Mobilizing a System Response to Caregiver Support

Informal Caregiving in the Formal System: From Ideas to Solutions

Healthy Connections Conference
June 9, 2011

Camille Orridge
CEO, Toronto Central LHIN
Toronto Central LHIN: Diverse Caregiver Needs

• 41% immigrants
• 10% identifies as LGBT
• 5,000 homeless
• 19% lone parent families

• 13% Seniors age 65 and over
  ▪ 34% aged 65+ living alone
  ▪ 54% aged 65+ with a disability
Areas of Birth for Toronto Central LHIN Recent Immigrants (2001-2006), 2006 Census

- Southern Asia: 23%
- Eastern Asia: 17%
- Eastern Europe: 12%
- Southeast Asia: 10%
- West Central Asia and the Middle East: 8%
- Northern Europe: 2%
- Central America: 2%
- USA: 3%
- Caribbean and Bermuda: 3%
- Southern Europe: 6%
- South America: 6%
- Africa: 6%
Informal Caregiver Support in TC LHIN

Percent of Population Reporting Hours of Unpaid Care/Assistance to TC LHIN Seniors, by SubLHIN, 2006

Data source: 2006 Census profiles from Health Analytics Branch, MOHLTC
Comparison of Total Hours Spent by Informal Caregivers (Toronto Central)

<table>
<thead>
<tr>
<th>Type of Informal Caregiver</th>
<th>Mean Hours Per Week</th>
<th>Number of Cases (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>18.9</td>
<td>1648 (23%)</td>
</tr>
<tr>
<td>Adult Child</td>
<td>17.7</td>
<td>3809 (52%)</td>
</tr>
<tr>
<td>Other Relative</td>
<td>17.5</td>
<td>1120 (15%)</td>
</tr>
<tr>
<td>Friend/Neighbour</td>
<td>6.2</td>
<td>715 (10%)</td>
</tr>
</tbody>
</table>

Not Statistically Significant
Total Missing Cases = 1116

A.Paul Williams, Alice Peckham, Kerry Kulusi, Robin Montgomery, Frances Morton and Jillian Watkins (March 2010)
Clients Placed in LTCHs with Scores of High or Very High as a Proportion of Total Clients Placed in LTCH in the Time Period

April 2008 - February 2011

% Placed High or Very High

Median
Delivering High Quality Care for All
Caregiving in High-Density Neighbourhoods

The high density of seniors in some New York City high-rises has produced an alternative form of senior housing. The term “NORC,” short for naturally occurring retirement community, describes a geographic area with a significant proportion of seniors living in housing that was not designed or planned with seniors in mind.

Over 25 years, the number of poor families living in high-rise apartments has increased from 34% (1981) to 43% (2006)

- Poverty by Postal Code 2: Vertical Poverty, United Way Toronto (Jan 2011)
Caregiving in the LGBT Community

The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada
Shari Brotman and Robert Cormier (2003)

“Having faced rejection from biological family, gay and lesbian people have often had to seek out friends with whom they can be themselves, be out, and be affirmed. These friends become family, or “fictive kin” (Barranti & Cohen, 2000).”
Going Forward: Excellent Care for All

TC LHIN Strategy 2011/12 - 2013/14

**Aim**
Drive sustainable system improvements to achieve better outcomes for people and communities

**Who We Serve**
- Patient/Client/Caregiver
- The Health System
- Our People
- Our Communities

**Goal**
- People have more and easier access to services across the system; services are more efficient and sustainable
- Organizational Capacity is Optimized
- Every person receives quality care

**Strategies**
- Improve Access to and Efficiency of Services
  - ER/ALC
  - Mental Health and Addictions
  - Diabetes
  - Value and Affordability
- Lead Provincial and Cross-LHIN System Improvement
- Optimize Internal Capacity
- Drive Excellent Care for All
  - Quality
  - Equity
  - System Capacity and Planning

**Indicators**
- Indicators for Integrated Health Services Plan -2 priorities
- Indicators for TC LHIN-led provincial initiatives including:
  - Senior Friendly Hospital
  - Resource Matching and Referral
- Indicators for:
  - Business Intelligence
  - Knowledge management
  - Business continuity
  - Customer database
  - LHIN Shared Services and LHIN Collaborative
- System and sector indicators for:
  - Quality
  - Equity
  - System Capacity
Every person receives quality care: Drive Excellent Care for all

**Goal**

Drive sustainable system improvements to achieve better outcomes for people and communities

**Indicators**

- Quality:
  - 100% of HSPs adopt quality indicators
  - 25% of eligible agencies using RAI-CHA
  - 75% of LTC homes participating in Residents First
  - # of Caregiver Support projects underway
  - 100% of HSAs include Quality indicators
  - Hospital Reports to Primary Care EMR project initiated

- System Planning and Capacity:
  - Long-Term Vent plan developed and 25% implemented
  - Discharge Planning improvement model developed and 25% implemented
  - United Way service hub in place
  - % Integrate Care Program clients with hospital re-admission within 30 days

- Equity:
  - % of at-risk St. Jamestown clients identified and attached
  - Consumers, health equity experts, HSPs engaged in identifying LHIN-wide equity priorities
  - Hospitals collecting common demographic variables

**Key Activities & Deliverables**

- Quality:
  - Set of TC LHIN quality indicators established
  - Sector-specific quality indicators endorsed by sectors, included in LHIN scorecard
  - Resident First Quality Improvement Initiative in LTC homes
  - Phase I RAI-CHA (common assessment form) implemented in eligible CSS agencies
  - Caregiver Support projects underway
  - CCAC Enhanced Role implementation

- Equity:
  - Establish set of TC LHIN equity indicators that relate to Quality indicators
  - Sector-specific equity indicators endorsed by sectors, included in LHIN scorecard
  - Begin to implement focused set of LHIN-wide health equity initiatives
  - Begin process of collecting common demographic data, beginning with hospitals

- System Planning and Capacity:
  - Long Term Ventilation needs planning
  - Discharge planning improvement model
  - Role & criteria of rehab & CCC in TC LHIN defined
  - Integrated Care for Complex Patients projects
  - Integrated Care Model in North St. Jamestown
  - United Way to service hub in high-needs areas
  - Coordinated access to targeted MHA services
Developing the health care system around

*people and communities*