ISSUE BRIEF
J. Seniors' Health Hub

Resolved, that Canadian healthcare leaders commit to transforming the traditional nursing home model into one that offers a community-based health care hub to support seniors' living at home and provide facility-based care for those with more complex care needs who can no longer remain at home.

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ISSUE

Canadians want a health care system that is safe, effective and there when they need it. They want better communication between health care providers, patients and families and seamless integration between service delivery providers. More and more seniors are looking to be supported to live in the community for as long as possible.

Meeting these expectations require a variety of public policy initiatives to create age friendly communities, provide a range of retirement living and supportive housing options, and increased investments in home and community care. Achieving rapid system change is difficult without considering alternative service and business delivery models. This requires innovative approaches.

BACKGROUND

The demographics in this country are changing, Canadians are living longer and the boomer generation is reaching an age where they will need more care. The increased prevalence of chronic diseases (e.g., arthritis, heart and lung diseases) and the predicted exponential growth of dementias in the aging population and their associated negative impact on quality of life, increases pressures on Canada's health care system to respond.

Limited financial resources will require us to make decisions about health care priorities. Changes cannot only include infusion of new dollars, but instead should focus on transforming existing resources and integration opportunities across sectors. Recent national policy has focused on home care per se rather than on the broader concept of continuing care. A focus on home care alone (while helpful for clients) will generally only lead to added costs[3]. There is a necessity for the home and community care sector to leverage and build on the existing public-private partnerships to allow new business models to emerge.

Progress has been made towards system integration in many ways, both within our borders and internationally (e.g., Denmark, Australia, State of Arizona[3]). A relatively new Ontario example was the introduction of Health Links. Health Links facilitates greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports. With improved coordination and information sharing, patients receive faster care, spend less time waiting for services and will be supported by a team of health care providers at all levels of the health care system.[6]

Nursing homes, or long term care homes have a vast footprint of health infrastructure in our country. We submit that this sector is an untapped resource, and scaling up innovative long term care models will enable us to reach our broader goals of patient-centredness, integration, cost-effectiveness and providing the right care in the right place at the right time.

CONSIDERATIONS

In 2012, we convened a Long Term Care Expert Panel[1] who recommended six models to enable sector transformation. The models outline a transformation of the traditional nursing home model to correspond more closely to consumers' expectations for care of frail seniors. We propose adoption of one or more of these models. These models are not new – many providers are already ahead of the curve. If implementation is scaled up, these recommendations will:

- Improve coordination and access to community-based services for older adults;
- Improve long term care utilization;
- Reduce unnecessary hospital visits and readmissions;
- Reduce the unit cost of post-acute care; and,
- Simplify consumer choice and improve access, quality and accountability.

Post-acute skilled nursing model. This model focuses on skilled nursing care and assess and restore programs. Homes that adopt this model would specialize in short-term intensive nursing and rehab care for medically complex and injured or disabled older adults following an acute care stay.

Specialized stream model. This model provides a higher level of care for populations with specialized needs, including persons with late stage dementia, severe mental illness and addictions, and those at end of life. This model could also support Canadians who cannot or do not want to remain at home at end of life, but who want to die with comfort and dignity in a home-like setting rather than in hospital.

Hub model. This model sees long term care homes as the centre for the delivery of a wide range of seniors' services; some co-located and others managed by the long term care home. This model takes advantage of investments in physical spaces and existing long term care programs and services by centralizing care and expertise.

Integrated care model. This model would enable providers of 'continuums' with an enrolled population, or within a defined geographic area, to develop a variety of integrated home and community support services and receive incentives for managing chronic conditions, reducing emergency department visits and acute care admissions, and possibly coordinating long term care admissions within the continuum.

Designated assisted living model. This model bridges the gap created by long term care's shift to higher acuity residents by enabling physically and mentally frail older adults who require a protected environment but can continue to live independently with assistance with activities of daily living and limited nursing care to receive publicly-funded services in a wider range of community-based congregate settings. This could allow providers with excess capacity in retirement homes, to designate units or floors within those buildings as supportive living hubs eligible for publicly funded services. In addition to expanding consumer choice with respect to accommodation, this model would also enable aging in place by providing more options for seniors in a wider variety of naturally occurring retirement living environments.

Culture change model. This model puts resident needs, interest and lifestyle choices at the centre of care. It maximizes the ability of all residents, including those with dementia, to participate in decisions about their care and surroundings, and to exercise autonomy over their day-to-day lives. This model is relevant to all residential care settings.

Constraints: As with any transformative shift, there are constraints to implementation, they include: fiscal constraints; legislation and regulations that constrain care delivery and draw boundaries on innovation; expertise and human capital (recruitment, retention, skills training needs) and burden on unpaid caregivers; need for complementary reform in partner sectors (e.g., strengthening primary care for older adults; enhancing home and community services); including both public and private sector partners; and addressing ageism.

Spread and scale: The transformation proposition we have put forward is not a simple one. We submit that there are many successful case examples of each of the six models. These are examples led by early adopters, which must next be transferred to individuals, through organizations and systems. A road map for spread and scale that could be considered is IHI's Guide for Planning Large-Scale Improvements. The guide outlines a list of questions that serve as a discussion guide for those contemplating multi-stakeholder improvement initiatives. These fall into the categories of: Motivation; Foundation; Aim; Nature of the intervention; Nature of the social system; and Network building (communication and support).[5]

NEXT STEPS

The next steps for moving forward include:

1. Capacity and service planning at a system level;
2. Investments in community capacity to care for residents requiring episodic or less intensive care and services;
3. Move to outcome based performance and accountability frameworks that allow providers more discretion to determine how care is provided;
4. Build capacity of the care team for transformation;
5. Harnessing technology; and,
6. Rebuilding homes for the future.

Stakeholders that should be involved include:

1. Health care service providers, including long term care facility owners/operators, the hospital sector, home care services, retirement homes, and national, provincial and territorial associations related to hospital care, long term care, home care, retirement services, etc.;
2. Provincial governments and regional networks (if applicable);
3. Experts in system transformation: e.g., Canadian Foundation for Healthcare Improvement, Institute for Health Improvement; and,
4. Health system and long term care researchers: e.g., Centres for Learning, Research and Innovation, Age-Well Network Centres of Excellence.

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REFERENCES

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[2]Evidence Network: Aging Population and Its Potential Impact
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[3]An Evidence-Based Policy Prescription for an Aging Population Neena L. Chappell and Marcus J. Hollander HealthcarePapers, 11(1) April 2011: 8-18

[4]Elements of an Effective Innovation Strategy for Long Term Care in Ontario. Conference Board of Canada, 2011

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[6]About Health Links. Ontario Ministry of Health and Long Term Care
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