Creating a Vision for Long-Term Care Homes as Centres of Learning

Options and Opportunities for Ontario

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Who is CAHO?

- The Council of Academic Hospitals of Ontario is the association of Ontario's 25 academic hospitals and their research institutes.

- CAHO provides a focal point for strategic initiatives on behalf of our members.

- Our hospitals provide the most complex and urgent care, teach the next generation of health care providers and foster health care innovation derived from discovery research.

CAHO Council of Academic Hospitals of Ontario

CAHO Members

Baycrest — Enriching Care, Enhancing Knowledge, Enlightening Minds
Bloorview KIDS REHAB
Soins continus Bruyère — Continuing Care
camh
CHEO
Hamilton Health Sciences
SickKids
KGH
London Health Sciences Centre
Hôpital Montfort
Mount Sinai Hospital — Joseph and Wolf Lebovic Health Complex
North York General Hospital
The Ottawa Hospital — L'Hôpital d'Ottawa
Providence Care
Services de santé RoyalOttawa Health Care Group
St. Joseph's Healthcare Hamilton
St Joseph's Health Care London
St. Michael's — Inspired Care. Inspiring Science.
Hôpital régional de Sudbury Regional Hospital
Sunnybrook Health Sciences Centre
Thunder Bay Regional Health Sciences Centre
Toronto Rehab — Everything Humanly Possible
University Health Network
Women's College Hospital

CAHO Council of Academic Hospitals of Ontario

Research, Teaching & Clinical Care

Academic hospitals have an integrated four-part mission to:

1. Conduct cutting-edge **research** and translate new science into best practices for the system as a whole

2. **Teach** tomorrow's health care providers in specialty and sub-specialty areas

3. Deliver **tertiary and quaternary clinical services**

4. Work with our partners to **improve the health of the community** through capacity-building

CAHO Strategic Plan 2010-2015

Vision:

Ontario's Academic Health Sciences Centres leading the transformation of health care through the integration of research, education and specialized patient care to drive quality improvement.

CAHO Mission:

As key partners in the health care system, the CAHO community will harness our collective research and innovation strengths to advance world-leading patient care and a sustainable health care system.

How are we making this real?

Strategic Focus:

Enable the rapid movement of research evidence into practice to improve quality

Task:

Demonstration projects moving research evidence into practice in CAHO hospitals

Outcomes:

- Demonstrate the value of collaboration, creating building blocks of trust and accountability for future collaboration
- Generate learnings as to how to speed the translation of evidence into practice
- Create building blocks for future implementation of those learnings onto a system-wide provincial platform

Scholarship in Long Term Care
CAHO perspective
Karima Velji, RN, PhD, CHE

Baycrest
Enriching Care
Enhancing Knowledge
Enlightening Minds

Objectives

CAHO perspective

Enabling research uptake and evidence based practice in LTC

Academic Health Sciences Center (AHSC)

Healthcare entities whose (synergistic) missions are aligned to integration of:

- Clinical Care
- Education
- Research

AHSC

Overriding purpose is to improve health care of the community and society in which they reside through exemplary patient care, education and research

Create new knowledge and rapidly move into practice rapidly and appropriately

Demonstrate value by measuring performance, sharing data openly and providing evidence of continued improvement

Leadership in reducing disparities in health and health care between less fortunate and more advantaged members (social mission)

Clinical scholarship

Nature of Evidence
- Research
- Clinical Experience
- Patient Preferences

Context
- Culture
- Leadership
- Measurement

Facilitation
- Characteristics
- Role
- Style

Hub and Spokes

(Kitson, 1998)

Report card for clinical scholarship

Output Indicators (Don't harm me, Heal me, Be nice to me)

- "Don't harm me" - Safety (falls, pressure ulcers, restraints)
- "Heal me" - Functional status (activities of daily living; physical activity), Symptoms (pain, fatigue, dyspnea, nausea)
- "Be nice to me" - Satisfaction and perceptions of care

Report card for clinical scholarship

Input Indicators

- Staffing and productivity levels
- Staff mix and care delivery model
- Educational background
- Staff turnover
- Span of control of middle managers
- Staff engagement/satisfaction
- Years of experience

(Dunton et al. (2007); Kane et al. (2007)

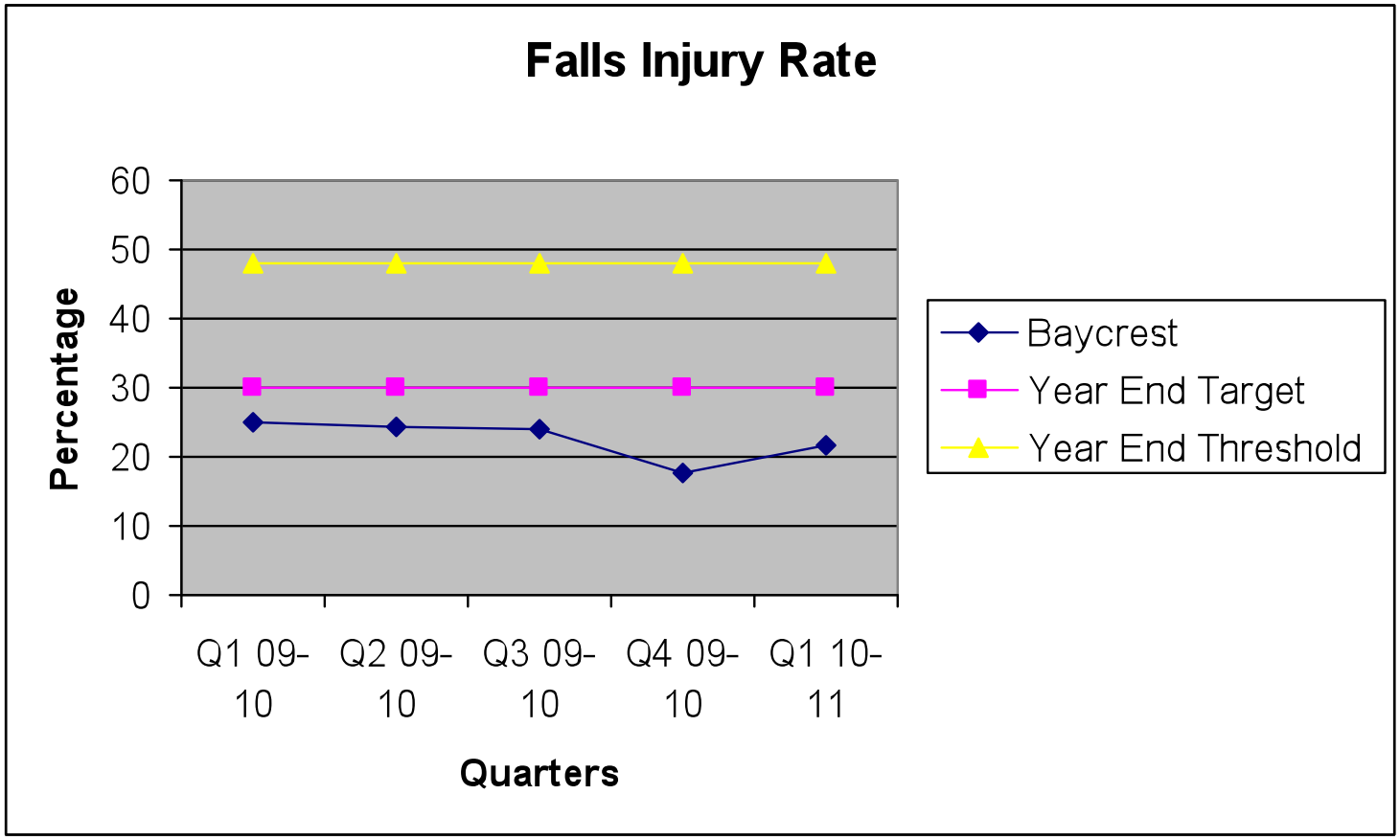
Report card for clinical scholarship

Process Indicators

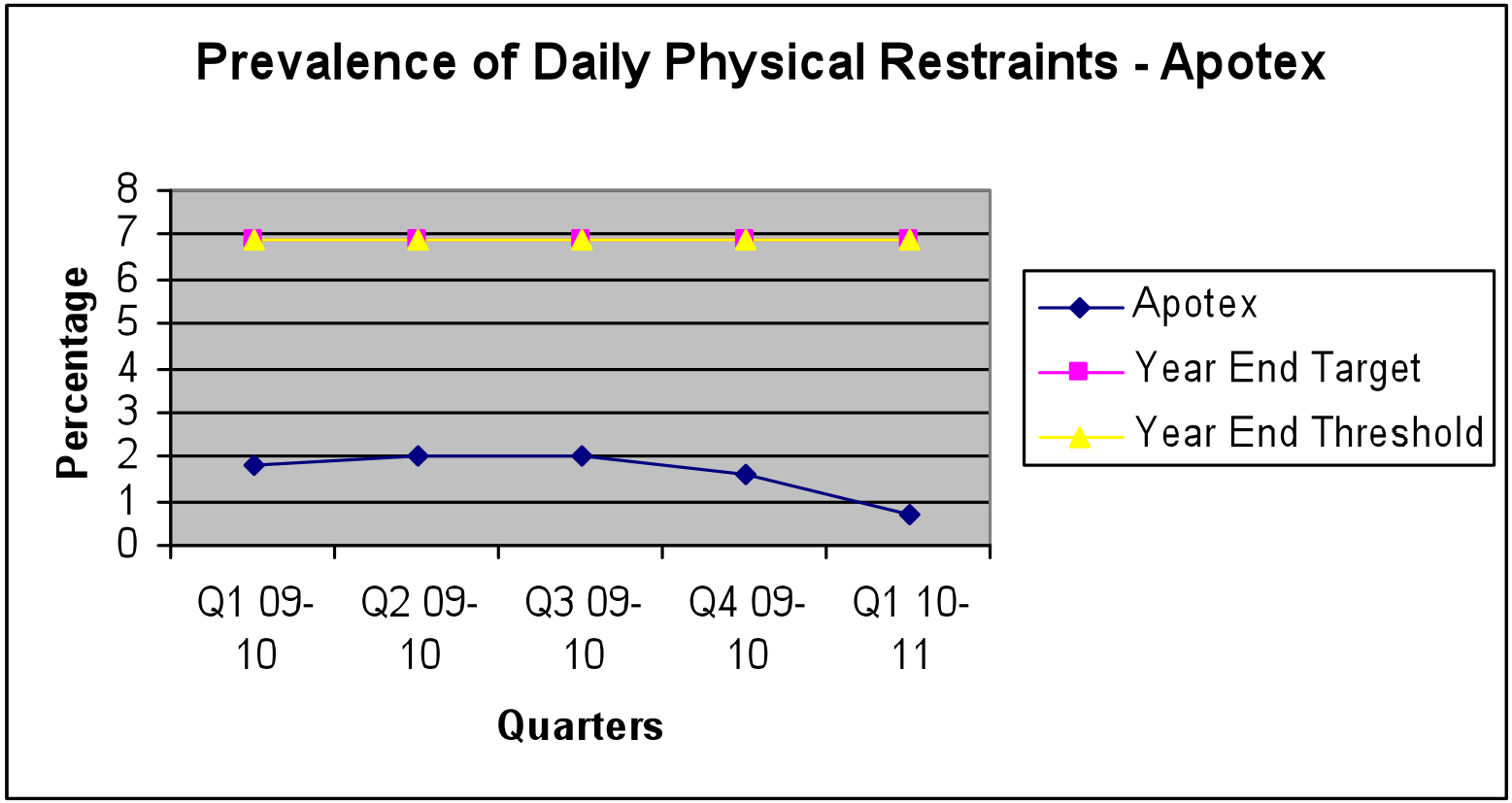
- Screening protocols
- Assessment methods
- Interventions
- Model of care

(Dunton et al. (2007); Kane et al. (2007)

Falls injury rate



Physical restraints - LTC



System considerations

Dramatic increases in the number of seniors living in long-term care institutions. 38 percent of women and 24 percent of men 85 years and older live in an institution.

For many seniors, home care is the preferred method of receiving care. One in four people placed in LTC could potentially be cared for in alternative settings.

90 percent of older seniors living in long-term care institutions suffer from a mental disorder. In Ontario, 88 percent of these institutions receive only five hours or less of psychiatric services per month for the entire resident population.

Shortly after entering an LTC home, one in six residents receives a new antipsychotic drug that he or she was not taking before, and one in four receives a new drug for anxiety or sleep.

Quality Monitor OHQC (2010)

System considerations

Wait times for an LTC bed are too long — an average of 105 days, or more than three months. For people waiting while at home, the wait time is 173 days (almost half a year). Wait times have tripled since the spring of 2005.

Frail individuals who cannot go home typically spend 53 days in hospital waiting for placement. As a result, currently 16% of all hospital beds in Ontario are occupied by patients designated as ALC, who do not need to be in hospital.

Today, health sector spending accounts for about 46 cents of every program dollar. If left unchecked, cost drivers could push health care spending to 70 cents of every program dollar in 12 years. Health sector expense is projected to increase by $6 billion from 2009-10 to 2012-13.

Quality Monitor OHQC (2010)

Source of health expenditures slides: MOHLTC Ontario website (2010)

Quality - ECFAA

On June 8, 2010, the *Excellent Care for All Act, 2010* (ECFAA) received Royal Assent.

Beginning with hospitals, the Act requires health care organizations to:

- Develop and post annual quality improvement plans.
- Implement patient and employee satisfaction surveys and a patient relations process.
- Link executive compensation to achievement of quality plan performance improvement targets.
- Develop declarations of values after public consultation.
- Create quality committees to report to each hospital board on quality related issues.
- Related amendments to Regulation 965 under the *Public Hospitals Act* (PHA)

Summary

Scholarship in LTC will need to consider:

- Consider nature of evidence, context and facilitation
- Input, process and output indicators
- Robust benchmarking and trending
- Legislative and system considerations; system oriented indicators to monitor clinical scholarship