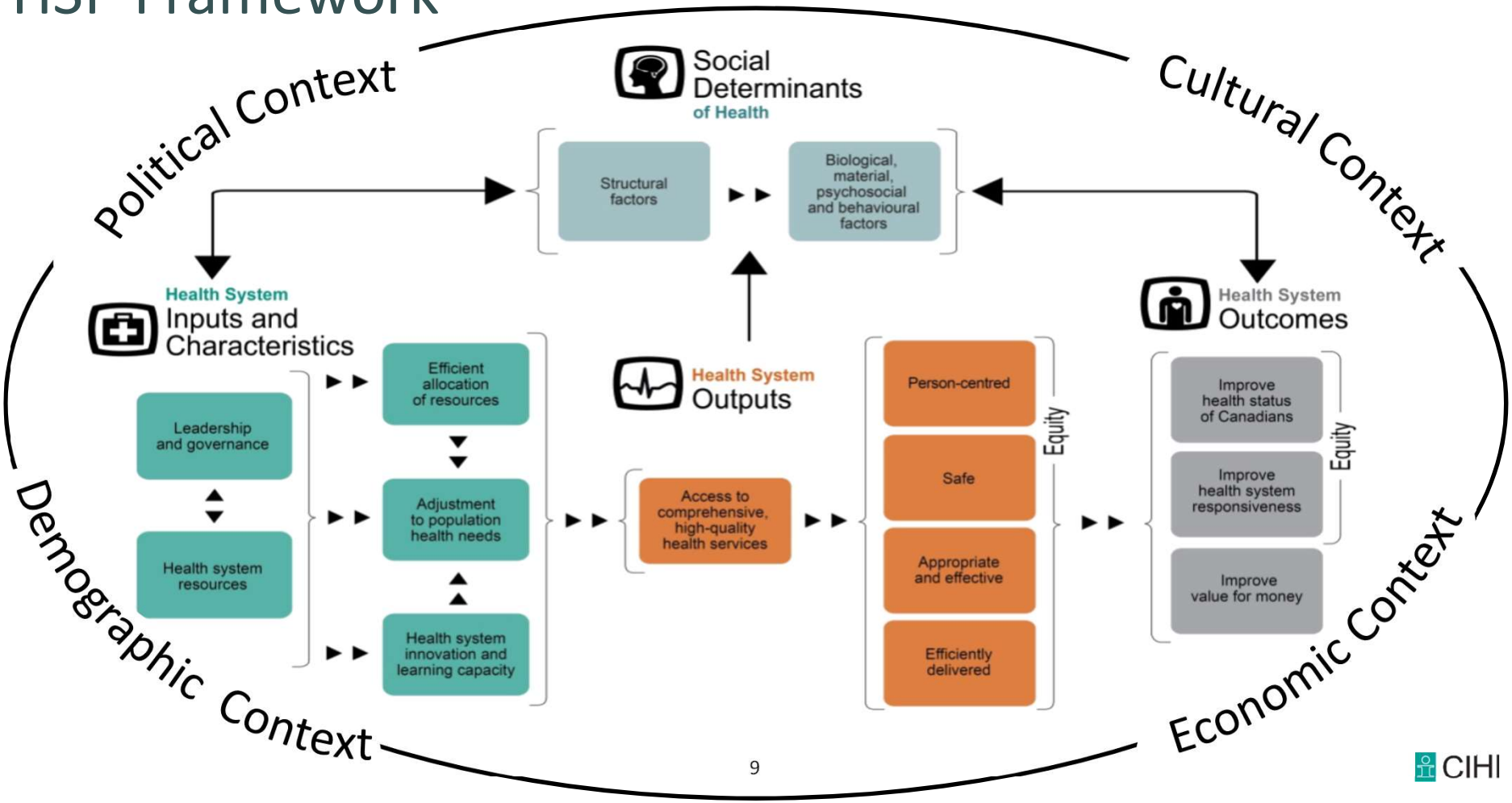
Assessing health system performance (HSP)

HSP Framework



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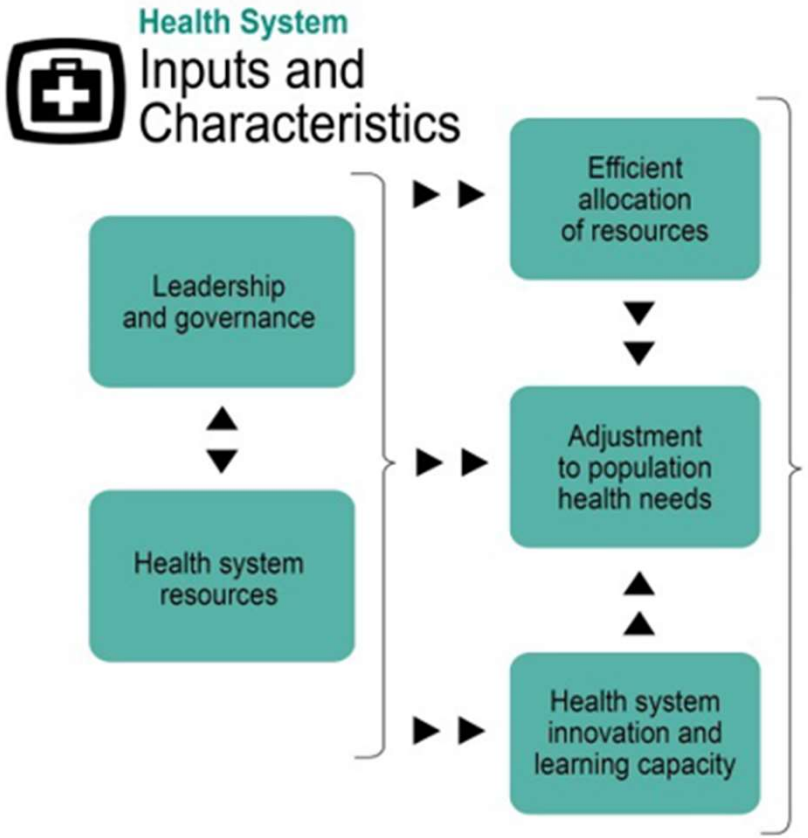
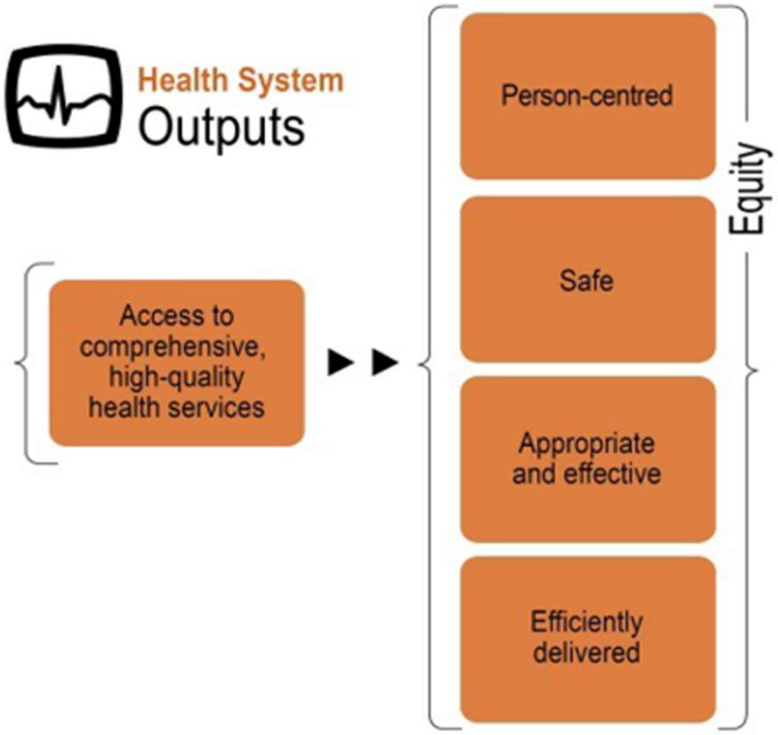
Health System Inputs and Characteristics



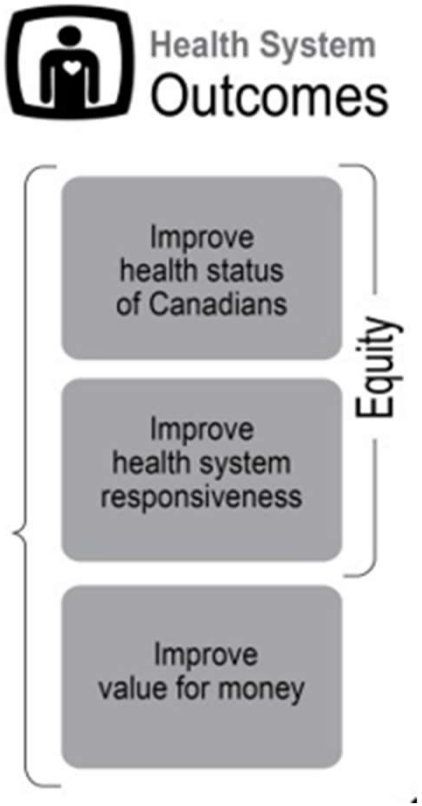
- **Health system resources examples:**
  - Infrastructure, facility staff and staffing levels, personal protective equipment
- **What we know:**
  - In Ontario, 35% of registered nurses working in long-term care have a part-time or casual position

Health System Outputs



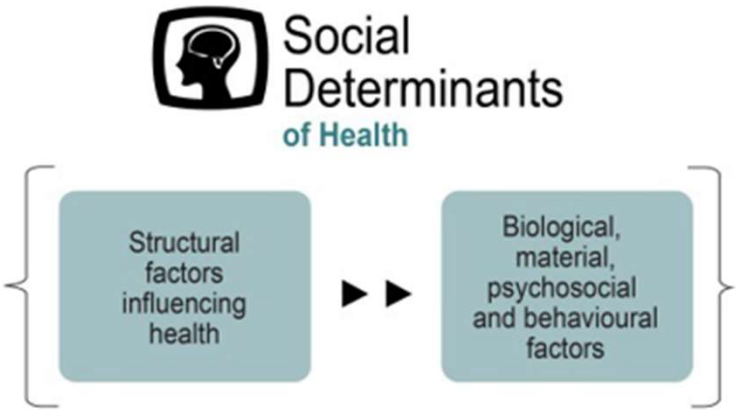
- **Safety examples:**
  - Infection control practices and policies, patient safety measures, at risk subpopulations
- **What we know:**
  - Nearly 1 in 5 COVID-19 infection cases in Canada and 17% of cases in Ontario were among health care workers

Health System Outcomes



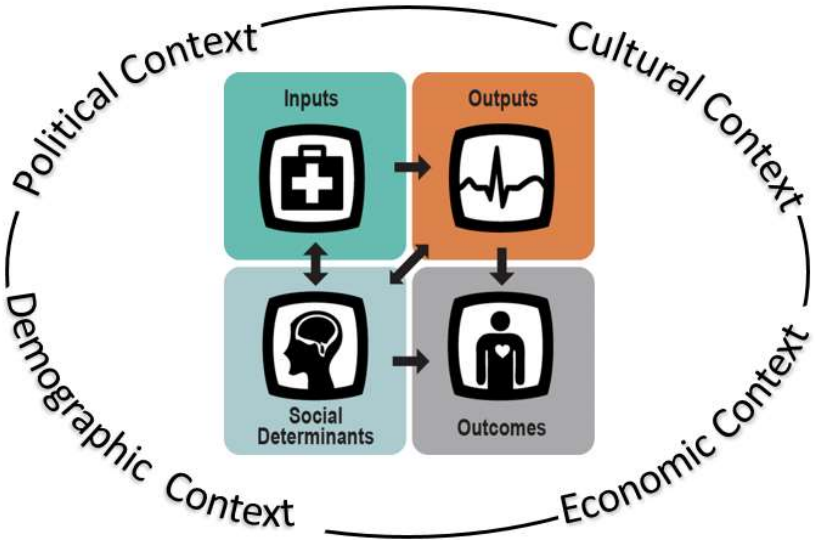
- **Health status examples:**
  - Diseases and health conditions, mental and social well-being, quality of life
- **What we know:**
  - 79% of Ontario long-term care home residents were at moderate risk of severe complications from COVID-19 and 14% were identified as high risk

Social Determinants of Health and Equity



- **Social determinants of health examples:**
  - Urban and rural geography, race/ethnicity, gender, employment conditions
- **What we know:**
  - Seniors living in rural areas were 50% more likely than urban dwellers to be admitted to long-term care when they could have been cared for at home with the right supports in place

Political, social, economic and demographic context



- **Context includes:**
  - Age of population, funding models, timeliness of interventions, role of caregivers
- **What we know:**
  - While no clear differences in pandemic outcomes were observed in OECD countries across funding models (public, private or mixed) countries with centralized regulation and organization of long-term care generally have lower numbers of COVID-19 cases and deaths

Observations of data and information quality: Current state of data in long-term care

Strengths	Key Gaps	Opportunities
• CCRS/IRRS[1]: Clinical information on residents • Information on selected health care professionals (e.g. registered nurses)	• Information on personal support workers • Resident and family experience • Expanded financial and statistical information on LTC facilities	• Integration of data across the continuum of care • Timeliness of hospital data to better understand transitions of care (e.g. patient transfers) • Mortality data on residents in long-term care

1 Continuing Care Reporting System, or its newer evolution: Integrated interRAI Reporting System

Addressing data and information gaps

- More timely and comparable pan-Canadian data about COVID-19 and outbreaks in long-term care settings
- Comparable information about characteristics of long-term care facilities
- Comparable resident and family experiences or quality of life information
- Information on personal support workers and health workforce statistics (e.g. staffing ratios etc.)
- Improve efficiency and reduce burden for resident clinical care data submission and reporting

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Appendix

Appendix

1. **CIHI's intervention scan**
2. **Other resources**
3. **Key concepts and definitions**

Appendix 1: CIHI's intervention scan

CIHI's Intervention timeline is an interactive tool developed to explore the timeline of COVID-19 interventions and daily case counts by selecting a jurisdiction, time period and type of intervention (CIHI, 2020).

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Appendix 2: Other resources

Additional resources on COVID-19 and Long-term Care

The following resources provide further information that could be of interest to the Commissioners:

- National Institute for Aging (NIA) Long-Term Care COVID-19* Tracker (https://ltc-covid19-tracker.ca/) provides up-to-date information on outbreaks at the facility level across Canada.
- CIHI's June 2020 snapshot: Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries?. CIHI; 2020. Note that a more detailed CIHI report on the pandemic experience in Canada's long-term care sector is planned for later this year.
- Canadian Armed Forces report on deployment to 5 Ontario long-term care homes
- A Balsillie School paper outlines an international perspective on COVID-19 and the future of nursing homes
- Canadian Foundation for Healthcare Improvement's "Reimagining Care for Older Adults: Next Steps in COVID-19 Response in Long-Term Care and Retirement Homes"
- The OECD has a series of policy responses papers, including one that examines the workforce and safety during the pandemic

Note: Further resources are found in the Ontario long-term care COVID-19 commission package from CIHI

Appendix 3: Key concepts and definitions

- **Health system outcomes** (framework quadrant 1) correspond to the intrinsic goals of the health system. These outcomes are the improvement of the level and distribution of health in the population, the health system's responsiveness to the needs and demands of Canadians and value for money to ensure health system sustainability.
- **Health status** of individuals and the population covers three components: health conditions, health function and well-being.
- **Health conditions** reflect the health problems and alterations of an individual that may lead to distress, interference with daily activities or contact with health services. They may be a disease (acute or chronic), disorder, injury or trauma, or they may reflect other health-related states such as pregnancy, aging, stress, a congenital anomaly or a genetic predisposition that can lead to death.

- **Health function** corresponds to the general health status and functions of the population and is associated with the consequences of diseases, disorders, injuries and other health conditions. Health functions include body functions/structures (impairments), activities (activity limitations), participation (restrictions in participation) and life expectancy.
- **Well-being** reflects the level of physical, mental and social well-being of individuals and of populations as it relates to material conditions, quality of life and sustainability of well-being over time.1
- **Health system** responsiveness corresponds to the capacity of the health system to respond to the needs and expectations of the population.2 It also includes the element of trust in the health system, corresponding to the population's confidence in the health system3 —that the system will be there for them and will respond to their needs.

- **Equity (in health status and system responsiveness)** is an overarching health system outcome that encompasses the equitable distribution of health status and system responsiveness across socio-economic groups—the equity of the health system. This implies that "everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided."[4]
- **Value for money** is related to the system outcomes of health status, system responsiveness and equity of the health system. It is a measure of the level of achievement of these three goals compared with the resources used.[2]
- **Social determinants of health** (framework quadrant 2) are represented in two levels:[5] the structural and intermediary (biological, material, psychosocial and behavioural) factors that influence the health of a population and inequalities in health.

- **Structural factors** influencing health are those that shape individuals' and families' socioeconomic position, such as income and social status, education and literacy, and gender and ethnicity. Taken together, the structural factors can expose individuals to and make them more vulnerable to unhealthy conditions.
- **Biological, material, psychosocial and behavioural factors** are collectively referred to as "intermediary determinants of health." Biological factors include genes, aging processes and sex-linked biology. Material circumstances include characteristics of neighbourhoods, housing, working conditions and the physical environment. Psychosocial circumstances include stress, an individual's sense of control and social support networks. Behavioural factors include such things as smoking, physical exercise, diet and nutrition. There are interrelationships among these intermediary factors, as there are between intermediary and structural factors influencing health.

- **Health system outputs** (framework quadrant 3) are the services delivered that result from activities undertaken by the organizations and individuals that are a part of the health system. The dimensions within the Health System Outputs quadrant describe the characteristics that contribute to the quality of the services. These characteristics apply to all services delivered by the health system, including public health and health promotion and disease prevention services delivered to populations, as well as services delivered to individuals, for example, hospital, physician, mental health or long-term care health services.
- **Access to comprehensive, high-quality health services** corresponds to the range of health services available, including public health, health promotion and disease prevention services, and the ability to meet the needs of the population or an individual without time delay, financial, organizational or geographical obstacles standing in the way of seeking or obtaining health services. The attributes of “high-quality” health services are defined by the other dimensions in this quadrant and encompass the definition of quality developed by the Institute of Medicine.

- **Person-centred** health services are respectful of and responsive to the preferences, needs and values of individuals and ensure that their preferences guide all clinical decisions. This also refers to the integration of and connections across health system structures, functions, sectors and professionals that put the individual receiving services and his or her informal caregivers at the centre of delivery and that support continuity of care.
- **Safe** health services are those that avoid injuries to individuals from the care that is intended to help them.
- **Appropriate and effective** health services are provided based on scientific knowledge about who could benefit from the service, reducing the incidence, duration, intensity and consequences of health problems. Services are appropriate and effective when they are provided to all who could benefit and when person-centred decisions are made to refrain from providing services to those not likely to benefit.

- **Efficiently delivered** health services avoid waste, including waste of equipment, supplies, ideas and energy. This corresponds to the technical efficiency of the health system and refers to maximizing outputs (services) for a given level and mix of inputs (resources), or minimizing the inputs used to deliver a given level and mix of outputs.
- **Equity (in health system outputs)** refers to the capacity of the health system to deliver comprehensive, high-quality outputs (services) to individuals and populations in an equitable way, without the imposition of financial or other barriers to receiving care that is person-centred, safe, appropriate and effective, and efficiently delivered.
- **Health system inputs and characteristics** (framework quadrant 4) refer to the relatively stable characteristics of the health system, including the governance and leadership capacities in the system, the resources available for use, the distribution and allocation of those resources, the capacity to adjust and adapt to meet population health needs, and the innovation and learning capacities of the system.

- **Leadership and governance** involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system design and accountability.[6]
- **Health system resources** are the financial, human, physical, technical and informational (including evidence and high-quality data) resources that are available to the health system.
- **Innovation** represents the implementation of an internally generated or borrowed idea— whether pertaining to a product, device, system, process, policy, program or service—that was new to the organization at the time of adoption.[7]
- **Learning capacity** in the health system refers to the extent to which the system is "skilled at creating, acquiring, and transferring knowledge, and at modifying its behavior to reflect knowledge and insights."[8]

- **Efficient allocation of resources** measures how resources are combined to produce health services to meet the population-based demands and needs of a society.[9]
- **Adjustment to population health needs** refers to the capacity of the health system to continually adapt itself to meet the health needs of the population through innovation and learning and also by adjusting the allocation of resources.

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