

FROM ALTERNATIVE TO APPROPRIATE LEVELS OF CARE

**OTTAWA ALC STRATEGIC COMMITTEE
REPORT OF RECOMMENDATIONS**

August 2006

EXECUTIVE SUMMARY

The Alternative Level of Care (ALC) occupancy rate in acute care beds in Ottawa hospitals is now in excess of 19%¹ and continues to rise. In fact, in the past year the total number of patients waiting for ALC has increased by 70% (i.e., increased from 115 to 196 patients). The majority of these patients (76%) are waiting for a placement in a Long Term Care Home (LTCH). Based on local population demographics and the current health system capacity, the unmet demands for LTCH beds in Ottawa will experience a 40% increase by 2010, which will lead to increased ALC pressures in hospitals.

This situation has several serious impacts on the delivery of health services in Ottawa and the ability of health partners to deliver on provincial priorities. The high number of patients waiting ALC results in an excessively high occupancy of acute beds and often leads to patients receiving care in inappropriate settings, an overload of patients in Emergency Rooms awaiting admission, cancelled surgeries and compromised management of trauma patients. High occupancy of acute care beds related to patients waiting ALC is one of the primary reasons for Ottawa hospitals not being able to meet, or agree to increase, wait time targets. There are also potential implications for accountability relationships given that the ministry, the Local Health Integration Networks (LHINs) and local providers are all expected to be more accountable to certain performance indicators (e.g., wait time targets and percentage ALC days).

Over the past 5 years, the system partners in Ottawa have worked together to implement many innovative initiatives to monitor and address ALC issues. A couple of examples of initiatives include establishing a process for weekly reporting of ALC pressures, developing and implementing the supportive care pilot, and most recently, implementing a pilot for Priority Access to LTC. However, despite the ongoing system improvements, the number of patients awaiting ALC in acute care hospitals continues to rise.

The demand for LTCH beds in Ottawa is higher than the provincial average while the supply of LTCH beds in Ottawa (98.4 beds per 1,000 75+ population) is aligned with the provincial average. The occupancy of these LTCH beds is higher than provincial average and currently every LTCH in Ottawa has a waitlist. In addition, in a comparison of all of the 14 LHIN areas across the province, Champlain LHIN has the 2nd longest median waiting time to placement in a LTCH². Additional LTCH beds are required to address a portion of the excess demand. It will take time to add LTCH capacity to the system.

¹ Definition: percentage of acute beds occupied by patients awaiting ALC. Acute beds include medical, surgical, combined medical/surgical, and ICU beds.

² Ministry of Health & Long Term Care, Long Term Care Planning & Renewal Branch (dataset: Second Quarter 2005/06). Statistic includes individuals waiting in both the hospital and community settings for LTCH placement.

To stabilize and reduce the demand to supply ratio for LTCH placements, new initiatives to address prevention and early intervention, to increase capacity in other appropriate settings, and to improve the utilization of existing community-level LTC service settings are urgently needed. The four strategies outlined in this report include 13 potential recommendations that in combination, and in addition to those already implemented and being piloted (see Appendix 1), will have a significant and positive impact on the ALC pressures.

The four strategies are:

1. Promote early intervention and risk screening (4 recommendations);
2. Create and improve the utilization of alternative LTC community capacity (5 recommendations);
3. Enhance the pre-admission screening and discharge planning processes (1 recommendation); and
4. Improve access to LTCH beds (3 recommendations).

The local partners are committed to continuing to identify and work on strategies to improve early screening and care planning. It is recognized that a significant investment is also required to plan and implement the recommendations that will have the greatest benefit in improving the utilization of existing acute and LTCH resources and in improving the ability to serve patients in the most appropriate settings for the future.

Following a priority setting process, the ALC Strategic Committee has highlighted the 7 recommendations of the thirteen that are the highest priority based on a fit with the criteria and require ministry and local stakeholder commitment and investment. On an on-going basis, the local partners will monitor and regularly assess the need for implementing any of the remaining 6 recommendations or other potential opportunities that may arise.

The seven priority recommendations are categorized as short-term and long-term initiatives. With immediate approval, the short-term initiatives may be implemented and impact on both ALC volumes and the Wait Time Strategy within a 12 month period. These priority recommendations are:

Short-Term Priority Recommendations

- Initiate a pilot subsidized Assisted Living Program in Ottawa;
- Increase the presence of Geriatric Emergency Management (GEM) Nurses in Emergency Rooms;
- Provide enhanced case management and care services to seniors living in City of Ottawa Subsidised Apartments;

Long-Term Priority Recommendations

- Develop a supportive housing program for seniors in Ottawa to address current and projected demand;
- Develop a “one number to call” system to improve physician, patient and family awareness of, and access to, community support services, CCAC services and the regional geriatric assessment program;
- Increase the number of LTCH beds in Ottawa; and
- Review the appropriateness of the current provincial ratio (60:40) of preferred to basic LTCH beds.

The ALC Strategic Committee firmly supports and endorses the findings, strategies and recommendations, outlined in this report, and believes that the report accurately reflects both the strong spirit of integration that exists in Ottawa and the seriousness of the ALC situation. It is the committee members’ opinion that the above priority recommendations need to be adopted immediately, and appropriate investments made available, to allow planning and implementation to proceed without delay.

From Alternative to Appropriate Levels of Care

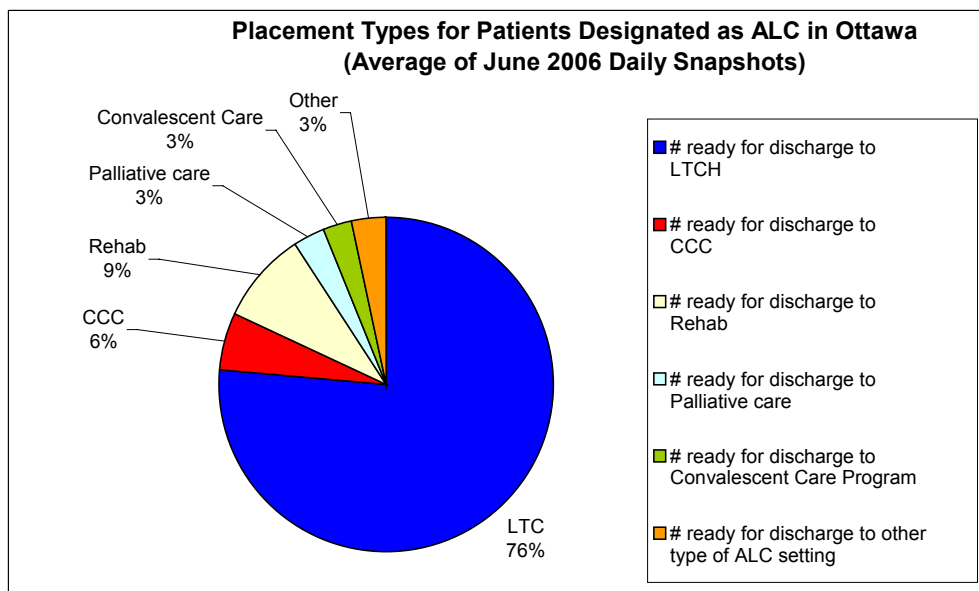
ISSUE	6
BACKGROUND.....	7
FINDINGS	9
ALC Trends	9
Evidence of Improved ALC Management	10
Impacts of Assessment and Early Intervention.....	11
LTCH Bed Occupancy	11
LTCH Resident Acuity	12
LTCH Bed Demand and Supply	13
Capacity of Alternative Community LTC Services	14
RISKS ASSOCIATED WITH CONTINUED HIGH ALC PRESSURES	14
Quality of Care Risks.....	14
Provincial Priority Risks	15
Resource Efficiency Risks	15
STRATEGIES & RECOMMENDATIONS	16
1. Early Intervention & Risk Screening	17
2. Alternative LTC Community Capacity	18
3. Pre-Admission Screening & Discharge Planning Processes	20
4. Access to LTCH Beds	21
CONCLUSION	22
APPENDIX 1: ALC INITIATIVES IN OTTAWA	25
APPENDIX 2: OTTAWA ALC STRATEGIC CO. PARTICIPANT LIST.....	26
APPENDIX 3: ESTIMATE OF LTCH BED REQUIREMENTS.....	27
APPENDIX 4: SUMMARY OF INDICATORS.....	28

From Alternative to Appropriate Levels of Care

ISSUE

In 2004/05, Ottawa hospitals experienced very high pressures related to patients waiting for Alternative Level of Care (ALC). The percentage of ALC days to total patient days was 11.1% compared to the provincial average of 9.3%³. This situation has rapidly deteriorated over the past year. In fact, in the past year the total number of patients waiting for ALC in Ottawa hospitals has increased by 70% (i.e., the average daily number of patients waiting for ALC have increased from 115 to 196). The proportion of patients that are designated as ALC waiting Long Term Care (LTC) placement has increased significantly over the past few years and the unmet demand (in excess of the supply) is projected to increase 40% by 2010.

As indicated in the chart below, the majority of patients currently waiting for ALC (76%) are waiting for a placement to a Long Term Care Home (LTCH).



The high number of patients waiting for ALC results in an excessively high occupancy of acute beds which has a negative impact on the hospitals' operations. This situation has resulted in patients receiving care in inappropriate settings, an overload of patients in Emergency Rooms awaiting admission, cancelled surgeries, and compromises the management of trauma patients and the ability to achieve wait time targets.

³ Information source: Provincial Health Planning Database (PHPDB), including only acute care hospitals and excludes activity related to children (<15 years old).

Since June 2005, seven (7) 1A systemic crises have been initiated (each lasting a 2-week period) for Ottawa hospitals. In April 2006, a pilot project, initiated in the East Region, has given patients waiting for ALC priority access to LTC bed placements on 2 days per week. At the present time every LTCH in Ottawa has a waiting list. Due to the shortage of available LTC beds, priority access has become less and less effective in reducing the ALC pressures in hospitals.

The East Region Office, in partnership with hospitals, the Ottawa Community Care Access Centre (CCAC) and other community stakeholders continue to seek additional opportunities to further improve coordination, processes and planning. The consensus of the system partners is that there are no longer opportunities remaining that will have a significant impact on the pressures. To achieve a long-term improvement for the ALC challenges, the ALC Strategic Committee believes that the next level of solutions will need to address prevention, early intervention and an investment to increase capacity in appropriate settings and improve the utilization of community-level LTC service alternatives. The overall goal of the recommendations outlined in this report is to reduce the pressure on Ottawa hospitals and to improve the quality of care for patients by implementing strategies that will improve access to appropriate levels of care.

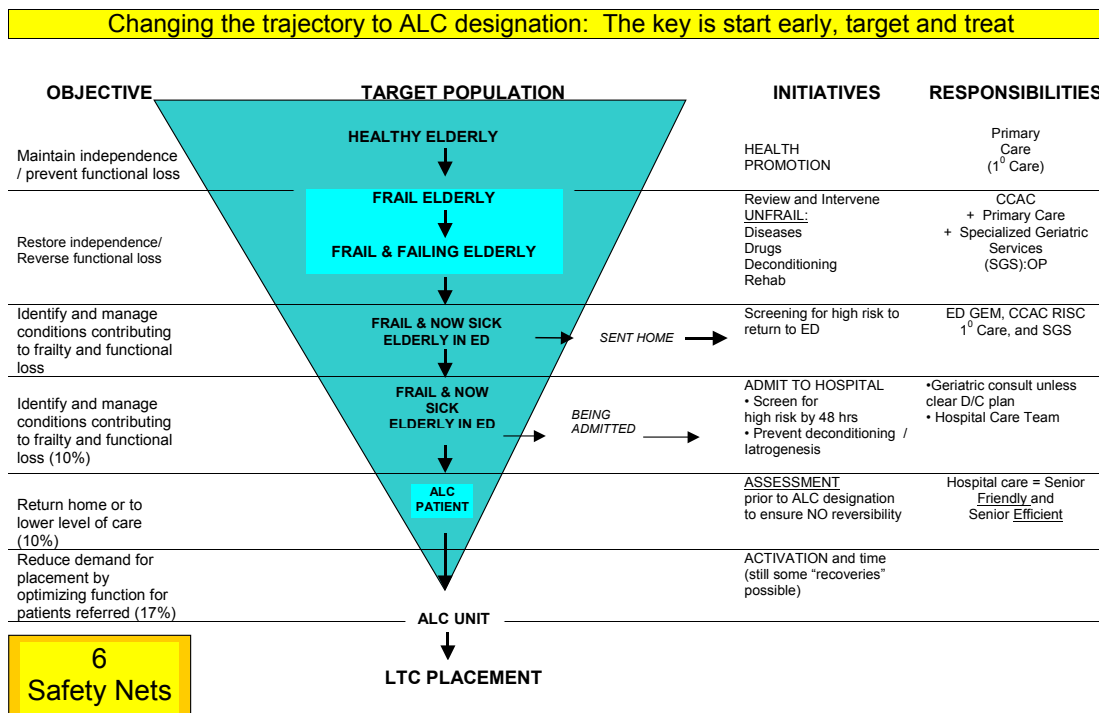
BACKGROUND

ALC pressures have a significant impact on the performance of the health system in Ottawa, particularly patients in acute care hospitals.

In 2000, the Ottawa ALC Working Group, comprised of all acute and non-acute hospitals, the Ottawa CCAC, the Regional Geriatric Assessment Program (RGAP) and representatives from local LTCHs and the ministry, was established to monitor and develop strategies to address ALC-related pressures. This effective partnership has led to the planning and implementation of several innovative initiatives (see Appendix 1). The initiatives have ranged from improved ALC definitions, monitoring, education, development of care plans, and the creation of, and enhancement of care in, alternate non-acute settings. As a result of these concentrated efforts, there have been dramatic decreases in the average length of stay of patients waiting for ALC in Ottawa hospitals (33 days in 2000/01 reduced to approximately 15 days in 2004/05).

In May 2004, the East Region Office hosted an ALC Forum to bring together stakeholders from across the region to share their experiences and lessons learned and to develop local-level action plans. These action plans were documented in the report from the forum, entitled "Caring about the Alternatives: Report from the East Region ALC Forum".

In December 2005, the ALC Strategic Committee was established to consider and make recommendations concerning strategic opportunities required to address system issues that contribute to ALC pressures. This ad hoc group is comprised of senior representatives from Ottawa hospitals, LTCH sector, CCAC, the RGAP, the Champlain Local Health Integration Network (LHIN), and the ministry (a participant list is provided in Appendix 2). The group referred to the framework⁴ below to guide their analytical and strategic thinking.



This framework demonstrates that a range of solutions to the ALC challenges⁵ needs to stem from a comprehensive understanding of the issues and should examine prevention opportunities as well as alternate service capacity issues. Research and practice in other jurisdictions has demonstrated that one of the most effective methods of reducing ALC pressures is to implement strategies that will impact on clients at the earliest stage in their care trajectory. This report outlines the findings and recommendations of the ALC Strategic Committee.

⁴ The framework was developed by the Ottawa Regional Geriatric Assessment Program (RGAP)

⁵ The framework illustrates the LTCH placement trajectory and accordingly refers primarily to the elderly population. It should be noted that the non-elderly patients also experience ALC challenges, however since the vast majority of the issues in Ottawa relate to LTCH placement solutions that target this population present the greatest opportunity to benefit the system.

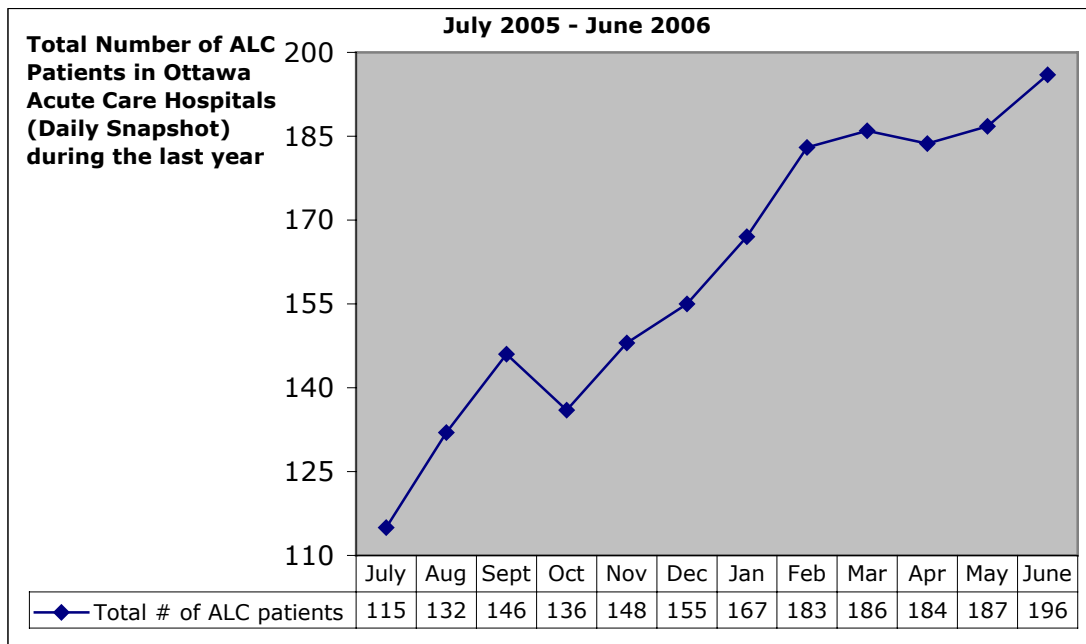
FINDINGS

This section provides an overview of the key observations and findings that have shaped the recommendations of the ALC Strategic Committee. The findings are categorized under the following headings:

- ALC trends;
- Evidence of improved ALC management;
- Impacts of assessment and early intervention;
- LTCH bed occupancy;
- LTCH resident acuity;
- LTCH bed demand and supply; and
- Capacity of alternative LTC community services.

ALC Trends

Over the past year, the number of patients waiting for ALC in Ottawa hospitals has increased by 70%. The chart below illustrates the significant increase in the number of patients waiting for ALC in Ottawa hospitals over the past year (July 2005 to June 2006). The majority (76%) of these patients are waiting for placement to a LTCH.



One standard performance indicator that is often examined in Ontario is the percentage of ALC days to total patient days⁶. The following table illustrates that the Ottawa area hospitals have experienced consistently higher ALC pressures relative to the rest of the province.

⁶ Information Source: Provincial Health Planning Database (PHPDB). The query from the database excludes patients days associated with children (<15 years old).

Fiscal Year	2001/2002	2002/2003	2003/2004	2004/2005
Ottawa Hospitals				
% ALC days / Total Patient Days	13.3%	14.8%	10.5%	11.1%
All Ontario Hospitals				
% ALC days / Total Patient Days	10.3%	10.6%	9.5%	9.3%

Data used in calculations include only hospitals that are hospital type = Acute and Adult Patients (i.e., excludes patients that are <15 years old)
 (Source: Provincial Health Planning Database (PHPDB). 2005/06 data is not yet available)

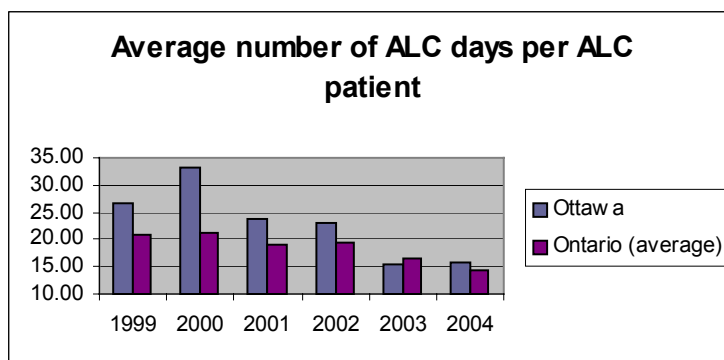
Using the most current snapshot data that is collected locally on a weekly basis, the ALC pressures vary across each of the acute care hospital sites in Ottawa serving the adult population. The snapshot data shows that the percentage of patients waiting for ALC to total acute bed capacity ranges from 17.2% at The Ottawa Hospital (TOH) to 26.8% at the Queensway Carleton Hospital (QCH).

% of Ottawa Acute Care Hospital Beds Occupied by Patients Waiting for ALC (June 2006)						
	TOH	GENERAL SITE	CIVIC SITE	QCH	MONTFORT	Total Acute Hospitals
Total # of Patients Waiting for ALC (Daily Snapshot) / Total Number of Acute Care Hospital Beds	17.2%	14.5%	20.5%	26.8%	21.2%	19.3%

For calculation, acute beds = med, surg, combined med/surg, & ICU
 Source: MOHLTC Priority Access Indicators (June 2006)

Evidence of Improved ALC Management

The average length of stay of patients waiting for ALC in Ottawa has been dramatically reduced over the past few years. In 2004/05, the average length of stay of an ALC patient was approximately 15 days which is in line with the provincial average.



An assessment of the 2004/05 activity revealed that 11.2% of the ALC days are associated with elective admissions. This observation suggests that there may be additional opportunities to enhance the pre-admission

screening to identify risks in relation to cognitive function (delirium) and functional loss or deconditioning. This would assist in initiating targeted interventions to prevent or reduce delirium, deconditioning and other unintended consequences of the elective procedures, which in turn, would either delay discharge, or potentially increase the rate of referral for placement and ALC designation.

The partners continue to seek these additional opportunities to further improve pre-admission screening, care coordination and planning. The consensus of the system partners is that there are no remaining process improvement opportunities that will have a significant impact on the current pressures.

To achieve a long-term improvement for the ALC challenges, the ALC Strategic Committee believes that the next level of solutions will need to address prevention, early intervention and an investment to increase capacity in appropriate settings and improve the utilization of community-level LTC service alternatives.

Impacts of Assessment and Early Intervention

A recent chart audit of patients waiting for ALC at the Ottawa Hospital identified that approximately 70% of these patients were not in receipt of any in-home services prior to being admitted to hospital. Follow up with the local academy of medicine and primary care physician's groups confirmed a need for education and outreach to ensure that physicians are aware of the community resources that are available.

LTCH Bed Occupancy

There are a total of 4,702 LTCH beds in Ottawa, of which 4,628 are long-stay beds, 33 are short-stay beds, 37 are convalescent care beds and 4 are interim beds. Ottawa is considered to have full utilization of LTCH beds, the only vacancies are due to the time required to fill the bed. For example in June 2006, the utilization rate of Ottawa LTCH beds was 99.5% compared with a provincial average of 98.2%.

The rate of utilization is consistently high for all bed types; in June 2006 the utilization rate for basic beds was 99.7% (provincial average 98.5%); for semi-private was 97.5% (provincial average 96.4%) and for private beds was 99.8% (provincial average 98.9%). Currently, every LTCH in Ottawa has a waiting list.

It is important to note that 80% of patients waiting for LTCH placement in hospitals are waiting for basic LTCH beds. Data collection during a one-week period of priority access for Ottawa hospitals revealed that patients in hospital waiting for LTCH beds could not utilize 50% of available beds, as they indicated that they were not able to afford, or willing to pay, the

additional cost of preferred accommodation. Consequently, the LTCH beds are made available to people in the community who are able to pay for the preferred bed.

LTCH Resident Acuity

A review of the 2005/06 acuity (Case Mix Index (CMI) level) of LTCH residents in Ottawa compared to the provincial average confirmed that there is a greater proportion of lower acuity residents (e.g., classifications of A, B or C) residing in Ottawa LTCHs.

CMI	Number of Residents (Ottawa)	% Of Total # of Residents (Ottawa)	Number of Residents (Ontario)	% of Total # of Residents (Ontario)	% Variance (Ottawa less Ontario)
A	6	0.1	39	0.1	0.1
B	361	7.9	4305	6.2	1.7
C	167	3.7	2935	4.2	(0.6)
D	333	7.3	4790	6.9	0.4
E	1429	31.4	15774	22.7	8.7
F	2256	49.5	41721	60.0	(10.4)
G	1	0.0	16	0.0	(0.0)
Total	4553	100.0	69580	100.0	-

In 2005/06, in comparison to the rest of the province, LTCHs in Ottawa had 55 more residents in CMI A,B and C

Source: Levels of Care Classification, MOHLTC, January 2006

In addition, the average age of LTCH residents at the time of admission in Ottawa is 80.3 years of age, which is slightly lower than the provincial average of 81.5 years. These observations suggest that there are some residents in the existing LTCH beds that could be supported in a lower acuity setting and that placement to LTCH beds has fulfilled the care needs of these individuals as an option of last resort.

In addition, recent research⁷ has also confirmed that there is considerable similarity between the needs of residents in retirement homes and those in LTCHs. The research found that 42.6% of individuals in retirement homes were assessed as eligible for placement and only 15.7% of these individuals were on a waiting list for placement to a long term care home.

Each of these observations reinforce the hypothesis that by increasing capacity in other appropriate settings and by increasing utilization of other existing capacity, the current LTCH capacity could be better utilized.

⁷ An Examination of the Health Profile, Service Use and Care Needs of Older Adults in Residential Care Facilities, Aminzadeh, Dalziel et al; Canadian Journal on Aging 23(3):281-294

LTCH Bed Demand and Supply

The supply⁸ of LTCH beds in Ottawa is in line with the provincial average (i.e. Ottawa has 98.4 beds per 1,000 population 75+ compared with a provincial average of 98.2). However, the demand⁹ for LTCH beds is much higher than the provincial average (i.e. 119.7 for Ottawa compared with the provincial average of 113.9). The demand/supply ratio for Ottawa is 1.25, compared with an ideal¹⁰ ratio of 1.10. In other words, for every 100 LTCH beds in Ottawa there are 125 people considered eligible for a LTCH bed, compared to a level that is considered ideal in which there would be 110 people that are eligible for a LTCH bed. In addition, in a comparison of all of the 14 LHIN areas across the province, Champlain LHIN has the 2nd longest median waiting time to placement in a LTCH¹¹.

In recognition of the relatively high pressures for LTCH beds, Ottawa was recently allotted 20 interim LTC beds as part of the provincial ALC Strategy. Applications for only 4 beds were received and approved in the first round of applications¹². The second round of applications yielded only one application from Kemptville District Hospital for 8 beds for Ottawa patients. Initially the uptake of the interim beds was slow due to the distance from Ottawa to Kemptville (approximately 40 kilometers outside of Ottawa), however after the first six months of operation; the interim beds are now fully utilized by patients from Ottawa hospitals.

Based on the current demand, 187 LTCH beds would need to be added to the system in Ottawa to lower the demand to supply ratio to the ideal level. Considering the rapidly increasing demand and the projected growth of the seniors' population, it is reasonable to suggest that Ottawa will require a significant number of additional LTCH beds by 2010. While further analysis is required to refine the estimate, even with consideration of the potential to meet a portion of the demand in other LTC community settings, the number is likely in the range of 300 to 400 new LTCH beds (see Appendix 3 for a sample approach to projecting the LTCH bed requirements for 2010). Additional LTCH beds would alleviate some ALC pressures, however this excess demand in part also stems from a lack of appropriate LTC community service options for seniors.

⁸ The definition of LTCH bed supply is the number of LTCH beds in operation (including Interim LTC Beds)

⁹ The definition of LTCH bed demand is the number of eligible people on waitlist plus the number of LTC residents (less the number of current LTCH bed vacancies)

¹⁰ Through monitoring of system performance, it has been observed by the ministry's Long Term Care Redevelopment Project (LTCRP) team that areas in the province that have a 1.10 demand to supply ratio of LTCH beds maintain good patient flow and full occupancy.

¹¹ Ministry of Health & Long Term Care, Long Term Care Planning & Renewal Branch (Dataset: Second Quarter 2005/06). Statistic includes individuals waiting in both the hospital and community settings for LTCH placement.

¹² Lack of capacity in LTC Homes and the minimal amount of start-up funding were cited as the main reasons for the low uptake on these beds.

Capacity of Alternative Community LTC Services

The ALC Strategic Committee undertook an analysis to benchmark the level of health services available to Ottawa residents relative to the provincial average and other communities with similar demographics (e.g., Hamilton and London) (see Appendix 4 for summary table of indicators). The analysis highlighted that the access to some services that would assist in supporting seniors in aging-in-place is relatively low.

In contrast to other similar communities, Ottawa does not have any supportive housing for seniors. In each of the communities that were compared to Ottawa, there is approximately 1 seniors' supportive housing unit per 1,000 75+ population. Based on the age profile of Ottawa residents, the Ottawa area would require approximately 50-units of seniors' supportive housing. However, with the projected increased demand in Ottawa and the potential for redirecting some demand to alternative settings, the future needs for seniors' supportive housing would be well in excess of 50-units in the next few years.

The ALC Strategic Committee also considered the potential to better support seniors that are living in existing seniors' subsidized apartments. In 2004/05, the seniors residing in these apartments in Ottawa accounted for 1,700 emergency room visits and a significant number of inpatient hospitalizations (equivalent to approximately 25 acute beds) in Ottawa hospitals. This observation suggests that providing enhanced case management and home care to this population may prevent future hospitalizations.

RISKS ASSOCIATED WITH CONTINUED HIGH ALC PRESSURES

There are a number of risks associated with the continuation of the elevated and increasing number of patients waiting for ALC in Ottawa hospitals. The risks include:

Quality of Care Risks

High levels of patients waiting for ALC affects the ability of the system to deliver timely and appropriate care to patients.

Symptoms of the ALC problem include:

- Declining function and increased dependency of patients that are being treated in an inappropriate setting;
- Increased level of frustration of patients and families faced with challenges in accessing appropriate services in a timely manner;
- Delays in necessary sub-acute care, such as rehabilitation and reactivation;
- Overload of patients in Emergency Rooms awaiting acute admission;
- Cancelled surgeries, including wait time strategy procedures;
- Reduced capacity to manage trauma patients; and

- Patients receiving care off-service¹³.

Provincial Priority Risks

The lack of capacity in the system will lead to on-going challenges in meeting provincial and local strategic priorities, specifically the wait time and the critical care strategies, other provincial priorities, and increased system integration.

In the wait time strategy reports that are available to the public, Ottawa continues to show relatively long wait times for most of the priority procedures, including hip and knee replacements and cataracts. Local providers have identified that the high-level of patients waiting ALC, and consequently the lack of acute capacity, has resulted in cancelled surgeries this year at both TOH and the QCH. The ALC issue is one of the primary reasons for Ottawa hospitals not being able to meet, or agree to increase, wait time targets. There are also potential implications for accountability relationships given that the ministry, the Local Health Integration Networks (LHINs) and local providers are all expected to be more accountable to certain performance indicators (e.g., wait time targets and percentage ALC days).

With respect to integration activities, the significant level of on-going effort and attention paid to addressing ALC crises and operational challenges is diverting resources and strategic focus away from other potential system integration initiatives.

Resource Efficiency Risks

In 2004/05, Ottawa hospitals reported 46,553 ALC days. Using a per diem cost of \$550¹⁴, the total cost of ALC care is almost \$25 million. By comparison, supporting these same ALC clients in a LTCH or other appropriate setting at a per diem cost of approximately \$83¹⁵ would cost the ministry approximately \$4 million.

The amount of \$83 was used in this calculated estimate, however some of alternative LTC-community service options that are being recommended in this report could be realized at a lower per diem cost. This analysis suggests the ALC issue poses a significant risk to the efficient use of system resources (i.e., in the order of \$21 million).

¹³ Off-service care refers to the treatment of a patient on a hospital unit that is not consistent with the diagnosis, such as a medical patient receiving care on an obstetrical unit.

¹⁴ Estimate of the direct per diem cost of medical/surgical beds (excluding critical care). Based on a weighted average of Patients waiting for ALC in a teaching and a community hospital setting.

¹⁵ Based on a 100 CMI, the LHTC per diem (effective July 1, 2006) is \$128.00. The ministry subsidy is \$82.80 and the remaining amount (\$45.20) is paid by the individual (if able to pay).

STRATEGIES & RECOMMENDATIONS

The Ottawa system partners have demonstrated a willingness and commitment to initiate many innovative strategies to work together to address ALC pressures (outlined in Appendix 1). The partners are committed to continue these initiatives and to seek additional opportunities. The consensus of the ALC Strategic Committee members is that opportunities to further improve coordination processes and planning to have a significant impact on the ALC situation have been exhausted. To achieve a long-term improvement, the solutions will need to address prevention, early intervention, increase the capacity in appropriate settings, including LTCHs, and improve the utilization of community-level LTC service alternatives.

Based on consideration of the analytical findings and the risks associated with continued high ALC levels, the ALC Strategic Committee members have identified several new strategies that each have the potential to alleviate some of these system pressures.

In their discussion, the members considered several criteria in assessing the relative merit of each potential strategy. The criteria that were considered include:

- Impact on the Client/Family
- Cost of Implementation
- Time frame to implement
- Impact on ALC volumes
- Impact on Wait Time Strategies (WTS)
- Legislation & Regulations
- Feasibility to implement
- System transition points

The strategies outlined in this report provide a range of recommendations that in combination, and in addition to the initiatives that are already implemented and piloted, will help reduce the pressure on Ottawa hospitals and improve the access to the appropriate level of care for Ottawa patients.

The strategies are:

- Strategy 1. Promote Early Intervention & Risk Screening
- Strategy 2. Create and Improve the Utilization of Alternative LTC Community Capacity
- Strategy 3. Enhance the Pre-Admission Screening and Discharge Planning Processes
- Strategy 4. Improve Access to LTCH Beds

Strategy 1. Promote Early Intervention & Risk Screening

This strategy includes the following recommendations:

- Develop a communication strategy with the academy of physicians and other primary care physician groups to educate them regarding ALC pressures and the importance of early screening and linking seniors to appropriate community supports to avoid crises;
- Improve physician, patient and family awareness of, and access to, community support services, CCAC services and the regional geriatric assessment program through the development of a “one number to call” system;
- Increase the presence of Geriatric Emergency Management (GEM) Nurses in Emergency Rooms; and
- Initiate screening mechanisms to identify seniors at high-risk of being designated ALC, within 48 hrs of admission. Develop targeted intervention strategies to prevent deconditioning and iatrogenesis.

	Physician Education	One Number to Call	GEM	High-Risk Screening
Fit with Criteria	High → Each of these strategies will impact on a large number of people (targets the top level of the diagram presented on page 4 of this report) → These strategies would have a relatively short implementation time. → Positive impact on client/family due to improved system navigation → No impact on legislation & regulations			
Rationale	ALC audit demonstrated that majority of patients waiting for ALC are not in receipt of support services prior to hospital admission. Linking people with appropriate services earlier can delay/avoid the incremental loss of functionality.		The GEM initiative has demonstrated effectiveness in avoiding hospital admissions through accurate diagnosis, appropriate disposition and linkages to services for seniors. Evidence suggests that every 10 cases that are screened prevents one admission.	Research indicates that up to 30% of frail seniors admitted to acute care lose function as a result of the hospital experience, independent of the effects of illness.
Cost	There will be a requirement for an investment to facilitate the development of Primary Care Education tools.	Based on an estimate of the potential call volume and staff resources, the operating costs would be approximately \$200K per annum.	\$320,000 (i.e., 4 ERs * ~\$80,000+ /GEM position)	To be determined.
Request for Local Stakeholder Support	RGAP, CCAC and other CSS agencies to work in partnership with academy of physicians to develop tools	The CCAC is prepared to house the service and absorb the cost of community engagement and marketing of the line.	Local hospitals to support expanding existing program.	RGAP, CCAC and hospitals to work together
Request for Ministry Support	Potential investment from Ministry of Health & Long Term Care and/or Ministry of Health Promotion	Ministry support and possible initial investment & on-going resources to support operating costs.	To support and cost share the expansion of the GEM program in Ottawa.	Ministry support for the concept.

Strategy 2. Create and Improve the Utilization of Alternative LTC Community Capacity

This strategy includes the following recommendations:

- Provide enhanced case management and care services to seniors living in City of Ottawa subsidised apartments;
- Examine the opportunities for a partnership between local hospitals and a retirement home to subsidize the retirement fee to remove the financial barriers for patients waiting for ALC with appropriate needs;
- Develop a supportive housing program for seniors in Ottawa to address current and projected demand;
- Initiate a pilot subsidized Assisted Living Program in Ottawa; and
- Work with the CCAC to develop an enhanced home care program in Ottawa.

	Supports in Subsidized Apartments	Retirement Home Subsidy	Supportive Housing	Subsidized Assisted Living Program	Enhanced Home Care
Fit with Criteria	Moderate → Potential for modest impact on ALCs (~10 beds) & WTS → short-term implementation (within 12 months) → No implications for legislation/regulations → Positive impact on client/family	Moderate → Impact on ALCs & WTS is dependent on size of program. → short-term implementation (within 12 months) → May pose issues re: liability and labour relations → Positive impact on client/family	High → Impact on ALCs is potentially high (depending on the number of units). → longer-term implementation (greater than 1 year) → Cost of providing supportive care is reasonable → Positive impact on client/family (more appropriate setting)	Moderate → Impact on ALCs & WTS is potentially high. → short-term implementation (within 12 months) → Cost of providing assisted living care is comparable to a LTCH setting → May pose some legislative/regulatory issues → Positive impact on client/family (more appropriate setting)	Low → Net impact on ALCs is low. → short-term implementation → Cost of providing enhanced care is very high. → Require permission to exceed the regulated service maximums. → Impact on client/family can be positive (more appropriate setting), however not likely to accept <24 hrs/day of care.
Rationale	The hospital utilization of seniors residing in these apartments account for ~ 25 beds per year and 1,700 ER visits (2004/05).	Review of LTCH resident acuity level confirms that a significant number of residents could be supported in a retirement home setting.	Ottawa does not have any supportive housing for seniors.	Review of LTCH resident acuity level confirms that a significant number of residents could be supported in Assisted Living Units within a retirement home.	Current regulations and service pressures prevent the Ottawa CCAC from supporting patients waiting for ALC who need more than 15 hours/week of personal support services to return home.

(Rec. 2 continued)	Supports in Subsidized Apartments	Retirement Home Subsidy	Supportive Housing	Assisted Living Program	Enhanced Home Care
Cost	CCAC requesting \$15,500 to fund development of models of care for seniors in subsidized apartments and Enhanced Home Care	A minimum of \$2,000 per month per client.	Consulting fees of \$25,000 to develop a program model for seniors supportive housing program.	Per Client: @ a minimum of: \$3,000 / month per client (i.e., \$2,000 accommodation + \$1,000 personal care supports) A 30-unit program would require \$1,080,000 per year plus some capital renovations.	Per Client: @ \$600 per day (i.e., 24 hrs of personal support per day) For example, a 12 person program would require \$2.6 M per year
Request for Local Stakeholder Support	Potential commitment from City of Ottawa to cover renovation costs. Additional CCAC funding would be required to support increased case management and in-home service costs.	Hospitals to explore the potential for a partnership with a retirement home operator to initiate a pilot to subsidize the Retirement Home costs for patients waiting for ALC whose needs can be met in this type of setting.	Possible partnership between United Way, City of Ottawa and MOHLTC to plan for a Supported Housing Program for seniors.	Stakeholder support for the concept.	CCAC in partnership with other CSS agencies are exploring ways to support seniors using a combination of services.
Request for Ministry Support	Obtain ministry: • Support for the idea; • Involvement in the planning discussions; and • Funding to develop models of care to maintain frail elderly in community.	Ministry to support the concept.	Obtain ministry support and funding for planning that will lead to the development a Seniors' Supportive Housing Program in Ottawa.	Obtain ministry approval and funding to develop a subsidized Assisted Living Unit for patients waiting for ALC within a Retirement Home on a pilot basis to explore this as a possible alternative care setting for seniors with lower acuity levels.	Obtain ministry approval and funding to provide enhanced case management and in-home services to support patients waiting for ALC that can return home with this additional support

Strategy 3. Enhance the Pre-Admission Screening & Discharge Planning Processes

While significant progress has already been achieved, the hospitals are committed to enhance early screening assessment and to improve care mapping and admission and discharge planning. While there has been a dramatic decrease in average length of stay of patients waiting for ALC in Ottawa hospitals, data analysis reveals that 11.2% of all ALC days in Ottawa hospitals are associated with elective admissions. This finding illustrates that some modest opportunities for improvements in pre-admission screening and discharge processes continue to exist.

Enhance Pre-Admission Screening & Discharge Planning	
Fit with Criteria	Moderate → Impact on ALCs (likely <5%) and WTS would be modest
Rationale	The implementation of standardized pre-admission screening for risk factors such as cognitive change, or functional loss could identify potentially reversible conditions which, if not managed or treated effectively, contribute to further functional loss and dependencies, further complicating /delaying the discharge planning process. Both general and orthopedic surgeons have suggested enhanced pre-admission screening to improve the management of elderly patients.
Cost	\$170,000 (i.e., 2 social workers would be required * ~\$85,000/position)
Request for Local Stakeholder Support	Local hospitals and CCAC will continue to work together to improve screening practices and care planning.
Request for Ministry Support	Ministry support for the concept.

Strategy 4. Improve Access to LTCH Beds

This strategy includes the following recommendations:

- Increase the number of LTCH beds in Ottawa;
- Initiate a pilot project to provide a subsidy to remove the financial barriers to allow interim placements of patients waiting for ALC to 20 preferred LTCH beds; and
- Review the appropriateness of the current provincial ratio (60:40) of preferred to basic LTCH beds.

	Increase Number of LTCH Beds	Pilot Project Subsidy for Preferred LTCH Beds	Review the Ratio of Preferred to Basic LTCH Beds
Fit with Criteria	High → Impact on ALCs is potentially high. → longer-term implementation (greater than 1 year) → Positive impact on client/family to increase access to the most appropriate setting.	Low → Beyond the initial 20 patients, the strategy would likely have limited on-going impact on ALCs given that once subsidized beds are full, the lack of availability of basic beds will continue to compromise the ability to move residents and free up the subsidized beds.	Moderate → High potential for a significant and impact on the ability to place ALC patients and free up acute capacity for WTS volumes. → Would require changes to current legislation/regulations and the present financial model of LTCHs across the province. → Given legislative and financial policy considerations this is a longer-term strategy (>12 months). → Client/Family Impact: By reducing the financial barrier there would be better access for patients that most require this level of care.
Rationale	To address current and future unmet demand for LTCH beds, it is reasonable to estimate that Ottawa would require an additional 300 to 400 LTCH beds by 2010 in addition to other LTC community alternatives.	80% of patients in hospital waiting for LTC are waiting for basic LTCH beds. Data collection during a one-week period of priority access for hospitals revealed that patients in hospital waiting for ALC could not utilize 50% of available LTC beds, as the additional cost was prohibitive.	
Cost	Per Resident: @ \$83 per day for the ministry subsidy. The annual cost would be \$30,295. The estimate for capital is ~\$75,000 per LTCH bed (i.e., \$10.35/day *365 days*20 years) The annual ministry cost for 300 to 600 LTCH beds would be \$9.1M to \$12.1M. The capital investment would be between \$22.5M and \$30M.	Estimated annual cost of the initiative would be ~ \$130,000 Per diem differential between a basic LTCH bed and other beds is: \$18.00/day for private accommodation \$8.00/day for semi-private accommodation (i.e., \$18/bed * 20 beds/day * 365 days/year = ~\$130,000)	Significant resource implications due to the impact that this policy change would have on the current revenue structure for LTCHs across the province.
Request for Local Stakeholder Support	LTCHs to submit applications for licences	Hospital, CCAC and facility involvement in project, as required	Willingness of LTCHs to participate due to potential financial implications
Request for Ministry Support	Ministry to consider increasing the number of LTCH beds in Ottawa to address an appropriate portion of the current and future unmet demand.	Request provincial consideration of a subsidy to remove this financial barrier for interim placement of patients waiting for ALC during a period of systemic crisis.	This group recommends that there be a provincial review of the 60/40 ratio of preferred to basic LTCH beds.

CONCLUSION

Ottawa hospitals are experiencing high levels of patients waiting for ALC and the pressures are projected to increase dramatically over the next few years. This situation results in too many patients that are not receiving the care they require in a timely-manner. The high occupancy of acute beds by patients waiting ALC reduces the ability of hospitals to satisfy the acute care needs of the local population and the government's clinical priorities, such as the wait time and critical care strategies. The ALC issue is one of the primary reasons for Ottawa hospitals not being able to meet, or agree to increase, wait time targets. There are also potential implications for accountability relationships given that the ministry, the Local Health Integration Networks (LHINs) and local providers are all expected to be more accountable to certain performance indicators (e.g., wait time targets and percentage ALC days).

Over the past few years, the system partners in Ottawa have worked together to implement many innovative initiatives to monitor and address ALC issues. This collaboration led to the successful implementation of the Supportive Care Pilot that resulted in the development of the provincial Convalescent Care Program. An early assessment of the Priority Access Pilot suggests that the initiative has improved the availability of LTCH beds to hospital patients without significantly compromising the clients that are waiting in the community.¹⁶ Despite the on-going and effective efforts, the number of patients waiting ALC, particularly for LTCH placement, continues to increase at an alarming rate. Based on population projections and current system capacity, the unmet demand for LTCH beds is forecasted to increase by 40% by 2010.

To achieve any long-term improvement for this system crisis, the ALC Strategic Committee believes that new solutions are needed urgently in addition to those already implemented and being piloted (see Appendix 1). These new strategies need to address prevention, early intervention, increase capacity in appropriate settings, including LTCHs, and improve the utilization of appropriate community-level LTC service settings. The four strategies outlined in this report include 13 potential strategies that in combination will have a significant and positive impact on the ALC pressures.

The four strategies are:

1. Promote early intervention and risk screening (4 recommendations);
2. Create and improve the utilization of alternative LTC community capacity (5 recommendations);

¹⁶ This statement is based on early analysis of a 3-month pilot period. An evaluation will be conducted shortly to assess the success and effectiveness of the Priority Access Pilot.

3. Enhance the pre-admission screening and discharge planning processes (1 recommendation); and
4. Improve access to LTCH beds (3 recommendations).

The local partners are committed to continuing to identify and work on initiatives to improve early screening and care planning. It is recognized that a significant investment is also required to plan and implement the recommendations that will have the greatest benefit in improving the utilization of existing acute and LTCH resources and in improving the ability to serve patients in the most appropriate settings for the future.

Following a priority setting process, the ALC Strategic Committee has highlighted the 7 recommendations of the thirteen that are the highest priority based on a fit with the criteria and require ministry and local stakeholder commitment and investment. On an on-going basis, the local partners will monitor and regularly assess the need for implementing any of the remaining 6 recommendations or other potential opportunities that may arise.

The seven priority recommendations are categorized as short-term and long-term initiatives. With immediate approval, the short-term initiatives may be implemented and impact on both ALC volumes and the Wait Time Strategy within a 12 month period. These recommendations are:

Short-Term Priority Recommendations

- Initiate a pilot subsidized Assisted Living Program in Ottawa;
Overall Fit with Criteria: Moderate
Potential Impact on ALC Volumes: Moderate
Resources: A 30-unit program would require \$1,080,000 per annum plus some one-time for capital renovations
- Increase the presence of Geriatric Emergency Management (GEM) Nurses in Emergency Rooms;
Overall Fit with Criteria: High
Potential Impact on ALC Volumes: Moderate
Resources: \$320,000 per annum to fund 4 GEM nurse positions (one position for each of the four Emergency Rooms in Ottawa serving adults).
- Provide enhanced case management and care services to seniors living in City of Ottawa Subsidised Apartments;
Overall Fit with Criteria: Moderate
Potential Impact on ALC Volumes: Moderate
Resources: \$15,500 one-time investment to develop models of care for seniors in subsidized apartments and enhanced home care.

Long-Term Priority Recommendations

- Develop a supportive housing program for seniors in Ottawa to address current and projected demand;
Overall Fit with Criteria: High
Potential Impact on ALC Volumes: High
Resources: \$25,000 one-time investment to develop a program model for seniors' supportive housing. Commitment to provide funding for an appropriately sized seniors' supportive housing program in Ottawa.
- Develop a "one number to call" system to improve physician, patient and family awareness of, and access to, community support services, CCAC services and the regional geriatric assessment program;
Overall Fit with Criteria: High
Potential Impact on ALC Volumes: High
Resources: \$200,000 per annum, plus some one-time start-up costs. CCAC is prepared to house the program and support community engagement and marketing of the line.
- Increase the number of LTCH beds in Ottawa; and
Overall Fit with Criteria: Moderate
Potential Impact on ALC Volumes: High
Resources: In the range of \$9.1M to \$12.1M per annum for 300 to 400 new LTCH beds, plus approximately \$22.5M to \$30M in capital costs over a 20 year period.
- Review the appropriateness of the current provincial ratio (60:40) of preferred to basic LTCH beds.
Overall Fit with Criteria: Moderate
Potential Impact on ALC Volumes: High

The ALC Strategic Committee believes that the collaborative approach and the resultant findings and recommendations, outlined in this report, accurately reflect both the strong spirit of integration that exists in Ottawa and the seriousness of the ALC situation. It is the committee members' opinion that the above priority recommendations need to be adopted immediately, and appropriate investments made available, to allow planning and implementation to proceed without delay.

APPENDIX 1: ALC INITIATIVES IN OTTAWA

Initiatives implemented in Ottawa to address the ALC pressures:

- **Supportive Care Pilot:**
The pilot project was implemented in March 2003. The program facilitates the discharge of hospital patients to supportive care beds for convalescence prior to returning home. The success of the pilot resulted in the development of the provincial Convalescent Care Program.
- **IV Therapy Initiative:**
This initiative involved developing the capacity for LTC Homes to care for residents needing IV therapy. The initiative commenced May 1, 2006, and should reduce the Length of Stay and in some instances eliminate the need for hospital admissions
- **Priority Access Pilot:**
The East Region adopted this approach on April 18, 2006. When ALC pressures in hospitals exceed benchmarks, patients will have priority access to vacant LTCH beds for at least two days each week. Access to LTCH beds for patients in the community will not be blocked for extended periods of time.
- **Increased CCAC Case Managers in Hospital Emergency Rooms:**
Increased presence of CCAC Case Managers in hospital emergency rooms to arrange for home care for individuals who can be cared for at home and avoid unnecessary hospital admissions (Implemented during 2005/06)
- **Resource Integration for Seniors in the Community (RISC Project):**
The project involves providing intensive case management and care coordination for "at risk" seniors to support and maintain them in the community and avoid hospital admissions and premature admissions to LTCHs. (Implemented in February 2004)
- **Conversion of Short-stay respite beds to Long-stay beds:**
This initiative was implemented to ensure better utilization of LTCH beds (Implemented in April 2006).

APPENDIX 2: OTTAWA ALC STRATEGIC COMMITTEE PARTICIPANT LIST

Participant Name	Institution
Gino Picciano	The Ottawa Hospital
Cathy Danbrook	The Ottawa Hospital
Dr. James Worthington	The Ottawa Hospital
Karen Nelson	The Ottawa Hospital
Gerald Savoie	Hôpital Montfort
Lucille Perreault	Hôpital Montfort
Johanne Pomerleau	Hôpital Montfort
Tom Schonberg	Queensway Carleton Hospital
Eric Hanna	Queensway Carleton Hospital
Maureen Taylor-Greenly	Queensway Carleton Hospital
Jane Adams	Queensway Carleton Hospital
Jean Bartkowiak	Sisters of Charity of Ottawa Health Services
Diane Hupe	Sisters of Charity of Ottawa Health Services
Bruce Swan	Royal Ottawa Health Care Group
Sandra Golding	Ottawa CCAC
Sheila Bauer	Ottawa CCAC
Mark Waldon	Hastings & Prince Edward Counties (HPE) CCAC
Norm Slatter	LTCH Representative
Cal Martel	Ottawa Regional Geriatric Assessment Program
Dr. Bill Dalziel	Ottawa Regional Geriatric Assessment Program
Dr. Robert Cushman	The Champlain LHIN
Suzanne Dionne	The Champlain LHIN
Jocelyne Contant	The Champlain LHIN
Donna Lordon	The Champlain LHIN
Kate Jackson	MOHLTC
Eric Partington	MOHLTC
Karen Slater	MOHLTC
Nathalie Menard	MOHLTC
Jane McIsaac	MOHLTC
Tom Bingham	MOHLTC
Tom Holland	MOHLTC
Jeremy Stevenson	MOHLTC

APPENDIX 3¹⁷: ESTIMATE OF LTCH BED REQUIREMENTS IN OTTAWA BY 2010 (SAMPLE CALCULATION)

Below is a sample calculation to estimate the number of LTCH beds required in Ottawa by 2010. Further work is required to refine the approach, however the calculation suggests that 300 to 400 LTCH beds need to be added to the health care system in Ottawa, in addition to other LTC community alternatives, to address the future demand and have an ideal demand to supply ratio of 1.10. In addition, the estimate also accounts for a significant level of redirection potential (i.e., assume that 100% of CMI levels = A to C can be redirected) of the current and future demand.

2010 Demand to Supply Ratio:

$$\frac{\text{Current Demand}}{\text{Current Supply} + \text{Planned new beds}} \times \text{\% growth in 75+ population to 2010} = \frac{\text{2010 Demand}}{\text{2010 Planned Supply}}$$

For Ottawa, the 2010 Demand/2010 Planned Supply Ratio = 1.35
(this projected ratio means that the current unmet demand will increase by 40%)

2010 Demand to Supply Ratio Adjusted for Improved Utilization:

$$\frac{\text{2010 Demand}}{\text{2010 Planned Supply}} \times \text{Current \% Appropriate CMI (I.e., D to G)} = \frac{\text{2010 Adjusted Demand}}{\text{2010 Planned Supply}}$$

For Ottawa, the 2010 Adjusted Demand/2010 Planned Supply Ratio = 1.19

2010 LTCH Beds Required for 2010 Adjusted Demand to Supply Ratio to be Ideal:

To reduce the 2010 Adjusted Demand/supply ratio to 1.10, 390 LTCH beds would need to be added to the system.

¹⁷ Information Sources: Long-Term Care Utilization: PAC Reporting Package as of June 30, 2006 for LTCH beds demand, supply and waitlist information. The Provincial Health Planning Database (PHPDB) for population projections.

APPENDIX 4:¹⁸ SUMMARY OF INDICATORS

Summary of Indicators

Legend: High Low

	Ottawa	Middlesex	Hamilton	Comparator Average	Ontario
ALC Situation					
% ALC days	9.52	5.14	5.43	6.70	8.48
Demographics					
% Population Growth (2001 to 2005)	13.30	11.77	12.41	12.49	14.02
% age 75+	5.59	6.44	6.99	6.34	6.01
Population density	278.60	121.50	438.90	279.67	12.60
% rural population	8.00	11.10	7.30	8.80	15.30
Medium Family Income	92,672	76,769	78,060	82,500	79,697
% of Labour Force (<\$20,000 per year)	33.80	39.45	37.12	36.79	36.94
% Visible Minority	17.97	9.35	10.88	12.73	19.08
Acute Services Access					
Volumes Performance (IPBA)	-0.05	-2.82	7.99	1.71	0.00
LTC Access (per 75+ population)					
Supply	98.40	103.40	96.10	99.30	98.20
Demand	119.70	122.00	110.30	117.33	113.90
Supply / Demand Ratio	0.82	0.79	0.94	0.85	0.86
Waitlist (% waiting in acute care)	9.46	9.36	14.29	11.04	9.48
CCC Access					
Beds per 75+ population	8.18	9.59	9.42	9.06	8.54
Inpatient Rehab Access					
Beds per 75+ population	28.47	27.4	31.02	28.96	18.7
Primary Care Access					
GP/FP per 10,000 population	11.29	8.81	8.29	9.46	8.42
Total physicians per 10,000 population	27.29	25.7	23.98	25.66	17.59
CSS Access (per 1,000 75+ population)					
Adult Day (units)	725	974	1,222	974	881
Adult Day (clients)	29	22	24	25	21
Meals on Wheels (units)	3,163	4,154	2,938	3,418	3,626
Meals on Wheels (clients)	38	31	42	37	77
Transportation (units)	999	2,017	704	1,240	1,655
Transportation (clients)	65	54	34	51	86
Home Maintenance (units)	232	64	27	108	122
Home Maintenance (clients)	66	42	12	40	20
Caregiver Support (units)	726	654	1,025	802	1,285
Caregiver Support (clients)	23	28	17	23	33
Home Making (units)	209	65	618	297	850
Home Making (clients)	159	22	102	94	122
Seniors Supp Housing (units)	-	424	717	380	2,836
Seniors Supp Housing (clients)	-	1	1	1	12
CCAC Access (per 1,000 75+ population)					
Visiting Nursing (Visits)	5,678	6,390	6,433	6,167	
Visiting Nursing (individuals)	192	286	222	233	
Shift Nursing (Visits)	2,753	3,455	1,952	2,720	
Shift Nursing (individuals)	8	4	6	6	
Physiotherapy (Visits)	446	341	716	501	
Physiotherapy (individuals)	56	69	143	89	
Occupational Therapy (Visits)	322	242	582	382	
Occupational Therapy (individuals)	45	94	146	95	
Social Work (Visits)	54	28	141	74	
Social Work (individuals)	8	6	20	11	
Personal Support & Homemaking (Visits)	21,885	14,182	18,076	18,048	
Personal Support & Homemaking (individuals)	179	183	164	175	

¹⁸ Information Sources include: Census Data (population characteristics); Provincial Health Planning Database (PHPDB) (population estimates); CSS/CCAC MIS data (2004/05), Daily Bed Census: FIM website (Bed Counts) www.mohltcfim.com; Ontario Physician Human Resources Data Centre www.ophrdc.org (physician counts).