

ONTARIO  
LONG TERM CARE  
ASSOCIATION



Mechanical & Industrial Engineering  
UNIVERSITY OF TORONTO

Meeting the Needs of Ontario's Seniors  
Optimizing our Health System

# Long-Term Care *Plus*

**Realizing Innovative Models  
of Care for the Future**

Andrea Wilkinson, Vinita Haroun, Nancy Cooper, and Candace Chartier

December 14, 2018

## Table of Contents

Executive Summary .....	<b>3</b>
Introduction .....	<b>5</b>
Background of Long Term Care Plus .....	5
Project Goals and Objectives .....	6
Methods .....	<b>7</b>
Research Design .....	7
Participant Homes .....	7
Case Study Procedure.....	8
Results .....	<b>10</b>
PART I: Models Refined.....	10
PSYCHOGERIATRIC .....	11
About the Psychogeriatric Model.....	11
What Psychogeriatric Care Provides .....	11
Innovation in Action.....	11
For Consideration .....	12
SPECIALIZED COMMUNITY CARE.....	13
About Specialized Community Care .....	13
Innovation in Action.....	13
For Consideration .....	14
COMMUNITY HUB .....	15
About the Community Hub .....	15
Innovation in Action.....	15
For Consideration .....	16
PART II: Overview of Six Key Ingredients .....	17
What it takes to create different models of care.....	17
PART III: Issues Identified that Impact Innovative Model Sustainability.....	21
Conclusions .....	<b>22</b>
Next Steps .....	23
Acknowledgements .....	<b>24</b>
References .....	<b>25</b>
Appendices .....	<b>26</b>
Appendix 1: Six Model Definitions from the Why Not Now? Report .....	26
Appendix 2: Original Model Descriptions .....	27
Appendix 3: Interview Guide .....	29

## Executive Summary

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In the last several years, the Ontario Long Term Care Association has conceptualized several innovative models of care to explore the *art of the possible* in resolving capacity challenges, specifically related to the seniors' population.

The purpose of the project was to move beyond the conceptual stage, to begin to provide evidence to demonstrate the real opportunity for the sector to lead health system transformation. This can be done by implementing new approaches to care that will help to reduce the hallway medicine crisis currently facing Ontario hospitals while also better aligning with the needs and preferences of our seniors' communities.

### PROJECT OBJECTIVES:

1. Understand how "Psychogeriatric" and "Seniors' Care Community" models of care are *currently* being implemented in the sector.
2. Examine requirements to enable model implementation (key ingredients).
3. Explore issues that impact model sustainability.

The research approach included a mixed-methods, case study, including a one-hour semi-structured interview, and (as appropriate) in-person site visits and review of administrative data and reports. In total, seven long-term care homes participated in the study.

### RESULTS SUMMARY:

#### Description of Innovative Models in Ontario Long-Term Care Homes

- **Psychogeriatric:** offers care for individuals who could not otherwise be cared for in a traditional long-term care bed. These individuals endure advanced psycho-geriatric symptoms, in combination with cognitive impairment (often dual diagnosis of dementia and another psychiatric condition). Specialized teams with enhanced staff-to-resident ratios are needed, in conjunction with tailored environment supports and programming.
- **Specialized Community Care:** offers support and programming to a target population (e.g., individuals with dementia) and also connects them to resources that exist in their surrounding communities.
- **Community Hub:** offers a variety of senior health care services (e.g., diabetes education, eye care, hearing and hearing aid care, foot and nail care) for residents in the long-term care home and seniors in the community, in one central and integrated location. Community Hubs help to reduce isolation, create a vibrant, lively environment and build community.

## Six Key Ingredients that Enable the Implementation of Innovative Models of Care

1. **Leadership.** Leaders who believe in change and are able to implement and support it.
2. **Team.** A team-based approach that goes beyond traditional care (e.g., supporting activities of daily living).
3. **Culture.** Homes that demonstrate success in innovation have an embedded culture of change.
4. **Programmatic approach.** New models of care are resident-centred and provide unique programming to a specific population.
5. **Additional funding.** All of the homes interviewed had additional investments beyond provincial funding to support the new model of care.
6. **Quality of life and care.** Where traditional long-term care has been structured and funded to primarily focus on health care and physical care, innovative models integrate and value both quality of care and quality of life outcomes.

Last, in order to sustain these innovative models of care, several key factors are required: continuous financial support; additional staff to support implementation or special programming; the right environment; and a true continuum of care that will allow seniors to seamlessly transition from home to retirement to assisted living, and finally into long-term care.

The long-term care sector has a special opportunity to get ahead of the capacity issues faced by the health care system (predicted to increase in the future) by learning about innovative models of care currently being implemented in Ontario homes.

To scale and spread these innovations, the health care system requires capacity planning and funding discussions that meet the needs of special populations, while fostering a culture of innovation that enables good leadership and empowers long-term care staff. With the province's announcement to add 30,000 new beds over the next 10 years and redevelop more than 300 long-term care homes, now is a particularly unique time to evaluate how to spread implementation of these innovative models of care. Armed with this information, we can begin to frame the legislation, policy and regulation changes required to support implementation and sustainability of three innovative programmatic models of care: Psychogeriatric, Specialized Community Care and Community Hub.

## Introduction

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### Background of Long Term Care *Plus*

Ontario's long-term care homes are legislated and funded to provide 24-hour personal and nursing care for a population with physical and cognitive decline. The model of care has been in place for 40 years, but it isn't going to be enough to meet the growing needs of Ontario's seniors.

Currently, there are nearly 34,000 people in Ontario waiting for one of approximately 78,000 long-term care beds (Ontario Long Term Care Association, 2018). Many of these individuals will end up being hospitalized while they wait for placement, adding to the hallway medicine crisis currently facing the province. And that's just the situation today. Over the next 25 years, Ontario's seniors are expected to almost double (Ontario Ministry of Finance, 2018), continuing to mount pressure on our fragile health system.

The Ontario government recently committed to build an additional 30,000 long-term care beds over the next 10 years. While this is welcome news, the reality is that these new beds would only help to alleviate *today's* waitlist, while the rate at which seniors access the health care system continues to increase. Other creative solutions are needed. The *Long Term Care Plus* project offers alternative solutions to help alleviate capacity issues by reducing admissions to hospital and increasing transfers from hospital into long-term care.

Back in 2011, an expert panel was commissioned to look at the challenges facing seniors and long-term care in Ontario. They proposed a number of ways that the expertise of long-term care homes could be expanded to help seniors waiting for long-term care, as well as several changes needed within long-term care to help homes care for different populations and meet growing expectations (see Appendix 1 for definitions of the original six models for long-term care transformation, as proposed in the *Why Not Now?* report) (Long Term Care Innovation Expert Panel, 2012).

Since that time, in Ontario and across Canada, a number of long-term care homes have been evolving and experimenting with these enhanced models of long-term care to address gaps in seniors' care and services.

In 2017, the Ontario Long Term Care Association, in collaboration with the University of Toronto, received funding for a Canadian Institutes of Health Research (CIHR) Health System Impact Fellow to research several of these innovations, called "Long Term Care *Plus*." The research project involved looking specifically at two models, Psychogeriatric Care and the Seniors' Care Community. The purpose of this project was to learn what these innovators are doing differently, and the factors that are contributing to their success.

## Project Goals and Objectives

The main purpose of *Long Term Care Plus: Realizing Innovative Models of Care for the Future* is to learn from the experiences of Ontario's long-term care operators who are currently implementing innovative models of care, and to explore the art of the possible in resolving capacity challenges, as they relate specifically to the senior population.

These goals can be broken down into three main objectives:

1. Understand how "Psychogeriatric" and "Seniors' Care Community" models of care are *currently* being implemented in the sector.
2. Examine requirements to enable model implementation (key ingredients).
3. Explore issues that impact model sustainability.

## Methods

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### Research Design

This research approach included a mixed-method, case study design to identify recommendations for system changes required to support the operationalization and sustainability of the two care models. The Association's Quality Committee was consulted to identify long-term care homes meeting model definitions (see Appendix 2), as well as key informants to invite to participate in the research.

Each home of interest was initially contacted via email to solicit participation in the *Long Term Care Plus: Realizing Innovative Models of Care for the Future* research project. In this email, homes were provided with an official 'Invitation to Participate' and were asked to be involved in three key ways:

1. Participate in a semi-structured key informant interview with the research team to describe the existing program and their vision for an ideal state (via conference call).
2. Participate in a tour of the home/campus (in-person, if applicable).
3. Provide additional data or reports, if relevant (e.g. administrative data; program data; staffing models; funding models).

### Participant Homes

Seven long-term care homes and care staff who were currently implementing a Psychogeriatric Care (n = 3) or Seniors' Care Community model (n = 5) agreed to participate in the interviews (see Appendix 2 for original model descriptions). A one-hour conference call was scheduled at a mutually convenient time between March and June of 2018. One of the interviewed homes was implementing both a psychogeriatric and seniors' care community model and was interviewed accordingly. The long-term care homes that were interviewed included a variety of operator types, home size and location (see Table 1 for more details).

## Case Study Procedure

Participants agreed to take part in a one-hour semi-structured interview (see Appendix 3 for the interview guide). Key content addressed in the interviews included describing the models of care and implementation issues. Interviewees were also encouraged to think about barriers and facilitators to model implementation, as well as what they considered to be the “art of the possible.”

All interviews were conducted by the lead researcher (AW), and at times included other research team members (VH or NC). After the interview concluded, the target home was asked to share any relevant documentation (e.g., administrative, programmatic, staffing or funding models, etc.) with the research team.

If a site visit was planned, these took place after the one-hour conference call (between July and September 2018). The site visit included a tour of the long-term care home or campus. The main purpose was for the researcher to develop a visual representation of the innovative model of care that was discussed during the interview, through the capture of photographs and gathering of unstructured observations. The site visits were unstructured, but were guided by the home staff to visit spaces that were relevant to the execution of the innovative model of care discussed during the interviews. The researcher asked questions for clarification and took photos of spaces (no individuals), as appropriate. Site visits were deemed appropriate if the target sample home was located with a three-hour driving distance for the researcher.

Table 1.

*Sample Characteristics of the Interviewed Long-Term Care (LTC) Homes (n = 7)*

LTC+ Model	Home	Operator Type	Operator	Size	Location
Psychogeriatric	Hoivakoti Nursing Home	Private	Finlandia Village	112 beds	Sudbury, ON
	McGarrell Place	Private	Revera Inc.	157 beds	London, ON
	Sandringham Care	Private	Revera Inc.	46 beds	Victoria, BC
Seniors' Care Community	Bloomington Cove Care Community	Private	Sienna Senior Living Inc.	112 beds	Whitchurch-Stouffville, ON
	Hoivakoti Nursing Home	Private	Finlandia Village	112 beds	Sudbury, ON
	Kensington Gardens	Not-for-profit	Kensington Health Centre	350 beds	Toronto, ON
	McCormick Home	Not-for-profit	McCormick Care Group	160 beds	London, ON
	The Village of Tansley Woods	Private	Schlegel Villages	144 beds	Burlington, ON

## Results

Long-term care staff who participated in the phone interviews had a variety of different roles within long-term care, including chief executive officer, director of care, executive director, administrator and nurse manager. Phone interviews were transcribed and coded using Nvivo software.

### PART I: Models Refined

Following the case study analysis, it became apparent that there were actually three innovative models of care for consideration. While the Psychogeriatric model remained, the Seniors' Care Community models was sub-divided into two: Specialized Care Community and Community Hub (see Figure 1).

In the next section, we will describe each of these three models in-depth, including a fictional vignette to illustrate "the need" that each model would satisfy, a description of how each model is currently being implemented in Ontario and points for consideration that are meant to inspire discussion and thought around what impact a wider dissemination of these innovative models would have across the sector.

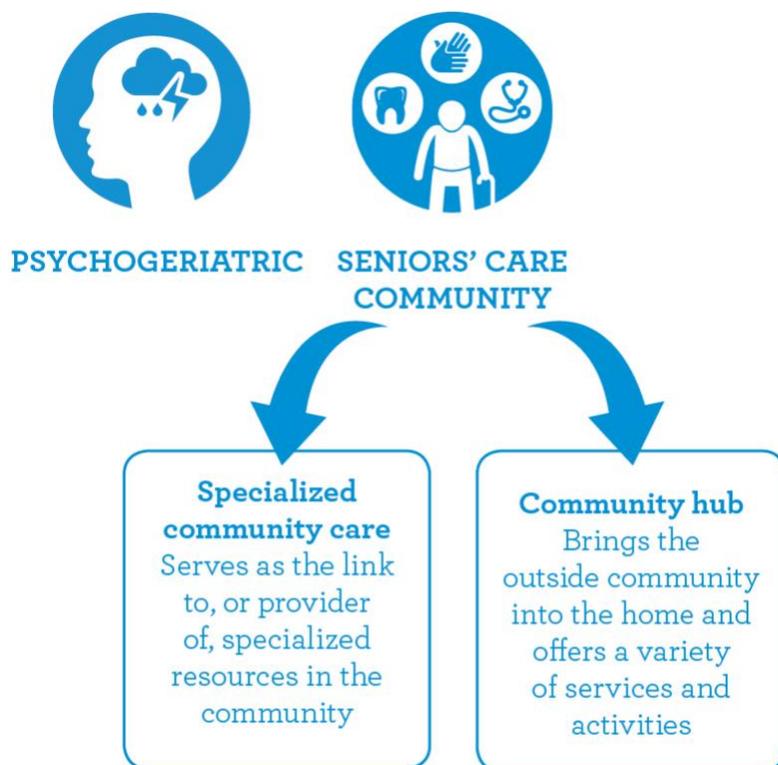


Figure 1. Visual depiction of the three innovative models of care: Psychogeriatric, Specialized Community Care and Community Hub.

## PSYCHOGERIATRIC

**THE NEED.** John is a 78-year-old man with a history of addiction, severe psychiatric disorders and dementia. No long-term care home has been able to accept him, because they don't have the specialized psychiatric knowledge or staff resources that are needed – both for John's care, and to keep other residents safe. For the last year, John has been living at the hospital as an ALC patient.

### About the Psychogeriatric Model

The province has a number of specialized behavioural units for people with severe dementia-related behaviours, but they are not designed for seniors with dual diagnoses of dementia and psychiatric conditions. These combinations can lead to some very challenging behaviours, which can make it difficult to provide care and may pose a risk to other residents.

People with these challenges typically wind up in hospital, without the appropriate environment and supports and where they are often heavily medicated, because there is nowhere else for them to live safely.

As the population ages, there is going to be a growing number of people with both dementia and psychiatric conditions. They don't belong in the hospital or in the province's few remaining psychiatric facilities. What they do need is their own, new type of long-term care: the psychogeriatric model.

### What Psychogeriatric Care Provides

- Care for people who could not otherwise be cared for in a traditional long-term care bed.
- A multidisciplinary team with an enhanced staff-to-resident ratio.
- More intensive care, environmental support and programming for those with late-stage dementia, severe mental illness and addictions, who might experience psychotic episodes or other advanced psychogeriatric symptoms.

### Innovation in Action

In one example, the Local Health Integration Network (LHIN) identified there was a need for this service in the region and provided \$500,000 in funding to one of the region's long-term care homes to develop a specialized eight-person psychogeriatric unit.

The home set up a separate and secure unit, hired additional care staff to provide more time in one-to-one care and arranged a partnership with geriatric psychiatry from the hospital. They also provided specialized training for everyone – from nurses to housekeepers – on how to create a calm and nurturing environment, as well as how to respond appropriately to behaviours arising from the residents' dementia or psychiatric conditions.

With this program in place, the home was able to accept a resident with severe behaviours who had previously been in the hospital for two years as an alternate level of care (ALC) patient.

Initially, the home thought they would be able to develop a care plan for residents that would allow them to be transferred to a traditional long-term care home once their conditions had stabilized. While some residents do transition out, many will never discharge because of their care needs. In order for their conditions to remain stable, most residents will need the intensive level of support provided on the specialized unit for the rest of their lives.

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*"We've seen tremendous benefits from the additional staff. It's not necessarily the physical care they provide, although that's absolutely part of it; it's that we now have more staff who can engage our residents in activities that have meaning to them – and as a result, their behaviour is more stable."*

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### For Consideration

Many Ontario hospitals' ALC patients are waiting for long-term care. **Could implementing psychogeriatric units reduce costs to the health care system, and help to address Ontario's hallway medicine crisis?**

Although every home has access to a multidisciplinary team, the traditional model of long-term care focuses primarily on staffing by nurses and personal support workers to provide health care and personal care. But teams using the psychogeriatric model are seeing that the opportunity to add more staffing with other health care roles, such as activity coordinators and recreational therapists, allows for an increased focus on residents' quality of life. **Does the staffing model in long-term care need more flexibility?**

The experience of psychogeriatric units is showing that most people with dementia and psychiatric conditions and/or addictions need the extra supports and specialty care the unit provides in order to remain stable. **Do we need to move to a new model of permanent accommodation and care for this population, rather than assuming that they can eventually move back to the community or a traditional long-term care home?**

## SPECIALIZED COMMUNITY CARE

THE NEED. Betty has dementia and lives with her daughter and her family. They promised Betty she could always live with them, but none of them understood how the disease would progress. Betty has developed dementia-related behaviours, such as continuously disrobing and calling out, which are distressing to both Betty and her family. They have looked into long-term care, but have been told it could be months before a space is available. Betty and her family need the expertise of long-term care, available to them in the community.

### About Specialized Community Care

Living at home can be a challenge for seniors with cognitive impairment and their loved ones. An estimated 70 per cent of all people with dementia will eventually need long-term care, even if they have extensive home care support and a very involved family.

With the current long waitlists for long-term care, there is an opportunity to provide services to specific populations and communities in need.

In the Specialized Community Care model, the long-term care home leverages their expertise to provide specialized programs and care services for an underserved population of seniors in the community.

### Innovation in Action

One large long-term care home leverages their expertise in dementia care to operate a day and overnight program for people in the community with dementia. Families can opt for this program part-time or full-time, days and/or nights, and can also use the services for vacations or much-needed respite. Families are even able to call and book a spot with short notice, if they are in urgent need of care for their loved one.

This popular program allows people in the community to stay at home for longer, and helps to reduce the isolation of both seniors and their families. The program was funded by the province's dementia strategy and the home's charitable foundation, along with a small co-payment from families. The home also helps to link families to other community supports and has partnered with local volunteer agencies to provide transportation for participants, reducing even further stress on families.

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*"Some families send their loved one to the day program seven days a week, and schedule overnights too, when they need them. It's their way of delaying long-term care as long as possible."*

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### **For Consideration**

A day and night program for seniors in the community is helping to meet the needs of those waiting for long-term care - and their exhausted families - and/or delaying the need for others. Research shows that twice as many family caregivers are experiencing severe distress than five years ago. **Could this type of program significantly reduce caregiver burden?**

**Would this type of program be viable for other long-term care operators? What restrictions would need to be lifted to encourage this kind of innovation?** As one example, "private" long-term care homes are restricted from accessing public funding for this kind of programming.

**Could this be a solution to help people with dementia in rural and remote communities, where there are fewer community resources?**

## COMMUNITY HUB

**THE NEED.** Richard is 88 years old and lives at home with diabetes, hearing loss and problems with his short-term memory. His wife, 83, is finding it increasingly difficult to arrange the many appointments he needs. They are both becoming increasingly isolated and depressed. Richard is now on the waiting list for long-term care. They need to be more connected to a community, and they need somewhere to access care and services that understands seniors.

### About the Community Hub

A number of long-term care homes in Ontario have a “campus” model of care, offering privately-funded retirement and assisted living, as well as publicly-funded long-term care.

Typically, these campuses have a doctor’s office, pharmacy and visiting support services (such as diabetes education, eye care, hearing and hearing aid care, and foot and nail care). Many homes also bring in services that residents might need, such as sales for adaptive clothing, and walker and wheelchair repair.

These services benefit the residents who live there, but a number of homes are also reaching out to seniors in the community and encouraging them to make use the home’s many services. This allows community seniors to be seen by health care specialists who specialize in seniors’ care and offers a central and integrated place for their health and seniors’ care needs. It also helps to reduce isolation, create a vibrant, lively environment and builds community.

### Innovation in Action

The organizations that are exploring this model of care are often doing more than offering services to the broader community – they are actively seeking out community seniors to take part in the life of the home and its many special events, such as craft sales and concerts.

Several organizations are also committed to bringing the outside world in to enrich the lives of seniors and to change public opinion about seniors and seniors’ living. One organization has experimented with an onsite restaurant that serves the whole community; another has an onsite daycare.

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*"We want to draw in people from the outside community. In one part of our building we have programs for our residents and community seniors that we either operate ourselves or have an independent operator run for us. We put family health teams on the main floor to bring people in, and a pharmacy. Then we have a restaurant on the top floor, and anyone can come to it."*

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### **For Consideration**

**Could providing centrally located services help meet the needs of those waiting for long-term care?**

**Could participating in a community hub help to reduce the isolation and depression that can result in home-bound seniors and their caregivers?**

**Could creating community hubs help to reduce some of the stigma around aging?**

Some of the services provided in the seniors' community hub model are from the LHINs, being provided by agencies that have contracts with the LHIN. **What if organizations with the campus model were allowed to bid on these contracts for services on their campus?** That could help to provide more consistent care, and continuity of staffing to residents and the community. **Would it also save the health system money?**

## PART II: Overview of Six Key Ingredients

Spreading innovative care models across the province will require discussions with a broad group of stakeholders, including government, about capacity planning and funding to meet the needs of special populations.

### What it takes to create different models of care.

Expanding what long-term care can offer requires specific key ingredients. In every location that the Association studied, a combination of these six key factors were in place.

1. **Leadership.** Leaders who believe in change and are able to implement and support it. They take risks, they communicate well (e.g., with their staff, residents, families and government), and they inspire and empower their teams. Home-level leadership projects a vision that drives staff to go beyond the status quo and enables homes to make changes. Leaders are also creative, adaptive and leverage off what others have done.

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*"I think the staff need a lot of support, and you need the right staff to do that job. **They need to be able to trust the leadership team and their supervisors. They need to know that they're doing a good job because if the resident is not wanting to do something, it's okay.** They're still doing their job, they're still taking care of them. They're not just giving up. They're going back and they're using a different approach or they're using a different technique. Maybe not at the end of the day, but the next day, that resident will get their shower."*

***"It comes from the top down.** The overall team in the home, everyone is really, really supportive. **It really has to start at the top.**"*

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- 2. Team.** A team-based approach that goes beyond traditional care (e.g., supporting activities of daily living). In addition to nurses and personal support workers, homes are leveraging an expanded group of professionals and increasing the involvement of other staff such as social workers, activity coordinators, recreational therapists, art therapists, occupational therapists and physical therapists – and even maintenance, housekeeping and kitchen staff. Caring for people with dementia in long-term care is more than just symptom management and providing physical care – the team’s collective goal is to increase the focus on each resident’s quality of life. Outside of direct health care needs, the professional designation is less important than whether the team member is the right person to help support a particular resident.

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***"It's not just one person that's providing the care, it's a team... everybody brings something different to the table."***

*"What we've seen from the benefits of this program is adding those **additional staff – it's not necessarily the physical care that's required – it's absolutely part of it; but, it's more about engaging our residents in meaningful activities.**"*

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- 3. Culture.** Homes that demonstrate success in innovation have an embedded culture of change. Staff are empowered to make decisions in the best interests of the residents. The home allows for experimentation and flexibility. The teams align around a vision, and they embrace change and risk.

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*"I mean one of the things that I really firmly believe in, and really will be a key component to success, and has been previously, **is the culture of the home. That can absolutely make or break this type of program.**"*

***"There is a fabulous culture here – a can-do culture. They don't really say no to anything. To me that is the number one key component for success."***

***"Yeah, I think really the 'hush, no rush' is so important and it takes a long time to change a culture within a home, in order for a staff to really practice that approach."***

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- 4. Programmatic approach.** New models of care are resident-centred and provide unique programming to a specific population. The future of long-term care is more than universal. Specialty units provide programs and an environment that works for the people in their care, rather than asking residents to fit into the classic model of long-term care with its schedules and activities. By targeting specific pockets of a population who are an appropriate fit in the home based on their quality of life and care needs, long-term care has the opportunity to respond to the needs of a particular population.

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*"We need to provide care in the moment for the residents we care for – not because of their care plan, not because of... you know, **we need to move away from this medical care and go through person-centered [care].** Everybody needs to. Everybody needs to get on board including the Ministry."*

*"And they're based all on assessing cognitive, physical ... Making sure they're **social, emotional ... We're touching base on all different areas to provide therapeutic recreation for our seniors.**"*

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- 5. Additional funding.** All of the homes interviewed had additional investments beyond provincial base funding to support the new model of care. Additional funding sometimes supported care, but was also allocated to non-traditional spending items, such as activity and recreation staff, as well as the costs associated with redesigning a space. It was also noted that the homes got creative with funding (patchwork), as the money came from a variety of different sources, such as their LHIN or local fundraising. Where cost-benefit analyses have been completed, they show a net overall savings to the health care system.

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*"**We ended up getting some funding sort of halfway through our construction** and so what we did – we used Murphy beds. **We had to get creative and use Murphy beds within our program in order to accommodate those overnight.**"*

*"**The funding came for the dementia strategy** and it, at this point, ended on March 31, 2018. But, we kept it going until May."*

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**6. Quality of life and care.** Where traditional long-term care has been structured and funded to primarily focus on health care and physical care, innovative models integrate and value both quality of care and quality of life outcomes. While care outcomes are the activities that homes are required to measure and report on to government, the understanding of dementia has grown in the last decade. As such, there has been a movement to ensure that every person with dementia is engaged and has the best possible quality of life, *in addition to* good health care and physical care. Each of the case studies examined in this research project focuses on providing an environment, activities, and relationships with staff to enrich each residents' quality of life. Homes are evaluating their programs in new ways to show how the changes are benefitting not only residents, but the health care system overall.

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***"We are seeing the benefits of residents needing to be engaged in order to reduce those behaviours. When there's boredom and loneliness the behaviours are more significant; so, we're just keeping them maybe away from certain residents that may trigger them and the noise levels."***

***"So it's like, either keep me engaged or I'm going to find something to do. And that's what we're trying to look for in terms of changing that culture of care. We seem to be able to care for people in the day program. And then sometimes they go to long-term care and they just go completely out of control"***

***"What we really want to do is focus on how do we improve the quality of life for those in long-term care or in our day program or in the community that are dealing with dementia."***

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### **PART III: Issues Identified that Impact Innovative Model Sustainability**

Four primary supports have been identified as necessary to promote sustainability of the proposed innovative models of care. Of note, further work is needed in this area to develop tangible solutions given the current landscape of the long-term care sector:

- 1. Funding** – Continuous financial support is needed to maintain the model and consideration needs to be given to how base provincial funding is provided in a sustainable manner. All of the homes included in the case study have some level of transitional/temporary funding, leaving the sustainability of these impactful programs in jeopardy.
- 2. Staff** – Additional staff are needed to support implementation of the innovative models. This comprises, for example: recreation, dietary, social work, occupational therapists, personal support workers, life enrichment, and behavioural support; but it also includes housekeeping and maintenance staff. Furthermore, it is important to utilize onsite staff, rather than mobile or transient LHIN staff, so that residents can get cared for by the cross-functional teams that already exist within the home.
- 3. Innovative design (space/environmental)** – Sustainability of innovative models of care requires appropriate home environments. Long-term care may need to expand their facilities or redesign them to accommodate the needs of the target population being served by the new model.
- 4. True continuum of care** – In order for the spread and scalability of these innovative models to success, it is important to consider legislative or policy changes to enable the seamless graduation from home to retirement to assisted living to long-term care.

## Conclusions

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With the capacity issues currently facing the broader health sector, there is an opportunity to optimize services and care to specific populations and communities in need. Three innovative models of care were described and discussed:

1. **Psychogeriatric** model of care is more than just a cookie cutter recipe. Proper psychogeriatric care requires engagement, support and care that varies by the target population that is being served.
2. **Seniors' Care Community** consists of two sub-models:
  - **SPECIALIZED COMMUNITY Care** offers support to a target population (e.g., individuals with dementia) and connects them to community resources.
  - **COMMUNITY HUB** brings the outside community into the home and offers varying levels of care based on needs.

Innovative models of care are seen to be successful when they truly take a resident-centred and programmatic, rather than “one-size fits all,” approach. Furthermore, the homes that were interviewed for the Long Term Care *Plus* project displayed features that are akin to “early adopters of innovation” – leadership, plus a learning and team-based culture. New models of care focus on outcomes that go beyond care, taking into account a resident-centred approach that equally values quality of life and quality of care outcomes.

To scale and spread these innovations, the health care system requires capacity planning and funding discussions that meet the needs of special populations, while fostering a culture of innovation that enables good leadership and empowers long-term care staff. In addition, some key recommendations should be considered:

1. Use *all* staff (not only registered staff) to engage residents in meaningful ways.
2. Shift away from only focusing on quality of care outcomes, to also prioritizing quality of life goals.
3. Get creative about finding and using funding.
4. Leverage community resources and partners.

## Next Steps

First, it is important to ensure that success and progress is being measured over time. In this regard, it is imperative that work is done to identify desired and measurable indicators and outcomes of the various innovative models of care.

Second, the work presented here did not include an economic evaluation or costing models; therefore, additional work is needed to cost out the three different models presented herein. Of note, costing can be divided into "direct costs" (e.g., additional staff, capital/infrastructure) and "indirect costs," such as administration, food services and housekeeping. For example, there are operating costs associated with the administrative burden of increased turnover rates.

Last, with the province's announcement to add 30,000 new beds over the next 10 years and redevelop more than 300 homes, future work should explore the specific environmental requirements and space modifications needed to implement innovative models of care. With this, Ontario long-term care homes that want to execute a new model of care can have a comprehensive understanding of the structural modifications needed to realize the new vision for their home.

The long-term care sector is already working to resolve the capacity issues it will face in the future and, despite the fact that homes have to fit new models within their existing regulatory structure, they are still innovating. With the dedication to innovative, creative and quality-based care we see the art of the possible within long-term care is endless.

## Acknowledgements

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This research was funded by the Canadian Institutes of Health Research (CIHR) Health System Impact Fellowship (HSIF) in collaboration with the Ontario Long Term Care Association and the University of Toronto.

A special thank you is extended to all of the operators who participated in this research, including Finlandia Village, Revera Inc., Sienna Senior Living Inc., Kensington Health Centre, McCormick Care Group and Schlegel Villages.

We would also like to thank the guidance provided by the Ontario Long Term Care Association's Quality Committee throughout the duration of this project.

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## Appendices

### Appendix 1: Six Model Definitions from the *Why Not Now?* Report

<i>Post-Acute Model</i>	Specializes in short-term skilled nursing and intensive rehabilitation for medically complex and injured or disabled older adults returning to the community following a hospital admission.
<i>Specialized Stream Model</i>	Provides higher level of care for special needs populations including persons with late stage dementia, severe mental illness and addictions, and those at end of life.
<i>Hub Model</i>	Takes advantage of long-term care's expertise and investments in physical plant by centralizing seniors care and services in rural and northern communities.
<i>Integrated Care Model</i>	Enables 'continuums' with an enrolled population, or vertically integrated providers in 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, etc.
<i>Designated Assisted Living Model</i>	Bridges the gap created by long-term care's shift to higher acuity residents.
<i>Culture Change Model</i>	Revitalizes traditional nursing homes.

*Note:* Definitions for the six models for long-term care transformation taken from "Why Not Now? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults" by Long-term care Innovation Expert Panel, 2012. Retrieved from [https://www.oltca.com/oltca/Documents/Reports/WhyNotNowFULL\\_March2012.pdf](https://www.oltca.com/oltca/Documents/Reports/WhyNotNowFULL_March2012.pdf).

## Appendix 2: Original Model Descriptions

### 1. Psychogeriatric Care Model

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*The PSYCHOGERIATRIC CARE MODEL provides transitional treatment and stabilization services provided by a multi-disciplinary team with enhanced staff-to-resident ratios. It includes a higher level of care for psychogeriatric residents, while blending the social and medical models of care.*

This model could support a growing segment of the senior's population who have much more profound cognitive challenges, which often presents as a dual-diagnosis of dementia plus another psychiatric condition (e.g., bipolar, schizophrenia). These are individuals who may endure psychotic episodes or other advanced psychogeriatric symptoms. The proposed specialized stream model would reduce hospitalization of this population (lowering the number of alternate level of care [ALC] patients) and allow for a higher level of care for this population.

Regular long-term care homes (not currently providing specialized behavioural programs) do not have the necessary staff and expertise to effectively manage residents displaying aggressive or violent behaviours. Support from regional mental health outreach teams and designated psychogeriatric inpatient programs, dedicated funding for behaviour support staff, and education have not been enough to enable homes to keep up with the increase in acuity and complex care requirements of seniors who age in place in the long-term care home, who seek admission from the community, or who apply for transfer from a hospital.

When a resident with these psychiatric and sometimes violent behaviours overwhelms the resources of the regular long-term care home or residence in the community, transfer to hospital is often the only option available, adding to the ALC population and hallway medicine crisis.

An additional challenge arises as hospitals are not designed to care for this group of seniors, as their programs are designed to deliver acute, episodic care. In particular, hospitals do not have the physical or social environment to provide long-stay complex, specialized care required in caring for seniors with unmanageable behaviours. Hospitals, however, must take on the responsibilities of caring for this group because there are currently not enough options available.

The current study explored the concept that specialized psychogeriatric programs, located within a long-term care setting (or similar), could be designed to meet the unique care needs of these individuals. The proposed transitional treatment and stabilization services could be provided by a multi-disciplinary team with an enhanced staff-to-resident ratio and multi-disciplinary care planning, as compared to traditional long-term care, and who are supported by a consulting psychogeriatrician associated with the hospital-based mental health outreach program.

In line with long-term care strategies to end hallway health care, applicants to such a program could be admitted from hospitals, regular long-term care homes or the community.

## 2. Seniors' Care Community Model

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*The SENIORS' CARE COMMUNITY MODEL is a hub of co-located specialized programs and care services for older adults with varying levels of functioning.*

The Seniors' Care Community Model creates an enriched "continuum of care" environment, with access to specialized programs and care (e.g., primary care, chronic disease management, rehabilitation, adult day/night programs, and specialized geriatric services collaboratively delivered with hospital and community partners), for older adults with varying levels of functioning. It is believed that the Seniors' Care Community Model could enable improved access to health care services for seniors and the communities in which they reside by ensuring multiple services are available in one setting.

Access to care in many communities might be constrained for a variety of reasons, whether due to geographical issues (e.g. rural and remote) or because of land value issues that hinder development (e.g. major urban/downtown Toronto). The government should consider certain Seniors' Care Community Models that could increase access to a greater number of services in one central location.

Furthermore, this model could also be developed to support ethno-cultural groups, as well as First Nations' communities. This model takes advantage of investments in physical and existing long-term care programs and services by centralizing care and expertise.

The Seniors' Care Community Model would also enable the 'graduation' of individuals with an enrolled population, or within a defined geographic area to develop a variety of integrated home and community support services.

Many operators of seniors' care (e.g., Finlandia Village, Schlegel Villages, etc.) have been creating care communities over the past several years with the intention of supporting the seniors they serve, in some cases culturally focused, to graduate through each model of support/care as they age and as their needs intensify (community → retirement/seniors' apartment → assisted living → long-term care).

Revisiting the regulatory structure regarding admissions, specifically the treatment of waitlists to allow seniors who choose to reside in an integrated/campus setting to graduate through such bundled care models, to ensure that spouses and families can remain together, and further that access to culturally-specific programs and services can be realized for seniors with those specific backgrounds, is required.

### Appendix 3: Interview Guide

1. Please describe your current model of care/program.
  - Outline program rationale and goals
  - Who is eligible to participate (inclusion/exclusion criteria) and how do they enroll (admission criteria)?
  - Is your program funded? What is the funding policy? Funding approach?
    - Is the home providing the program within the current funding envelopes or has the home received LHIN funding for the program?
    - What is the cost per resident day (subsidized?)/compared to LTC?
  - What is the staffing model and how much does it cost?
  - List included/excluded program services.
  - Identify physical program requirements (e.g., space, equipment).
  - What positive and/or negative outcomes are you seeing in program participants and their families?
  - How do potential program participants and their families learn about this care option? (marketing/advertising?)
2. If you could start from scratch – what would your ideal “specialized program” look like? (Goal is to tease out the barriers, ideal program parameters, etc.)
3. You have tried to be creative within the current parameters; but now we want you to think about what you really want to do...and what would be required for your organization to get there; Identify what you would really like to be doing vs. what you are currently able to do within the constraints around LTC.
  - What would it take (resources, changes) to achieve the “art of the possible,” i.e., go beyond the constraints?
4. What would the home like to see as program criteria for admission?
5. From your perspective, what is the potential value-adds in this “art-of-the-possible” approach and how could we get there?
  - Resident outcomes
  - Staff satisfaction
  - System benefits – e.g., financial, integration
6. How could this “ideal” model be expanded to better realize anticipated benefits?
7. What are the biggest obstacles to realizing your envisioned “art of the possible”?
8. What would it take for other organizations to provide a similar program (replication)?
  - Identify facilitators and barriers
9. What is needed from government to support implementation or sustainability of the program?
  - Legislation? Policy? Regulatory?