

**UPDATED OVERVIEW of the Report Titled
*Review of the Increasing Pressures of an Aging Population on the
Health Care System in the City of Timmins
and the District of Cochrane***

Note: The update is confined to the District of Cochrane, with the exclusion of the James Bay Coastal Area.

***Produced for HSRC Network 13
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Background Information

Eighteen months have elapsed since the Timmins and District Hospital was forced to mobilize all its internal and external resources to deal with a bed shortage crisis, resulting in the hospital having no acute medical, surgical or ICU inpatient beds. This crisis resulted in the Ministry of Health and Long-Term Care issuing a Category 1-A Crisis Designation which meant that patients at Timmins and District Hospital awaiting placement to a long term care home (LTCH) were to be given top priority within the Cochrane District, as a means of facilitating the movement of clients from the hospital into a long-term care setting. The designation was in effect from June 1st, until July 31st, 2004.

In June of 2004 the Algoma, Cochrane, Manitoulin and Sudbury District Health Council (ACMS DHC) produced a comprehensive overview of the long-term care continuum within the District of Cochrane. The report titled *Review of the Increasing Pressures of an Aging Population on the Health Care System in the City of Timmins and the Cochrane District* guided the efforts of community stakeholders in their attempts to develop community-based solutions that would alleviate the current crisis and prevent a reoccurrence.

In July of 2004, guided by the finding of the ACMS DHC report, five proposals were drafted by community stakeholders and submitted to the Ministry of Health and Long-Term Care for consideration. Collectively the proposals will contribute to lessening the demands of the geriatric population on the health care system. The proposals reflect the community's belief that addressing the systemic pressures requires enhancements to the entire continuum of care and the proposals demonstrate the community's will to work collaboratively in an effort to ensure stability within the long-term care continuum.

The five-point strategy included the following proposals:

1. Reinstatement of a district home help homemaking co-payment service;
2. Development of a supportive housing model;
3. Establishment of coordination centres for the geriatric and palliative populations;
4. Designation of inpatient rehabilitation beds; and,
5. Allocation of interim/permanent long-term care home beds.

Status Update

District hospitals and the Cochrane District Community Care Access Centre (CD CCAC) have been monitoring closely key indicators such as long-term care placement waitlists and alternate level of care days over the past few years. **While the system is relatively stable at this point in time due to the addition of interim long-term care home beds, key indicators demonstrate that the system remains 'fragile'**. Pressures are slowly mounting and the system's limited capacity to accommodate any additional demand caused by seasonal fluctuations (*i.e.*, influenza outbreak, elderly falls) means that a crisis situation could easily erupt.

As part of the ongoing efforts to monitor the pressures within the system, it was determined that the data analysis contained within the ACMS DHC's report needed to be updated and the community's five-point strategy for addressing the pressures reevaluated based on the current systemic and political context.

To date, the five proposals developed by community stakeholders in the summer of 2004 have not been funded by the Ministry of Health and Long-Term Care. These proposals were shared with the Ministry's Long-Term Care Planning and Renewal Branch. They will be considered as part of the 2005 LTC Local Area Planning (LAP) process which is currently underway.

The LAP process should conclude by mid February 2006 and the final report should include:

- Recommended supply of LTCH beds until 2010 based on adjusted demand¹;
- Suggested supply required for 2010 for supportive housing in order to reduce LTCH bed demand as required in adjusted demand calculations;
- As appropriate, the report will discuss the needs of hard to serve populations;
- As appropriate, the report will discuss long-term care demand for which there are no Ministry programs – considered from the context of needs and preferences².

The LAP report will include new data systems and a methodology which will allow the measurement of demand for the full continuum of LTC services. LAP recommendations will then be integrated into the Ministry's 2006/07 Results Based Planning process.

Over the past 18-months the Ministry of Health and Long-Term Care has made some investments within the district. These include:

- The allocation of 21 interim long-term care beds;
- Funding for the establishment of a coordination centre for the palliative population (project received \$422,164 for an 18-month demonstration project ending on March 31st, 2006 with a potential extension until July 31st, 2006);
- The injection of new base funding (\$506,634) to CD CCAC to support the provision of acute homecare and (\$182,000) for end-of-life services for fiscal 2004-2005;
- One-time funding (\$60,000) to support clients with hip and knee replacements; and,
- Funding to expand the Adult Day Program in the outlying areas of the district (\$75,544).

¹ Adjusted demand for LTCH beds is an adjusted number from recognized demand. It is estimated based on assessed needs rather than the current expression of recognized demand.

² DRAFT 2005 Local Area Planning Process, Long-Term Care Planning & Renewal Branch, Ministry of Health and Long-Term Care, September 26, 2005.

Overview of the Health Care System in the Cochrane District

Factors Affecting Utilization Patterns

Demographics

The population of Northeastern Ontario declined by 4.4 percent between 1996 and 2001. During the same five-year period the population of Ontario grew by 6.1 percent. The Cochrane District experienced an even higher decline of 8.6 percent. **The percentage of seniors aged 65 years and over in the Cochrane District increased in proportion to the total population at levels similar to that of the province (12.2 versus 12.9 percent). The City of Timmins experienced a 3.2 percent increase in its seniors' population between 1996 and 2001 (increase of 155 seniors).**

The Aboriginal population in the Cochrane District is significantly higher than that of the province (9.8 versus 1.7 percent), and is considerably younger.

The life expectancy of residents in the ACMS planning area is about 2 years less than the provincial rate (76.6 versus 78.6 years).

In 2005 the Ontario Ministry of Finance released its population projections to 2031 based on the 2001 census³. Provincially the population aged 65 and over is projected to more than double from 1.6 million (or 12.8 percent of the population) in 2004 to 3.6 million (or 22.2 percent) in 2031. The provincial population aged 75 and over will more than double as well, increasing from 731,000 (or 5.9 percent of the population) in 2004 to 1.7 million (or 10.1 percent) in 2031. The growth in seniors' share of the population will accelerate after 2011 as baby boomers begin to turn age 65. This same cohort will begin to reach age 75 a decade later in 2021.

The population of Northern Ontario is projected to decline by 8.5 percent, from 810,000 in 2004 to 741,000 in 2031. This projected decline reflects Northern Ontario's recent migration trends and age structure. Among northern Census Divisions, Timiskaming and Cochrane are projected to experience the largest population decline.

In the District of Cochrane the total population is expected to decline 6.5 percent between 2001 and 2010. By 2015, the expected total population decrease is anticipated to be around 11 percent. In 2001, 12 percent of the total population was 65 years of age and older. It is projected that by 2010 the percentage of the total population aged 65 and over will climb to 15 percent and in 2015 it will climb to 18 percent.

In 2010, the 65+ segment of the population is expected to increase over 2001 levels by 13 percent (1380) this projection jumps to 28 percent (2940) by 2015. **The 75+ population – which is the cohort used to estimate need for a long-term care home bed – is anticipated to increase 11 percent (530) and 16 percent (770), from 2004 projected levels, in 2010 and 2015, respectively.**

³ The Ministry's demographic assumptions for growth reflect past trends in all streams of migration and the continuing evolution of long-term fertility and mortality patterns in each Census Division.

Provincially the overall dependency ratio, the ratio of the 0-14 and the 65+ age groups to the 15-64 age group, remains favourable until 2010, falling gradually from 45 "dependants" for every 100 working-age individuals in 2004 to 44 "dependants" in 2010. The favourable pattern of low dependency ratios will begin to change after 2010 with the arrival of large cohorts of baby boomers in the group aged 65 and over. The dependency ratio will climb to 60 "dependants" by the year 2031.

Determinants of Health

Determinants of health have an impact on health status and the demand for health care services. **Compared to provincial rates, the Cochrane District has a higher level of unemployment.** Meaningful employment has been identified as a key determinant of health. The unemployed are at greater risk of developing mental health problems and an overall lower health status.

The Cochrane District has a lower level of education in two categories - less than a high school education and those with a university degree. Studies have demonstrated a relationship between lower levels of education, general health problems, and increased hospital utilization.

Research has identified a strong link between income and health status. In general, low income correlates with lower levels of health status and higher rates of hospitalization. The profile of income or earnings from full-time employment for the overall population across the Cochrane District indicates that residents of the district earn on average 8 percent less than the provincial rate. **Information specific to income levels of seniors (aged 65+) reveals that average and median incomes for seniors living in the City of Timmins and/or the Cochrane District are lower than the provincial rates.** Median income for females over the age of 65 is below the threshold for low income cut-off. Income levels also have an impact on the ability of seniors to consider privately funded housing alternatives.

Seniors living alone may be at a higher risk for premature placement if they do not have sufficient levels of support by informal caregivers (family and friends). Census data reveal that the Cochrane District has a higher ratio of persons aged 65 years and over living alone when compared to the provincial rate (31 versus 26.8 percent).

The exodus of the younger segment of the northern population also has a corresponding impact on the availability of family members to provide support for aging parents and relatives.

Health Status Risk Factors

The health status of Northern Ontario residents is in general poorer than that of Ontario residents. **The prevalence of risk factors such as smoking, high blood pressure, obesity and binge drinking and the lower rate of fruit and vegetable consumption contribute to an overall poorer health status.**

Mortality and Morbidity

The Cochrane District experiences higher rates of mortality and morbidity. Over the five-year period, 1995 to 1999, mortality rates were 24 percent higher than the provincial experience. A review of select diseases including cancer, circulatory, respiratory, injury and poisoning reveals mortality rates that exceed the provincial experience.

Hospitalization rates (morbidity) for the same diseases all exceed provincial levels.

Age-related diseases such as dementia are also projected to increase substantially over the next decade. Dementia cases are projected to increase by 40 percent across Ontario and 37 percent across the Cochrane District.

Access to Primary Care

Access to comprehensive primary care services is a growing concern to all Ontarians. In spite of numerous practice opportunities, there are several physician and nurse practitioner vacancies in many communities. Although the physicians to population ratios in the Cochrane District are comparable to the province, accesses to specialists are considerably lower.

In 2002/03 the usage of hospital emergency rooms (ER) in the Cochrane District was 166 percent higher than the provincial rate. An examination of the main reasons for ER visits across the Algoma, Cochrane, Manitoulin and Sudbury area reveals that a significant volume of these visits are for health issues that could be provided in an alternate setting.

Emergency room data also provides insight into access to a family physician within the Cochrane District. Individuals indicating they have a family physician range from a low of 69.5 percent (Kapuskasing) to a high of 99.8 percent (Smooth Rock Falls and Bingham Memorial hospitals). The Timmins and District Hospital reported that 72.8 percent of patients presenting to the ER had a family physician. **Practice patterns of physicians in the north – most of whom share their time between private practice and hospital coverage – may affect timely access to care, which in turn may account for the high reliance on hospital-based services.**

The establishment of Family Health Teams across the province is anticipated to improve access by providing comprehensive primary health care services through an interdisciplinary team of doctors, nurses, nurse practitioners, and other healthcare professionals. This approach should also improve the capacity of primary care service providers and reduce reliance on the hospital system for non-urgent care. The City of Timmins is host to the White Pines Family Health Network. The Network offers extended evening and weekend hours facilitating timely access to care for patients of the Network.

An 18-month palliative care demonstration project is currently underway in the City of Timmins. One of the project's objectives is to shift the provision of care for palliative patients from a hospital to a community setting. The project is funded until March 2006 with a possible extension until July 2006. Part of the mandate of the program is to consider means of expanding the services of the Centre to the outlying areas of the

district. While it is premature to quantify the impacts of the project on palliative care hospitalizations, it is anticipated that the length of a hospital stay will be reduced as home-based palliative care services are enhanced.

In November of 2005, the Town of Kapuskasing was notified that it was chosen as a host community for the establishment of a community health centre⁴ in 2005/06, as part of a provincial expansion of this model of primary care service delivery. The community had been working on the development of this model of care for numerous years. As noted above, the community of Kapuskasing reports one of the lowest percentages of access to family physicians in the district.

Community Support Services

In March of 2005, the ACMS DHC released the findings of a needs assessment of support services⁵ within its catchment area. The needs assessment reviewed 8 key community support services using demographic and service utilization data and included stakeholder interviews. The eight services reviewed were:

1. Adult Day Services
2. Meals on Wheels
3. Diners' Club
4. Transportation
5. Caregiver Support Respite
6. Attendant Outreach Programs
7. Special Services for the Blind and Visually Impaired
8. Special Services for Persons with Acquired Hearing Loss

The needs assessment identified the need for an Adult Day Service for the frail elderly in the City of Timmins as the current Adult Day Service is predominantly for clients with Alzheimer and dementia (95 percent of clients).

The report substantiates this need by noting that the demand for Adult Day Services across the entire Cochrane District is expected to increase as a result of limited CCAC home support services, the out-migration of family and informal caregivers, the limited access to primary care professionals, and the increasingly poor health of local residents.

The needs assessment also identifies that not all sites have sufficient access to equipment. Should necessary equipment be made available, additional services such as bathing and toileting could be provided and consequently more clients could be served by the service.

Note: In the fall of 2004 The Canadian Red Cross received funding to enhance its Adult Day Service in the district (excluding Timmins) to care for an additional 35 clients.

⁴ The centres are to operate with teams of professionals including physicians, nurse practitioners, nurses, counselors, community workers and dieticians who deliver a range of services.

⁵ Algoma, Cochrane, Manitoulin-Sudbury District Health Council. *Long-Term Care Community Support Services Needs Assessment – Preliminary Findings*, March 2005.

Also identified as lacking are transportation services that facilitate access to primary care services and other community based supportive services such as an Adult Day Program. While the needs assessment notes that agencies are generally able to satisfy demand, volunteer-based agencies cannot accommodate clients in non-collapsible wheelchairs or the very frail client. Agencies do not however track requests from clients that they are unable to serve hence need is difficult to quantify. Additionally, the reimbursement rate per kilometer was noted as being insufficient to cover gas costs, which in turn becomes a barrier to recruiting new volunteers and impacts the retention of the current pool of volunteers. In many communities there are no public or private transportation services, hence ensuring that voluntary caregivers have access to adequate levels of support to care for the aging population remains paramount.

Attendant outreach service⁶ is a service identified as lacking within the Cochrane District (excluding Timmins). While the service is available in the City of Timmins, there is a need to expand the hours of care. The remainder of the district does not have access to this needed service. In response to this identified need, The Canadian Red Cross submitted a proposal in January of 2004 to the Ministry of Health and Long-Term Care to establish an Attendant Outreach Service in the district, beginning with Kapuskasing, to serve 8 to 10 clients.

Community Care Access Centre (CCAC) – Community Services

In 1999, **funding for the delivery of home help/homemaking services on a fee for service basis - delivered by a community agency other than the CCAC - was transferred into the Cochrane District CCAC's budget, at the request of the MOHLTC.** A number of other districts and regions of the province challenged the directive and ultimately were permitted to continue providing the service. Consequently, these areas now have access to both the CCAC's personal support/homemaking service and a community home help/homemaking support service on a co-payment basis. **In 2004, a proposal was submitted to the Ministry requesting the reinstatement of this service. Approval was never granted.**

In 2001/02, CCACs projecting deficits were mandated by the MOHLTC to balance their budgets. Cost recovery plans were developed and resulted in service level reductions for homemaking, personal care, attendant care, and respite. The need for personal care became a prerequisite for clients to remain eligible for CCAC services. The most noticeable cuts in units of service over the years were for homemaking, which declined 17 percent since 2000/01. Nursing services also declined over a three-year period; there was a 6.2 percent gain in the last fiscal year (2003/04), which resulted in service levels returning to 2001/02 rates. **The literature suggests that there is a correlation between reductions in community services and an increased demand for LTCH beds.**

⁶ The service provides homemaking and personal support services to people over 16 year of age with permanent physical disabilities who require assistance with the activities of daily living and have the ability to direct an attendant to carry out pre-determined tasks that they cannot physically do for themselves.

The CD CCAC received \$672,000 in new base funding for the 2005/06 fiscal year to enhance nursing and homecare services. **The organization notes that there are currently no waitlists for nursing and homecare services.** A waitlist for therapy services currently exists due to staffing vacancies. It is anticipated that staffing levels will be enhanced in the short-term and waitlists eliminated.

A review of CCAC assessment data was undertaken to provide insight into the profile of CCAC clients. This review revealed a number of areas of concern – such as support levels, prevention measures, homecare support, medication management, *etc.*, - that could be managed through an enhancement of community-based services such as homecare, and personal care.

The needs assessment notes that a service such as Caregiver Support Respite – which is available elsewhere in the province but not in the Cochrane District - could be offered as a function of other community support services such as Adult Day Services.

Community-based supportive services are needed to extend the length of time seniors can continue to live at home independently. It is well documented that providing supportive care at home provides improvements in the quality of care and results in substantial financial efficiencies to the health care system. It is worthy of mention however that in recent years, research conducted by Marcus Hollander expressed concern with a mindset that views homecare as a substitute for acute care. While the provision of homecare supports can in some instances facilitate the discharge of patients from an acute setting back into the community, Hollander emphasized that cuts to home support and housekeeping services (as a means of reducing hospital admissions) would result in an increased demand for acute health care services in future years. In his opinion, homecare supports need to be focused on preventing admissions and not on facilitating the discharge of individuals with chronic care needs.

Alternate Housing Options

The most conspicuous gap in the long-term care continuum within the Cochrane District is the absence of supportive housing⁷ for the frail elderly. An option that would ensure that seniors, who find themselves needing an increasing level of support yet are still too independent or high functioning to warrant placement within a long-term care home, have the ability to live independently longer. The level of support would increase as the individual aged and their self-sufficiency diminished to the point where admission to a long-term care home would become preferable. Supportive housing is a preventative measure that can delay institutionalization.

Determining the level of need for supportive housing within the district is a challenge in the absence of a provincial benchmark or a tracking system to monitor supportive housing need. **The LAP process, currently underway, is a planning exercise which**

⁷ Supportive housing is rent geared to income housing that provides services that support independent living. For example, access to Personal Support Workers 24/7, congregate dining and medication management.

will attempt to undertake this task with new Ministry data systems. The Ministry's methodology will also attempt to estimate how the development of new supportive housing and long-stay homecare supply would shift the demand for LTCH beds.

A recent ACMS DHC report⁸ tried to estimate the district's unmet need using benchmark models taken from the literature. However the application of these benchmarks is problematic as they fail to take into account health status and how the absence of key long-term care services affect the demand for other services along the continuum of care. The benchmarks also provide a very broad range. For example, the application of one benchmark estimates that the number of individuals in the District of Cochrane requiring supportive housing would be in the range of 311 to 725⁹. The application of two other benchmarks suggests more of a mid point figure of about 466 and 414 respectively¹⁰.

The literature also suggests that retirement living spaces should be subtracted from this estimated range as these supportive environments provide access to supportive care. This approach fails to account for those who cannot afford to consider a retirement home as an alternate housing option.

In an effort to mitigate the limitations of the benchmarks reviewed, CCAC staff was asked to estimate the number of clients on their caseload that could potentially benefit from a supportive housing environment. This exercise resulted in the identification of 103 individuals; this figure is considered conservative and does not account for clients who are not currently on the CCAC caseload but could benefit from supportive services. It should also be noted that a number of long-term care homes were able to identify clients who may have been more appropriately cared for in a supportive housing environment, if such services had been available, at the time of admission.

A private retirement home is being developed within the City of Timmins. It is slated for completion in the fall of 2006 and will provide 85 additional retirement living spaces. These additional spaces are a welcome addition given the low vacancy rates within the existing supply of retirement living units. It should be noted however that an inequity in the distribution of private retirement facilities exists across the district and will be heightened with this development. Timmins is home to all but one of the retirement facilities; Moonbeam is home to a small private facility with 13 units.

A number of communities within the Cochrane District have expressed an interest in developing supportive housing models. Timmins submitted a proposal as part of their five-point strategy. Hearst, Iroquois Falls, Cochrane, and Smooth Rock Falls are all at different stages of conceptualizing their models of care. The challenge for the district's

⁸ Algoma, Cochrane, Manitoulin-Sudbury District Health Council, *Examining the Need for Supportive Housing Services in the Cochrane District*, November 2004.

⁹ The low end of the range referring to individuals whose supportive needs would be considered high and the high end of the range referring to individuals with low supportive housing needs.

¹⁰ For additional information on the benchmark models one is referred to page 31 of the Algoma, Cochrane, Manitoulin-Sudbury District Health Council's report titled *Examining the Need for Supportive Housing Services in the Cochrane District*, November 2004.

stakeholders surrounds the development of viable proposals in the absence of a supportive housing policy, guidelines, and criteria for submission.

There are additional segments of the population that should be considered when one estimates the need for supportive housing spaces. Individuals whose supportive housing needs were not considered as part of the ACMS DHC report include individuals with a mental illness and/or developmental disability. Deinstitutionalization of these individuals will place some pressure on the current long-term care system.

The Ministry of Health and Long-Term Care is cognizant of this need and is working on establishing 8 additional supportive housing spaces for clients with a mental health diagnosis, with 1 FTE being assigned to provide supportive services. The intent is to facilitate the movement of this population out of the Schedule 1 facility (Timmins and District Hospital) and into the community with the help of supportive services.

Part of the government's transformation of developmental services includes the closure of the three remaining provincially-operated facilities for adults with a developmental disability, by March 2009. The Ministry of Community and Social Services recognizes that individuals with a developmental disability will require supportive services and anticipate holding public consultations on a draft plan in 2006. At this point minimal impacts on the demand for long-term care services are anticipated.

Supportive Care Program

In the spring of 2004 the Ministry announced the establishment of a provincial Supportive Care Program. The intent of the program was to provide short-term care, delivered in a long-term care home bed, to eligible individuals either coming from the community or being discharged from hospitals. Individuals prepared to return home or to a rehabilitative setting would have been eligible for the program¹¹. The goal of the program was to alleviate hospital pressures and meet the community's need for supportive care.

The Supportive Care Program addresses, in part, the objectives of the geriatric centre proposed for the City of Timmins as part of the five-point strategy aimed at lessening the demands of the geriatric population on the local health care system. Despite an identified need for this service, no long-term care home within the Cochrane District could consider applying for the program due to the chronic shortage of long-term care home beds. Long-term care homes are fully occupied hence beds could not be set aside for the purpose of establishing a Supportive Care Program.

Hospitals were not eligible to apply for funding under this program which is unfortunate as the Timmins and District Hospital was (is) willing to explore the possibility of converting some of their interim long-term care home beds into supportive care beds for clients awaiting rehabilitation. Additional funding would enable the hospital to hire

¹¹ Correspondence dated September 14, 2004 from Ann Matte, Regional Director (a) to Executive Directors, CCACs – Subject – The New Supportive Care Program – Data Request

additional therapeutic services and ensure that patients obtain the supportive care they require to facilitate their return back to a community setting.

Long-Term Care Homes

The goal of the 2005 LTC Local Area Planning (LAP) process initiated by the Long-Term Care Planning and Renewal Branch of the Ministry of Health and Long-Term Care is to “*guide Ministry initiatives to re-balance the LTC Homes sector. This work will also help identify where LTC Home demand is high because other LTC community services (such as Supportive Housing or Long-Stay Homecare) are in short supply*”¹².

In light of this ongoing process, an update of this section will be deferred until the data and analysis contained in this report are made available. Significant notes or methodologies identified in the LAP process that will impact the analysis contained in the ACMS DHC report are noted below in an effort to understand how the LAP process will expand on the data and information available to the ACMS DHC when their report was undertaken.

The Cochrane District has 626 approved long-stay beds, 7 short-stay beds, and 21 interim beds for a total of 654 LTCH beds scattered among 10 facilities located in seven communities dispersed within a land area of 141,244 square kilometers. Historically, the Cochrane District was considered above the provincial average based on the provincial benchmark of one hundred (100) long-term care home beds per 1,000 population over the age of 75. Consequently, the area was not eligible for additional long-term care home beds in the most recent provincial allocation.

The revised methodology being used in the Ministry’s LAP process should address any shortcomings of the previous approach. **Note: CD CCAC is identified as the CCAC with the highest demand for LTCH bed ratio in the province with a demand ratio of 160/1000 population aged 75+.** The average demand ratio for LTCH beds provincially is about 110/1000 population aged 75+. **The LAP recognizes that historically, the development of LTC services has been approached in isolation of other programs and failed to include an analysis of how LTC programs interacted and affected demand.** The CD CCAC has the fourth highest median times to placement among the 42 CCAC in the province.

A review of the level of care needs of residents (CMIs – Case Mix Index) occupying long-term care homes within the Cochrane District indicates that, on average, these residents are relatively healthier than residents in other provincial long-term care homes. Healthier residents housed within an environment which provides a high level of care will, naturally, live longer. Longer life spans will in turn affect the turnover rate within the facility, which in turn influences access to the current supply of long-term home care beds. **Note:** The Ministry acknowledges that lighter care residents have been anecdotally linked to the unavailability of other programs such as supportive housing.

¹² Correspondence dated September 28, 2005 from David Clarke, Director, Long-Term Care Planning & Renewal Branch, Ministry of Health and Long-Term Care to CCAC Executive Directors.

While one could question the appropriateness of placing residents within these long-term care facilities, it is important to note that an individual whose health care needs are relatively low can still satisfy Ministry criteria for placement within a long-term care home bed. The lowest priority ranking is a Category 3 – defined as a person who does not meet the requirement for placement in any other category – which does allow access to long-term care home beds for seniors who have no alternate housing options due to a lack of caregiver support, low-income levels, homelessness, *etc.* Once an individual becomes a resident, they usually continue to live in this environment for the remainder of their life.

The distance between facilities poses unique challenges to the placement of residents across the vast catchment area of the Cochrane District. The CCAC must balance bed availability from a system's perspective while keeping in mind the human aspect of ensuring that residents are placed in close proximity to family and friends. At times, loved ones are placed at a considerable distances from their community. Work continues to gain approval for the development of LTCH beds for residents of the James Bay Coast so that elders from these communities can live close to home and within their cultural environment.

The demand for some facilities far exceeds that of others. The Golden Manor in Timmins is the facility of first choice for 70 percent of clients awaiting placement within the district. There is an inequity in the ratio of beds to population within the district. The City of Timmins accounts for 51 percent of the total district population, yet accounts for 46.5 percent the long-term care home bed complement¹³. Equity in bed to population ratios would necessitate a 28-bed increase within the City of Timmins.

There are ongoing challenges with hard to serve population within the District of Cochrane, particularly individuals with a mental illness and/or developmental disability. Historically, there have been instances of mental health clients being refused admission to a long-term care home due to facilities requiring additional supportive services, and training to allow them to care for individuals with behavioral problems. The issue of an appropriate secure physical space to house hard to serve individuals has also been noted as a challenge.

Anson General Hospital proposed the development of an Affective Social Unit - a 10 bed secure unit for clients with dementia and other behavioral disorders - to the MOHLTC in the summer of 2003. The proposal never received funding. The hospital is willing to revisit the nature of its proposal to accommodate the hard to serve population requiring a secure long-term care environment.

¹³ Temporary beds excluded.

Hospital Utilization Data

Emergency Department

An analysis of emergency room data for the ACMS area revealed a rate of ER visits that well exceeds the provincial rate (166 percent higher). Health status factors account for almost twice as many visits (15.2 percent) in the ACMS planning area when compared to the provincial rate (8.19 percent). A number of these ‘health factors’ are issues that could be addressed in an alternate setting. Timely access to primary care likely accounts, in part, for the high reliance on the emergency department.

Complex Continuing Care

In general, an analysis of the RUG-III CMI for the Network 13’s complex continuing care beds revealed that the level of ‘resource needs’ of patients occupying these beds is less than the provincial average. However, three facilities within the Network 13 cluster of hospitals stand out as having CMIs that are higher than the provincial rate. These include the Timmins and District Hospital (19 percent higher), Anson General Hospital (4 percent higher), and Kirkland and District Hospital (6 percent higher).

High and low CMI rates must be considered within the context of alternate health care services available within a community as the absence of more appropriate services may affect the decision to enter a hospital for the provision of care. Conversely, the range of health care services within a community may influence the hospital’s ability to discharge back to the community to a more appropriate level of care.

The LAP process will analyze assessment data to estimate LTCH demand. RAI assessment data will be used on patients occupying complex continuing care beds and on clients on the LTCH waitlist to differentiate who may be placed appropriately in a LTCH based on level of care need alone. The Alberta Resident Classification System data from LTCH residents will be used to approximate the number of appropriate LTCH clients. This exercise will provide information on how the demand for long-term care home beds could change if other LTC services such as supportive housing or long-stay homecare were developed.

Alternate Level of Care (ALC)

As previously reported, establishing a clear understanding of the alternate level of care (ALC) pressures is complicated by individual reporting mechanisms. Collaboration across the district is ongoing and efforts are being made to standardize this reporting process. The Timmins and District Hospital reconciles its ALC numbers with those of the CCAC on a weekly basis, and the district hospitals reconcile their numbers with the CCAC on a monthly basis. Outlined below (Table 1) is a snapshot of ALC patients by community for a seven month period in 2005. Note that these numbers are ALC patients awaiting placement in a LTCH.

The Timmins and District Hospital has approximately 15 additional patients – not included in this table – which they classify as ALC palliative or ALC awaiting rehabilitation.

Table 1: Cochrane District ALC Patients - May 2005 to January 2006

15 th of each month	Timmins	Matheson	I. Falls	Cochrane	SR Falls	Kap	Hearst	Moose Factory	District Total
May 05	15	5	8	6	7	15	10	1	67
June 05	10	5	8	7	6	20	12	1	69
July 05	13	4	8	5	5	19	13	2	69
Aug 05	13	4	9	5	7	20	11	2	71
Sept 05	12	1	10	5	6	20	10	2	66
Oct 05	9	1	8	5	6	15	11	2	57
Nov 05	14	0	10	7	6	16	10	2	69
Dec-05	13	0	6	4	7	16	12	2	60
Jan-06	15	0	4	5	6	11	15	2	59

Source: Cochrane District Community Care Access Centre, February 2006

A detailed assessment of ALC patients over a 6-month period at the Timmins and District Hospital (October 2003 to May of 2004) revealed that 242 patients accounted for 355 ALC incidents. Seniors (65+) accounted for more than three quarters ($\frac{3}{4}$) of the ALC patients over the last five fiscal periods. Of all ALC incidents reported during this period, 17 percent did NOT have a family physician and 83 percent were over the age of 65. The most pressing level of care needs identified in this 6-month period included long-term care placements (37 percent), palliative care (10 percent), and rehabilitation (50 percent). Lack of homecare services accounted for less than 2 percent of ALC incidents.

Re-examination of the District's Priorities

The updated overview confirms that the five strategies developed in the summer of 2004 by community stakeholders continue to offer the best means of mitigating the demands of the aging population on the long-term care continuum in the Cochrane District¹⁴.

In the development of strategies for addressing the pressures, community stakeholders articulated that it was imperative that the approach to building up the long-term care continuum include enhancements to community supports and services in addition to increasing the number of beds in the long-term care homes.

Without an investment in the community, it was felt that individuals would continue to “clog up” acute care and LTCH beds.

¹⁴ Three additional areas of concern were identified in the update. They include:

1. The need for an adult day program for the frail elderly in Timmins,
2. Improving the stability of transportation services for the frail elderly across the district, and
3. Developing an attendant outreach program for the district (excluding Timmins).

The five point strategy developed by the community in response to the ALC crisis is outlined below. When possible a costing estimate is provided.

1. The reinstatement of a **district home help homemaking co-payment service** would provide seniors with the ability to purchase homemaking services and extend their ability to live independently in a community-based setting. **Estimated cost is \$228,800 (based on 100 clients averaging 2 hours per week for 52 weeks at a cost of \$22.00 per hour). Client is charged a \$5.00 per hour co-payment fee.**
2. Despite challenges in quantifying the level of need, there is widespread support for the development of **supportive housing models** across the district. While a number of communities are working on the development of models, The Canadian Red Cross has submitted to the MOHLTC a proposal to develop a supportive housing project in the City of Timmins. The building is operated by the CDSSAB. While the goal is to eventually have 30 supportive housing units, initially the project would begin 15 supportive housing units given the d. **Estimated cost of providing supportive services to individuals in the 15 units is \$80,000.**
3. The establishment of **coordination centres for the geriatric and palliative populations**.

The CD CCAC hosts the Timmins Palliative Centre, a Ministry funded demonstration project. Sustaining the Centre beyond its 18-month timeframe will be the primary focus in the upcoming year. With the funds received under End-of Life Care the CCAC anticipates being able to continue to provide coordinative services for the Centre and expand these services into the district. Funding needs to be secured for physician and pharmacist compensation. **Estimated cost is \$50,000.**

The geriatric centre proposed includes a number of initiatives that collectively would constitute the geriatric centre. **Estimated costs are outlined below in Table 2.** Note that the Supportive Care Program proposed by the Ministry would in part address the intent of the Therapeutic Day Program proposed for the geriatric centre.

Table 2: Costing Estimates for the Geriatric Centre

Initiative	One Time Cost	Annual Cost	Total
Marketing Coordinated Seniors Services	\$15,000	\$0	\$15,000
Geriatric Education For Health Care Providers	\$74,200	TBD	\$74,200
Therapeutic Day Program	\$30,680	\$514,730	\$545,410
Adult Day Program	\$0	\$117,000	\$117,000
Access to Primary Care (Nurse Practitioner) ¹⁵	\$1000	\$110,000	\$111,000
Intensive Case Management	\$0	\$183,500	\$183,500
Total	\$120,880	\$925,230	\$1,046,110

4. The Timmins and District Hospital continues to work towards the **designation of 20 inpatient rehabilitation beds**. This would include the conversion of 10 complex continuing care beds plus the addition of rehab 10 beds. The hospital is fourth on a Ministry priority waitlist for rehabilitation funding. **The estimated cost for the first year of operation is \$2,473,500¹⁶**. This includes \$410,500 in one time funding and an annual operating cost of \$2,063,000.
5. District long-term care home beds are operating at full capacity which speaks to the need to move forwards with the development of additional **permanent long-term care home beds**. Of great concern is the system's ability to avoid a crisis in the next few years given the length of time needed to develop new long-term care beds, once Ministry approval is secured. **Estimated cost not available**.

The relevancy of the five proposals/strategies developed to address the pressing needs of the long-term care continuum within the District of Cochrane are in line with the priorities identified in the Hospital Annual Planning Submission (HAPS) process, and the patient care priorities identified in the planning process for the Northeastern Local Health Integration Network.

Specifically, the HAPS process recognized the ALC challenges/hard to serve clients as a top priority for the hospital system. The top five patient care priorities identified for the Northeastern Local Health Integration Network relate in some manner to the pressures identified in this overview. Particularly, the importance placed on the role of community support services and the utilization of long-term care homes for total system support.

In the absence of the LAP analysis and its recommendations for the District of Cochrane, one cannot comment on how the recommendations will relate to the priorities identified.

¹⁵ The CD CCAC has recently advertised for a Nurse Practitioner to assist with this project. It is hoped that the professional hired could provide services to both the palliative centre and the geriatric centre if such an initiative was implemented.

¹⁶ Costs as per original request made to the Minister in 2003. Costing may need to be revised to reflect 2005/06 expenditures.

However **the LAPS process and its methodology are in line with the proposals developed by local stakeholders.** The end goal of the LAP process is to realign the continuum of LTC services to ensure that the supply of programs matches the demand for these programs.

Transitioning towards this desired state will be a challenge in the District of Cochrane. The lack of a physical infrastructure, which was the biggest impediment to the establishment of interim long-term care home beds, will challenge the district's ability to accommodate short-term solutions while long-term services evolve based on demand.