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To: **Ontario's Long-Term Care COVID-19 Commission**
From: **SE Health (Saint Elizabeth Healthcare)**
Re: **Pandemic-proofing long-term care in Ontario**

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Summary of Recommendations

Reserve capacity in long-term care (LTC) homes for those who really need to be there …

… while minimizing risk of further infecting people with COVID-19 …

… by shifting the delivery and financing of long-term care and support to older Canadians …

…. moving away from a paradigm focused on buildings, beds, and medical care tasks …

*… to a person-centred standard of care centred around **home** as the place to best achieve the life care goals of older Ontarians.*

These recommendations are in line with policy directions and trends globally that are shifting focus and health expenditures out of facilities and into the home. Adopting these recommendations will position Ontario as a future-forward leader in making the long-term care system work better for older adults and their families.

Thesis

"LTC" = a system of care, not a collection of facilities. The "LTC Commission" mandate should be framed around optimizing LTC in this manner.

With that as the starting point, the focus of this submission is on how to seamlessly connect the life care needs of older adults living with frailty in Ontario with appropriate home and community supports such that people can live, age, and receive medical and social care in the place of choice. These citizens are largely (67%[1]) on a fixed income (old age pension + some other pension or welfare program) and can no longer continue to live safely and/or

[1] Statistics Canada (2017)

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independently in their own home without care and support because of functional, physical, cognitive, psychosocial and/or mental health challenges. Currently, the default pathway for these individuals is to get on a wait list for a coveted spot at a LTC home, where the waits are >140 days[2], and the risk of contracting COVID-19 is high[3].

Yet, we know that:

- >90% of Ontario's seniors prefer to stay home for as long as possible[4]
- 95% think home is the safest environment to receive care during the pandemic[4]
- >75% prefer home health care for themselves and their loved ones over long-term care facilities[5]
- >70% prefer to die in their own home[6]
- 20-30% the current ~70K nursing home residents and ~40K on the wait list could stay at home with appropriate home care supports[7]
- There are proven and scalable models to integrate geriatric care into a community-based continuum[8], although they are not yet mainstream in Canada

Today's policy, care delivery and funding realities do not match this demand and opportunity:

- Many people getting care at home enter LTC facilities prematurely due to inadequate type or frequency of services available in the home[9]
- Caring for older adults over the long-term continues to be fragmented into siloed sectors within healthcare (acute care, primary care, home care, public health …) and across sectors (housing vs health vs social services, etc.)[10]
- Available home care services are focused on managing tasks, not supporting whole person health & aging in place[11]
- Non-medical supports (such as personal care services) are rationed and managed as a cost centre, with caps, and little-to-no connectivity to any other members of the circle of care[12]
- ~65% of Ontarians die in a hospital[13]

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[2] Health Quality Ontario *LTC Home Wait Times* LINK
[3] CIHI (2020) - *COVID-10 Rapid Response Long term care Snapshot* LINK
[4] Campaign Research Inc. study of 1003 Ontario residents aged 55+, on behalf of Home Care Ontario (July 2020) LINK
[5] *Bring Health Home* factsheet (2020) – LINK
[6] CIHI report on Access to Palliative Care in Canada (2018) LINK
[7] CIHI (2020) - *Why some patients who do not need hospitalization cannot leave: A case study of reviews in 6 Canadian hospitals* D Bender and P Holyoke (2018) in Healthcare Management Forum
[8] *Integrating long-term care into a community-based continuum: shifting from beds to places.* Ideas Analysis Debate, 2016; 59, 1-48 (2016)
[9] *Depression and loneliness are predictors of early LTC admission.* de Almeida Mello, J., Cès, S., Vanneste, D. et al. Comparing the case-mix of frail older people at home and of those being admitted into residential care: a longitudinal study. BMC Geriatr; 20, 105 (2020)
[10] *Older adults need integrated care and services across a continuum. McGrail K. Long-term care as part of the continuum.* Healthcare Pap. 10(4):39 (2011)
[11] *A task-based model of home care does not meet life care needs*. Gilmour H. Health reports 29(11):3-1 (2018)
[12] *Lack of non-medical support services & overreliance on family caregivers is a barrier to shifting care from LTC to the community.* Williams P, Lum J, Morton-Chang F, Kuluski K, Peckham A, Warrick N, Ying A.
[13] Statistics Canada (2017)

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Recommendations

Recommended Reframe #1: Health(care) at Home

We recommend any problem statements around long-term care for seniors no longer be anchored by a facility-based paradigm. "LTC" should be a system of care for older Canadians, not a building or bed. *Health(care) at Home* should be the default pathway, and facilities should be used in exception.

In a *Health(care) at Home* model citizens who want to – but can no longer – safely and independently live in their current home or community are given a reasonable budget to directly purchase the mix of medical and non-medical services they need to live, age, and receive care at home. In effect – the citizen is given the budget the state would have spent for a LTC home spot, but they instead use it to age in place. In models we have studied in Canada (Alberta[14]) and internationally (US[15], Australia[16], and the Netherlands[17]), the level and quality of care citizens access in their own home is on par with options that facility-based alternatives already offer.

Not "home care plus"

Home care clinicians are skilled at delivering person-and family-centred geriatric care that integrates physical, social, and emotional support.[18] However, shifting to *Health(care) at Home* cannot simply mean "home care plus" i.e., adding more hours of service using the same current model of care. It requires a rebase – a new model of home care that matches needs to the type and amount of services (vs task-based approaches), including both medical and psychosocial support.

Pandemic-proofing

This approach will be vital to minimizing further devastation in congregate facilities from COVID-19 and meeting the needs of the growing population of seniors as baby boomers continue to age.

So far, the focus of COVID-19 solutions has been on the activities within the four walls of the LTC facilities: addressing flow due to lack of beds/long wait lists, investing capital to upgrade old buildings, multiple strategies to address chronic staffing shortages, enacting Draconian family visitation restrictions, addressing shortages and lack of skills and compliance with PPE, testing and IPAC practices. Such an operational focus is important but is too narrow and short-sighted to respond to the transformational impact of COVID-19 on the health care system and the ways in which Canadians need and want to live, age, and receive care now and into the future. It is time to define a new normal for the long-term care

[14] Edmonton Zone *extended home supports* program (LINK to summary in report from 2019 Home Care Summit)

[15] Many case examples of PMCH (Patient Centred Medical Home) models of de-centralization of care from facilities to the home; Key examples include Care More Health, SCAN Health, Kaiser Permanente Focus Home, Dispatch Health, Landmark Health programs

[16] Australian Home Care Packages LINK

[17] Buurtzorg model of neighbourhood-based home care – founded in the Netherlands, now scaled to more than 25 international jurisdictions https://www.buurtzorg.com/

[18] Giosa, JL, Holyoke, P, Stolee, P *Let's get real about person- and family-centred geriatric home care: a realist synthesis* 38(4):449 (2019)

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of older adults in Canada; facility-based care alone is grossly insufficient for keeping seniors safe and healthy over the coming waves of the pandemic, and in the years ahead.

Recommended Reframe #2: From Medical Care to "Life Care"
The formal healthcare sector currently sets the regulatory and funding framework for long term care of older adults. As a result, it is a medical- and task-focused approach. This design, delivery and payment model for services does not consider the complete picture of what people need to live independently and safely, age in place, and match their health span to their (ever-growing) life span.

Life care as a paradigm begins with the goals of the person served: the older adult and their family caregiver(s). Medical goals (such as managing pain, blood pressure, wounds) are often only one driver for why people want and need access to publicly funded health and social care services. Other goals around agency, self-efficacy, independence, mobility and an ability to socialize are as important, if not more important than medical procedures[19].

To realize a *life care* paradigm, models of health and social care must be seamlessly blended into a single care experience. Because health is the goal, the payment model cannot be based on fee-for-service tasks. Rather, financing models would shift from paying for transactions to paying for health production, in the care setting of one's choice.

A Way Forward

Scientists in our SE Research Centre together with colleagues at the University of Waterloo recently reviewed more than 160,000 Ontario home care assessments for known medical and social risk factors of LTC home admission. Among many insights, they found some 80% of older Ontarians receiving long term home care support could be at risk of admission to LTC homes based on their life care needs.[9] This helps explain why the wait list for LTC homes in Ontario is >40K, and growing year over year.

Through retrospective analysis, SE Research Centre scientists clustered these 80% of 160K citizens into 6 archetypes, each with a vignette that represents the typical life care needs of the group.[20] Needs-based care packages of medical and social care services (with associated budget) are being developed to offer more choices to older Canadians for where to live, age and receive care as they age.

This model is aligned to a recent solution developed by the Australia geriatric care system, which rolled out 4 tiered "packages" to allow citizens at risk of admission to nursing homes to age in place[21]. By giving citizens a choice of which service providers they wish to work with – for medical and non-medical

[19] Example – Pillars of Positive Health framework in the Netherlands (LINK); British Medical Journal – global consortium to develop a new definition of "health" (2011) LINK
[20] SE Health Research Centre (2020). LINK
[21] Australia Home Care Packages Program LINK

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supports – they are empowered to be involved in decisions about their care and service.

Business Case

Reframing today's facility- and disease-based paradigm for long term care of older Ontarians to "health at home" and "life care" is a smart adjuvant policy innovation for addressing current capacity and infection challenges in congregate facilities. There are several value drivers:

- Reflects what most Ontario seniors and their families – who finance our public services - want
- Is more cost effective for both the care delivery and the net system savings downstream
- Immediately relieves pressure off wait lists, and people occupying facility beds who do not need to be there, without having to wait years and expend significant capital on building more facilities and beds
- Builds community infrastructure and capacity to quickly respond if flu surges or outbreaks happen in hospitals and LTC homes as there is a model to decant residents to the home setting, while prevent at risk community-dwelling seniors from being admitted

If a business case is about "ROI," the above points reflect the return (numerator) side of the algebra. The investment (denominator) required to achieve the returns reflects a marked shift in investments towards home & community-based services. The concept of "healthcare at home" has been on the agenda for some time as the engine, but without allocating proper funding as the fuel. Canada under-invests in seniors care overall, and of what we do spend, 90% goes to institutional care with only 10% to home and community (compared to OECD peer average of 35% of elderly care funding allocated to home and community)[22].

Re-balancing the health spending towards home and community will enable a robust system, thereby strengthen all sectors including and well beyond institutional long-term care.

About SE Health

We are a not-for-profit social enterprise applying our knowledge, vision and drive to forever impact how people live and age at home, today and into the future. With Canadian roots and 110 years of expertise, SE Health brings quality excellence and innovation to home care, seniors' lifestyle, and family caregiving. Through its team of 8,000 Leaders of Impact, SE Health delivers 20,000 care exchanges daily, totaling 50 million in the last decade alone. Visit us online at sehc.com.

[22] CD Howe Institute (2020) LINK