UNDERSTANDING THE DESIGNATION PROCESS FOR SPECIALIZED UNITS IN LONG-TERM CARE HOMES

A MULTI-STAKEHOLDER TOOLKIT

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BACKGROUND AND CONTEXT

Care requirements for the elderly are growing in Ontario and across Canada. Seniors’ care is provided by different sectors and through different arrangements, depending on the health status of the person in need and their financial ability to contribute to the costs. Long-term care (LTC) homes are a cornerstone of seniors’ care, combining care with housing and other services. They assist those who can no longer live in the community, as they require 24-hour nursing care, but are otherwise clinically stable.

The Ontario LTC sector is large; in 2015, 627 LTC homes had 78,400 long-stay beds. LTC is regulated and funded by the provincial government and by residents’ co-payments under the Long-Term Care Homes Act, 2007 (LTCHA). Approximately $5.3 billion was allocated to LTC in 2014/15. Around $4 billion of this was Ministry of Health and LTC (MOHLTC) funding, representing 7.8% of the total health budget, and $1.4 billion through resident co-payments.

Since 2010, LTC homes can seek to have one of their units, or a portion of a unit, designated as a Specialized Unit. A designated Specialized Unit (SU) established in a LTC home is a unique service arrangement that expands the role LTC plays in the continuum of care. SUs serve a well-defined group of residents who are eligible for LTC but whose needs go beyond what a regular LTC home can offer. While these residents have clinical needs that require 24-hour nursing care, they do not require the complexity and range of care provided in hospitals. The SUs allow these clients to stay in a LTC setting, rather than go to a hospital, with the help of a unique combination of adjusted services, programs, equipment, and/or adapted accommodation.

While the primary intention of the SU is to improve residents’ care, SUs can also improve system resource use, sometimes with cost savings. For instance, they draw on existing services (such as psychogeriatric resource consultants) rather than duplicate, they can prevent patients from becoming ALC (alternate level of care) in a cost effective manner, they can introduce new and unique services, and they can enhance care integration with greater collaboration among service providers across sectors. SUs can improve care in the host LTC home and in the LTC sector overall.

As SUs are part of the Ontario health system, determining whether or not to set up a Unit should be considered a ‘system decision’. A SU’s development and operation must take a broad systems perspective and requires that all relevant players to come to the table to discuss. Even though existing designated SUs have come about in different ways, the Local Health Integration Networks (LHINs) have taken a leading role by virtue of their regional and planning mandate. There are other key partners who are typically involved from the local, regional, and provincial levels: the Community Care Access Centre (CCAC); the proposed host LTC home, and the care/service providers who are already assisting the targeted group of clients. The early involvement of the representatives of the target population and their families is also important to ensure that the clients’ needs are considered.

This toolkit was developed based on:

- The LTCHA and Ontario Regulation (79/10), the policy Designation/Revocation of Designation for Specialized Units (2015);
• Presentations made by the Ministry of Health and Long-Term Care (MOHLTC) on SUs; and

• The findings of an extensive provincial consultation conducted by the Bruyère Centre for Learning, Research and Innovation (CLRI) in LTC in 2015.

The LTCHA, Regulation and SU Policy remain the authoritative sources on the SU designation process. The legislative context is discussed in detail below.

HOW TO USE THIS TOOLKIT

Designated SUs constitute part of our Ontario integrated health care system. In order for SUs to be successful, they require strong collaborations between a range of stakeholders, including LHINs, LTC homes, CCACs, care and service providers, residents, and families. This toolkit aims to assist this multi-stakeholder group to determine the need for and feasibility of a designated SU to enhance their clients’ continuum of care. Moving past the decision stage, the toolkit aims to help navigate the application/designation process, the set up and operation of the SU, and the monitoring and evaluating of the Unit throughout its life.

Why a toolkit? Developing any new program is far from straightforward. The designation process for SUs is complex. The LTCHA and its regulations lay out the legislative environment in which each Unit is designated and operates. These documents help understand the regulator’s requirements, i.e. what they need to see in a proposal to be able to consider whether to grant designation, or not, and what they want to see in order to be able to assess whether a Unit is successful. In turn, this toolkit helps stakeholders to understand what they need to do and consider at each step of the process in order to successfully seek designation and operate their Unit.

This toolkit may need to be read multiple times by stakeholders to fully comprehend the nuances of the process. The automated table of contents allows the reader to navigate the toolkit and easily access various sections. Questions are also included to help guide discussions during inter-organizational planning meetings and interactions.

While it tries to be comprehensive, like any other toolkit, this is just a starting point. This is a springboard for stakeholders who will add their own experiences, knowledge, and understanding of their own realities and needs.

WHAT IS A SPECIALIZED UNIT IN ONTARIO’S LONG-TERM CARE HOMES?

Specialized Units are a unique service arrangement that expand the role Ontario LTC homes can play in the continuum of care. Using licensed long-stay beds, these units provide transitional or permanent higher intensity care that is tailored to the needs of a well-defined, specific group of clients. These clients’ care needs go beyond what a LTC home generally offers, but do not go as
As a sector with proven capacity to offer high quality care in a home-like setting, Ontario LTC homes are key players in the continuum of care for seniors. As the numbers of population group increase and the prevalence of chronic disease and disabilities grow, LTC homes are encouraged to expand their services. This is in line with the commitment of the provincial government to increase the quality of care across LTC and for sub-populations with special needs. Years of fiscal constraints also prompt the provincial government to advance healthcare sustainability through reduced costs and the shifting of services away from acute care to lower cost sectors.

At the same time, homes are facing barriers. They are feeling the same overall fiscal constraints as other parts of the healthcare system. The overall complement of LTC beds has not increased for years. LTC homes are struggling with long waitlists that may make it appear that designating beds for SUs would be “taking away regular long-stay bed” capacity, thus affecting access. Indeed, SUs represent only one option for providing care for these sub-populations. There are other non-institutional or even institutional arrangements that may offer cheaper and more appropriate alternatives depending on the context. Additionally, LTC homes often struggle with negative public perceptions.

In light of these challenges, why do some LTC homes take on the extra work to design and operate a SU? Our research findings show the following:

- **NEW SERVICES**: A SU is one more option to serve residents better. The Units expand the range of services a LTC home offers to residents with more complex needs, thus offering the right care at the right time and the right place. The Unit can bridge the services between acute care, sub-acute care, and regular LTC, as well as between acute care and the community. They also help the LTC homes that host the Units elevate their overall services.
A recent analysis by the Ontario Long Term Care Association identified eleven target populations that would benefit from specialized care, based on international experiences. Using the Residence Assessment Instrument (RAI) data, Ontario LTC residents were assigned to categories of specialized needs. Some of these areas are already cared for through short stay beds (convalescent care) or through Specialized Units in long stay beds (dialysis, behavioural, and cognitive problems), while the others could be considered specialized target audiences by LTC homes (pulmonary, ventilation/respirator, and tracheostomy care; wound care; palliative hospice; cancer; AIDS/HIV; addictions; young adults; and neurological).

This general recognition of the potential for expanding SU programs in the LTC sector was also confirmed by the multi-stakeholder consultation conducted by the Bruyère Centre for Learning, Research and Innovation in Long-term Care (January-July, 2015). Clients younger than 65 years of age, clients with responsive behaviours, with acquired brain injuries, mental health, neurological or degenerative conditions, and those with developmental delay were listed most often as distinctive groups who would benefit from the care and services that a SU could provide them.

- **DESIRE TO SERVE THE HARD TO SERVE**: Homes that have SUs all have a specific mandate and values that guide them toward the “hard to serve” populations. In many cases, they have experience caring for the sub-population before the Unit is designated. As committed and recognized innovators, they are passionate champions for their residents and the LTC sector, building strong partnerships throughout the health and community sectors. They value the opportunity this model offers for extra staff training and team building.

- **WAIT LIST**: Care coordinators, currently housed at the CCACs, manage a separate waiting list for each Unit. This enables vulnerable clients to receive appropriate services faster, to avoid hospitalization and, in many cases, to continue to live near their families and communities.

- **ADDITIONAL FUNDING**: Designated SUs can negotiate to receive start-up funds and supplementary operating funding (e.g. staff, equipment) from their LHIN. This is valued as LTC budgets are eroded by inflation and homes struggle to care for residents with complex needs without compromising the care of others.

- **SYSTEM TRANSFORMATION**: A coordinated approach for the creation and expansion of SUs across a LHIN and the province has the potential to help with capacity planning, better system resource utilization, and capacity building in LTC homes.

  - Both LTC home and hospital capacity are valuable resources. Finding a better balance between these two institutional care providers can improve resource utilization. For example, designating long-stay LTC beds as a Behavioral Support SU can provide needed services to a sub-population that might otherwise end up in the hospital Emergency Room. It can also contribute to ALC concerns by providing a transitional service to a sub-population that cannot be effectively cared for elsewhere.

  - Considering the designated SU model as “a system decision” highlights not only the lead role LHINs play from the beginning in the designation process, but also the pivotal aspect of inter-institutional collaboration in the design, set up, and operation of such a unit.
LEGISLATIVE CONTEXT

The Long-Term Care Homes Act, 2007 (LTCHA), which received Royal Assent on June 4, 2007, together with Ontario Regulation 79/10, came into force on July 1, 2010. The policy Designation/Revocation of Designation for Specialized Units (2015) completed the legislative structure for SUs.

Section 39 of the LTCHA provides the LHIN with flexibility to plan for and address local area needs of an identified client group through Specialized Units. The Act defines the concept of SUs that offer alternative LTC home accommodation and programs for identified client groups:

> A “specialized unit” means any unit designated by or in accordance with the regulations to provide or offer certain types of accommodation, care, services, programs and goods to residents, but does not include a secure unit unless the secure unit is designated as a specialized unit by regulation. 2007, c. 8, s. 39 (3).

Sections 198 to 206 of the Regulation describe the SU designation, admission, and revocation processes led by the Licensing and Policy Branch. The designation may be subject to any terms or conditions specified by the Director under the LTCHA. Once approved by the Director, licensees must enter into an agreement with their LHIN to operate the SU through a separate agreement or an addendum to an existing agreement.

Placement coordinators, currently housed at the CCAC, maintain a separate waiting list for every designated SU. A modified admission process is used to provide access only to those individuals who meet the characteristics of the clients who would benefit from the services of the SU. This admission process has to be followed even if a person already resides in the LTC home where the SU is located.

Since 2013, two regulatory amendments help with client flow. The new admission category “former Specialized Unit resident” increased the clients’ level of priority when they were ready for admission to a general LTC home bed (after reaching their clinical goals in the SU). Furthermore, if there is no one on the SU’s waitlist, a general long-stay resident from the host LTC home’s regular waitlist can be temporarily admitted to a SU bed. This possibility has to be first approved by the Director under the LTCHA, who has to consider resident safety (in the Unit and in the LTC home in general). The general resident temporarily in the SU is moved as soon as a bed in the LTC home opens up. LTC homes must notify the CCAC of these transfers.

LTC homes can also seek designation for beds that provide accommodation, care, and services for residents of a specific religion, ethnic and/or linguistic origin. The placement process for these units is described under sections 165(2) and 173 of the Regulation. These programs cannot be designated Specialized Units as defined by the LTCHA section 39 (3).
EXISTING SPECIALIZED UNITS – CHARACTERISTICS AND CHALLENGES

As of February 2016, there were eight designated SU’s across Ontario.

Map 1. Location of Ontario’s Specialized Units by LHIN. See Appendix for full coordinates.

1. Baycrest Jewish Home for the Aged
2. Cummer Lodge
3. Hogarth Riverview Manor
4. Linhaven Home for the Aged (T. Roy Adams Regional Centre for Dementia Care)
5. Mackenzie Health Long-Term Care Home
6. Peter D. Clarke
7. Saint-Louis Residence
8. Sheridan Villa

Publicly available information on each Unit’s website and recent provincial consultation presents a diverse picture:

CHARACTERISTICS: LTC HOMES WITH SPECIALIZED UNITS

- LOCATION: All SU’s are located in urban areas, spread throughout the province (2 in Champlain; 1 in Hamilton Niagara Haldimand Brant; 1 in Mississauga Halton; 1 in North West; 2 in Central; 1 in Toronto Central).
- **TYPE OF OWNERSHIP:** All SUs are located in non-profit homes. Seven of these homes are managed by non-profit organizations, and one is managed by a private company. Four SUs are in municipal LTC homes; some municipal LTC homes can access additional revenues from municipal funding if necessary, as determined through the annual municipal budget planning process.

- **SIZE OF THE LTC HOMES:** One Unit is in medium-sized LTC homes (97-160 beds) while seven are in large LTC homes (>161 beds).
  - In total, these LTC homes have 2,336 beds. This represents 2.98% out of Ontario’s total number of beds. The average size of a LTC home with a Specialized Unit is 292 beds; the median bed number is 226.5.

- **SHARED CHARACTERISTICS OF HOST LTC HOMES:**
  - The homes have specific mandates and values that guide them toward the “hard to serve” populations; many have experience caring for the sub-population before the Unit is designated.
  - As committed and recognized innovators, these homes are passionate champions for their residents and the LTC sector, building strong partnerships throughout the health and community sectors. They build on these extensive collaborations/partnerships to design and operate their Unit.

**CHARACTERISTICS: EXISTING SPECIALIZED UNITS**

- **PROGRAMS OFFERED:** There are six Behaviour Support Units, one hemodialysis unit and one peritoneal dialysis unit. Specialized Behavioural Support Units wrap higher intensity care around residents with complex responsive behaviours. These residents can come from hospitals (where they are often in ALC beds), LTC homes, or the community. As the behaviours stabilize, the extra care requirements gradually taper off and the resident can return to their LTC home or to the community.

- **SIZE OF SPECIALIZED UNITS:** The number of designated SU beds in a LTC home range from 6-24, for a total of 137 designated beds. This represents 3-14.3% of the various host LTC homes’ total bed count and 0.17% of Ontario’s total LTC beds. On average, a SU has 17.63 beds (median is 18 beds). It should be remembered that not all designated SU beds are used as such all the time – when there is no demand for the Unit’s service, some beds can be used as regular long-stay LTC beds.

- **EXPENSES:** Specialized Units’ related costs consist of start-up/fit-up costs and operating costs. There is little publically available information about these costs.

- **SPECIALIZED UNIT STAFF:** There is limited public information about the staffing patterns of each Unit. In general, Units are staffed by interdisciplinary teams. A Unit’s staffing needs are met primarily through the LTC home’s existing human resources, with some additional hires. In contrast, staff training represents a significant portion of start-up costs, while the need for refresher training or to train new staff adds to operating costs.

- **SPECIALIZED UNIT’S STATUS:** All Units started out as a pilot, with an initial designation of 12-24 months. With the approval of the policy *Designation/Revocation of Designation for*
Specialized Units (2015), Units can consider applying for non-time limited designation. Cummer Lodge, for example, received its non-time limited designation in July, 2015.

COMMON CHALLENGES EXPERIENCED BY SPECIALIZED UNITS

- Additional funding does not resolve all resource challenges, i.e. covering private room co-payment when the resident cannot afford it; no funding for staff replacement, vacation pay or COLA (cost of living adjustment); insufficient funding to cover actual care costs; challenges to funding ongoing training needs.

- Freeing up beds to populate the SU can take a long time, in some cases as long as 18 months. The 2015 policy on SUs expects 98% occupancy by the end of the third month after designation. The 2013 regulatory amendments allow SUs to fill beds with regular long-stay residents, thus reaching full occupancy. However, in some cases this also means that the Unit is not receiving its top up operational funding which can impact the ability to offer optimal specialized programming/care. Lack of residents who meet the characteristics of the clients who would benefit from the services of the Unit also can challenge maintenance of specialized staff skills.

- Ensuring ideal client flow in and out of the Unit can be a challenge at the end of the service; many clients stay longer in the Unit than what is required clinically.

- For example, when a resident has reached their clinical goals but their preferred home does not have a bed open, the Unit has effectively an ALC resident. For Specialized Behavioural Support Units (SBSUs), this could destabilize the resident again as newer, more high-need residents are coming into the Unit. Furthermore, many Unit residents are so satisfied with the care they receive, that they request to stay in the host LTC home but are required to wait for a regular long-stay bed to become available. If a number of SU residents opt to stay in the host LTC home, they see an increase in a certain type of resident on their regular units, which become effectively “step-down” units for the SU.

- Possible negative perception of the SBSU, from the resident’s original home or family, can also deter applications; as can the incorrect perception among healthcare providers that “why bother applying as the Unit’s waitlist is too long?”.

- Assisting a higher number of residents entering and exiting the Unit also places a burden on the host LTC home’s administrative systems. In general, the introduction of a transitional service such as that offered by the Specialized Behavioural Support Units requires great skills in inter-organizational collaboration and network building. There is a heightened need to evaluate and refine admission criteria to ensure that the Unit has a reasonable waitlist, as the high-need clients eligible for the services of the Unit are often unable to wait for assistance.

- Units also struggle to design monitoring and evaluation frameworks that allow them to know whether they are successful. Data is still lacking that shows sub-population specific outputs and outcomes from SUs.
DESIGNATION PROCESS STEP-BY-STEP

The designation process is detailed in the LTCHA and in the associated regulations and policies. This section of the toolkit presents a step-by-step outline of the process as a LHIN, a LTC home and their partners move from service gap analysis to concept and partnership development to initial pilot Unit approval and eventual non-time limited approval.

The designation process is described in a step-wise fashion. A one-page summary of the steps can be found in the Appendix in order to help guide group discussions. The understanding is that designation is far from linear and stakeholder groups might have to revisit a stage several times. For example, a designated SU might not be appropriate for a region at a given time because an in-depth gap analysis showed that the sub-population’s needs could be better met through enhanced community-based services. Ongoing program evaluation and demand analysis may encourage stakeholders to review their initial outcome expectations and assumptions and revisit their earlier decision not to pursue designation. The decision to move forward with seeking designation can be abandoned at any stage.

LHINs and LTC homes could be at different stages of readiness and planning when they start the journey towards a SU. Some might already have a regional capacity plan and have a good sense of the client needs and service gaps. Others may have very strong stakeholder partnerships to help support specific client sub-groups. Yet, others might have identified a gap and are just starting to reach out to the relevant stakeholders. Overall, experience shows that, on average, groups spend around two years actively working on their designation process.

Developing a designated SU is a joint venture from the beginning, bringing together different provincial, regional, and local players. For each step of the designation process, a lead organization is identified, expected outputs and outcomes are laid out, an evaluation plan is set up, and then specific tasks are defined and assigned.

A list of questions is provided within the toolkit at the end of each step to help stakeholders assess stage completion. None of these lists are exhaustive. They are based on the experiences of organizations that applied for designation, collected through consultation, and also on program development literature. Finally, for each step, useful resources are provided.

The role of the lead organization(s), as identified in this toolkit, is to deliver on the outputs of each step by leveraging partners committed to the proposed SU. This does not mean that the lead itself has to complete each task, but that it should oversee the designation process to ensure that each task is accomplished. The lead is expected to “project manage” the particular stage of the designation process and to keep all partners informed. It is recognised that the tasks, questions, and outcomes are not necessarily within the full accountability of the lead organization.

The LHINs are a natural lead agency for most of the steps in light of their regional mandate, system connections, and in-house capabilities.
**STEP 1: PERFORM SERVICE GAP ANALYSIS AND ASSESS THE APPROPRIATENESS OF ESTABLISHING A SPECIALIZED UNIT**

**LEAD ORGANIZATION:** LHIN, possibly with a LTC home

Experience shows that considering the setup of a designated SU to serve a sub-population is often needed in a multi-organizational setting (e.g. regional meetings or committees) where attendees have knowledge of the needs emerging or existing among their clients. The LHIN would then take on the responsibility of undertaking a “deep dive” through further data analysis to better understand the needs. As the organization that coordinates access to community and LTC, the contribution of the CCACs is also useful from the beginning. CCACs can help define and characterize the target population based on the kind of clients who are applying for LTC, as well as provide both a regional and system perspective.

Comprehensive regional capacity plans that span prevention, through public health, acute and home care, to LTC, have helped some LHINs decide to setup a Unit; while elsewhere a multi-stakeholder review of region level needs led to the decision that a Specialized Behavioural Specialized Unit (SBSU) was not what the region needed, as the demand was for more community-based services to help clients in the milder dementia.

It is possible for a LTC home to approach the LHIN with a service gap that it identified based on its historic population, current resident population, and/or waiting list. Experience shows that, even in this situation, the LHIN plays a critical role in the needs assessment due to its regional mandate, its primary focus on healthcare services’ integration, and the fact that any additional funding for the Unit must come from the LHIN. LTC homes are best positioned and able to understand their own microcosm – the combination of their own residents’ needs.

**EXPECTED OUTPUTS AND OUTCOMES:**

- A service gap in the region is identified and is expected to continue into the future.
- The appropriateness of the SU model is confirmed to fill the service gap.
- A map of stakeholders and external environmental supports/risks is developed, including both regional and provincial perspectives.
- MOHLTC’s support in principle is obtained on the concept of the SU.

**TASKS TO COMPLETE:**

- Identify potential service gaps based on needs signaled by the LTC sector and regional priorities set out in the LHIN’s Integrated Health System Plan.
  - Consider local pressures on the health care system and on the LTC home (such as funding, ALC, and human resources limitations), effects of the proposed program on other health care providers, and how the proposed SU may impact these pressures.
  - Consider provincial pressures and priorities as the designated beds are provincial resources, i.e. anybody in Ontario could apply for their services. Clearly connecting with provincial priorities and showing provincial benefits will strengthen the proposal.
Review the questions in Step 5 that the LHIN has to cover in its review and sign off for the MOHLTC.

• Determine ultimate program goals.

• Determine target population characteristics and how they differ from LTC population.
  
  o For some sub-populations, this is relatively easy to define; e.g. offering peritoneal dialysis requires that LTC staff acquire new skills and the home partners with the Ontario Renal Network to acquire new equipment (large amounts of new nursing supplies that have to be stored on the premises). In other cases, very careful segmentation of the population is needed to justify the extra resources invested in the designated Unit. For example, while 60% of the LTC residents have some level of cognitive impairment, there is a small portion of residents that will have behavioural health needs that exceed system resources such as those available through the Alzheimer’s Society, community-based Psychogeriatric Consultants, and Seniors Mental Health Services. The specific type of dementia and other characteristics of the target population (e.g. whether the unit is set up to help residents who need two person transfer) would be determined based on the needs prevalent in the community and on the specificities of the LTC home.

• Review historical and existing CCAC waitlists in the region, at the sub-regional level, and for the possible host LTC home’s regular catchment area. Experience shows that in many Units, 70-80% of the residents come from the regular catchment area of the host LTC home. For example, the Mental Health Commission of Canada’s methodology to design Comprehensive Mental Health Services for seniors (see full reference below) can be useful to understand the demand for behavioural support services at the sub-regional population level.

• Estimate future waiting list/demand expectations (10 and 20 years) based on catchment’s demographic projections and the state of alternative services or care. Reflect on emerging new technologies or care delivery developments that could significantly affect demand.

• Understand available community resources – are there realistic care alternatives to LTC for the client? Project these out to 10-20 years. Compare current and projected costs of different delivery modalities, based on the client’s expected care path.

• Review best practices for providing the service. This can help establish the right size of the unit (critical mass).

• Assess how and why current care practices do not meet clients’ needs.

• Review the experience of existing SU(s) that offer the same/similar service (see list in Appendix). Talk to them and arrange a visit. Approach the LHINs where the Units are located to find out more about the regional perspective.

• Consult with other LTC homes that offer similar care. The CCACs or LTC Associations could connect the LTC home to others who have experience with caring for these populations.

• Starting with those who initially/already work in the service gap, discuss plans with key stakeholders to get their input and buy in (e.g. LTC homes, CCAC, clinical partners, primary expected referring sources, and advocacy groups). Ultimately, a SU is offering customized
care thus the program objectives will help determine who the critical partners are to have around the table.

- Consider how to secure resources for setting up and operating the SU. Typically, some additional resources will be needed to run the Unit, thus evidence needs to be produced to justify this need to the LHIN and the MOHLTC.

- Approach the MOHLTC for an introductory discussion and to see if they support the SU idea, in principle.

**BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:**

- What are the biggest service gaps in our region?
- What are the characteristics of a client who would be served by this SU? What demand do we see for this service in our region? What trends could affect demand (scenario analysis)?
- What do best practices for this service tell us about the pros and cons of using a SU to fill the service gap?
- Who is already serving this client population in our region?

**RESOURCES:**


- Central West LHIN: Meeting Senior Care Needs Now and in the Future Highlights and Key Findings from the Report Submitted to: the Central West Local Health Integration Network (LHIN) to inform a Community Capacity Plan for the Central West LHIN 2015 (full document available online)

- North West LHIN: Health Services Blueprint: Building Our Future, Final Report, 2012 (full document available online)


- Mental Health Commission of Canada: Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (2011). The guidelines are available for download at: [http://www.mentalhealthcommission.ca/English/document/279/mental-health-commission-canada-seniors-guidelines-print](http://www.mentalhealthcommission.ca/English/document/279/mental-health-commission-canada-seniors-guidelines-print). These guidelines identify benchmarks for staffing outreach and community teams as well as inpatient and LTC home SU beds. When combined with home level demand analysis (waitlist) this can help determine future SU demand and also can contribute right sizing the unit.

  (LHINs regularly conduct supply and demand analysis to understand LTC bed distribution and need for redevelopment).

• Emerging research that explores predictors of LTC admissions and which post-acute services (including LTC) seniors use, can be useful for the estimation of future demand for SU services in a sub-region. All presentations and podcasts can be downloaded at http://clri-ltc.ca
  
  
  
  
  o Patrick, J. (2015) Improving transitions in care and wait times: Modelling community care services for alternate level of care (ALC) patients. A webinar

• The Health Planner’s Toolkit: The Planning Process (Health System Intelligence Project, The Ministry of Health and Long-Term Care (MOHLTC), 2006) http://www.health.gov.on.ca/transformation/providers/information/im_resources.html

• Specialty Population Roadmap (OLTCA, 2005) Available upon request. This document provides a detailed description of designing specialty programs in LTC.

STEP 2: STRENGTHEN PARTNERSHIPS

LEAD ORGANIZATION: LHIN and LTC home(s)

EXPECTED OUTPUTS AND OUTCOMES:

• Identified LTC home(s) interested in running the SU and committed to review requirements of designation process.

• Key stakeholders have been informed of the possibility of developing a SU and have confirmed their interest in supporting a LTC home through the designation process.

TASKS TO COMPLETE:

• Consult to assess the level of interest of those LTC home(s) in the region that:
  
  o have experience with providing the target service (most successfully designated Units are housed in LTC homes that had experience providing services and specialized programming to the target population for 2-5 years prior to designation, had well developed program plans and documented positive outcomes),

  o have existing connections with key stakeholders related to the target population and the proposed service, and

  o would have sustainable demand in their regular catchment area for the proposed service.

• Discuss plans with key stakeholders to get their input and buy in (e.g. CCAC, clinical partners, any community services for the potential clients, primary expected referring sources, associations, advocacy groups, and hospitals)
• Select a LTC home(s) to deliver the proposed program, based on their existing experiences or through a Request for Proposals.

BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:

• Which LTC home(s) in the region have experience with serving the target population? What has been the experience in these LTC homes’ with offering similar services?
  o What do they identify as the biggest barriers to their current programming model (e.g. offering the service without a designated SU)? How would designation help overcome these barriers?
  o How do the LTC homes identify clients who would benefit from their services? What are the characteristics of the people who would benefit from the Unit?
  o How does the LTC home know that the program is benefitting their clients?

• Are there other LTC homes in the region who may be interested in operating a SU?

• Who are the key stakeholders for this service to bring around the table (CCAC, clinical partners, any community services for the potential clients, primary expected referring sources, associations, advocacy groups, hospitals, potential host LTC home’s residents and their families)?

STEP 3: ASSESS LTC HOME’S READINESS FOR CHANGE

LEAD ORGANIZATION: LHIN and LTC home

A number of LTC homes could be completing this step in parallel, depending on the needs and capabilities of a region, and on the way the LHIN plans to allocate resources for a SU (e.g. sole sourcing or through a request for proposals).

EXPECTED OUTPUTS AND OUTCOMES:

• Internal validation of readiness and commitment from the LTC home to develop a proposal for a SU and to operate the new service.

• Understanding of areas of strength as well as areas that the LTC home may need to strengthen for successful implementation.

• LHIN confirmation that the LTC home is in good standing in terms of regulatory compliance and finances (external validation of readiness), and is therefore ready to develop a proposal for a designated SU.

TASKS TO COMPLETE:

• Assess LTC home’s experience with caring for the sub-population and whether it has strong links with relevant stakeholders and partners.

• Assess internal support across the organization, from front line to the Board of Directors, with special attention to existing residents and their families. It has worked well in the past for LTC homes exploring designation to organize meetings for each shift to get all the workers’ views, in combination with a short survey to assess staff’s comfort level with
offering a new service. Residents and families can be engaged through the monthly meetings of the Residents’ Council and the Family Council.

- Review LTC home’s past experiences with new program implementations and change in general.
- Identify strengths and gaps in the LTC home’s capacities (including culture of innovation, human resources, finances, and quality indicators).
- Review the LTC home’s regulatory compliance and financial records (external validation of readiness, due diligence). A review of the evidence of working collaboratively with others also helps position the LTC home as a committed systems player.

**BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:**

- How does the proposed service fit with the culture and expertise of the LTC home?
- What is the internal support across the organization (from front line to the Board of Directors, including residents and families)?
- What is missing in the LTC home? How can these gaps be addressed and how would designation help to fill these gaps?

**STEP 4: DEVELOP THE PROPOSAL**

*Note: The elements of a proposal are further described in the next section. Step 4 and the proposal elements should be reviewed together.*

**LEAD ORGANIZATION:** LTC home, LHIN, and partners

While this step is led by the LTC home and its partners who have experience with supporting the potential future clients of the proposed SU, the LHIN could also contribute and thus expedite the LHIN review of the final proposal (Step 5). Any Request for Proposals document from a LHIN would also provide a lot of guidance for the preparation of the SU proposal, especially related to regional priorities and expected demand.

**EXPECTED OUTPUTS AND OUTCOMES:**

- SU package for submission to the LHIN
- Strong partnerships built with key stakeholders, including existing relevant programs in other LTC homes that would help with setting up and operating the Unit after designation.

**TASKS TO COMPLETE:**

- Develop a comprehensive clinical and business case to establish the SU in the LTC home and obtain necessary organizational approvals.
  - Continue to consult with existing SU serving similar clients or LTC homes that offer similar programs, as well as with other stakeholders to get feedback and validate proposed program benefits, processes, costs, and feasibility. Experience shows that setting up a multi-stakeholder proposal development advisory group greatly helps with
this coordination and in obtaining consistent feedback. The terms of reference of the advisory group could be updated to ensure ongoing support for the Unit once designated. Clearly document these consultations, articulate the overall support for the proposal and show how the Unit will fit into the continuum of care for the community.

- Clearly identify the population to be served by the SU, how the care needs of the target population differ from those of other LTC home residents and how this justifies the designation of the Unit. The description should also include, if applicable, a clinical profile of the group to be served by the Unit.

- To determine the right size and characteristics of the Unit:
  
  - Assess both the local needs and the provincial-level needs; consider how far the clients and their families would be realistically willing to travel for the service. As discussed earlier, experience shows that in many Units, 70-80% of the residents come from the regular catchment area of the host LTC home.
  
  - In light of the SU policy’s stipulation that the Unit has to reach 97% occupancy within 3 months of designation, consider how many existing residents would benefit from the care and services of the proposed Unit, how long it would take to fill the remaining designated beds based on the regular turnover rate of the Home, and whether it is possible to have regular long-stay residents occupy a designated bed on a temporary basis (for example, a Behavioral Unit may not be able to safely mix regular LTC residents with Unit clients, depending on the characteristics of the people who would benefit from the Unit’s services). Existing designated SUs’ experience shows that reaching full occupancy with the targeted populations can take 12-18 months.
  
  - Assess the space requirements to accommodate best practice (e.g. should the Unit only have private rooms? Should there be space for intensive rehabilitation?)
  
  - Assess what staffing level and mix is indicated by best practice (e.g. if 1 extra RN and 3 extra PSWs would need to be added per 10 Unit residents, perhaps it is better to have 10 beds rather than 13 beds, even if there is space).
  
  - Review available space in the LTC home (e.g. should a whole unit of 26-32 beds be designated or could a sub-unit be created? Could this sub-unit have all the security features that might be needed, depending on the clients? Do the designated beds have to be congregated in a single unit of the Home or can they be spread across the LTC home?)
  
  - Ensure that the Unit will be financially viable for the LTC home to run. Determine how the Unit will be funded, if any additional funding approvals are required and how to access and secure these. Assess if the target population would be able to pay for private accommodation if this is part of the care plan requirements.

- Assess opportunities and risks presented by the proposed Unit (for the LTC home and the region), with mitigation strategies.

- Describe the accommodations, care, services, programs, and goods to be provided by the SU and how these differ in any way from those provided to residents in the general population of the LTC home. If the proposal contains an enhanced staffing model, the description should
compare the proposed staffing levels with those in other areas of the LTC home. Clearly articulate which portion of the services are enhanced.

- Make sure that care plans will be compliant with regulations. Even with the best laid out care plans, further discussions may be needed between the LTC home and the MOHLTC to ensure that what is proposed meets compliance requirements.

- Describe how the care plan will be adjusted for clients who are moving to a different LHIN once they have reached their clinical goals.

- Determine the indicators that will be used to evaluate the operation of the Unit, how the data will be collected and how the evaluation findings would be integrated into the Unit’s operation.

- Describe how the proposed Unit would advance the LHIN’s integrated health service plan.

- Based on the detailed business plan, prepare a proposal which may take the form of an HSIP (generally HSIP is the executive summary for a detailed business plan or initial pre-proposal).

**BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:**

- Which sub-group of LTC eligible clients are we proposing to serve and what are the details of our programs or services?

- How will we deliver the service – do we have a solid clinical and business case to setup the SU in our LTC home?

- Do we have the long-stay licences to dedicate to the Unit or do we need to seek additional licences?

- Do we have the demand to reach 100% occupancy in 3 months? What could prevent us from reaching 100% occupancy and how do we plan to manage these risks?

- Do we have a solid plan for facilitating appropriate care for the Unit’s clients once they reach their clinical goals and are ready to leave?

- Do we have the right stakeholders around the table to ensure that our “graduating” clients continue to receive the right care they need in a timely manner and in the right setting? Will these processes work for clients who return to their home or LTC home in another LHIN? If the Unit provides permanent care, what is our process to manage the Unit’s waiting list?

- How does the proposed Unit advance the LHIN’s and provincial priorities?

- Do we have indicators drawn from our past experience caring for these clients that can be used to report on utilization and evaluation of the effectiveness of the Unit?

**RESOURCES:**

- See the detailed proposal outline in this next section of this toolkit.

- *Government Grants and Other Funding Proposals: Beyond the Basics.* Occasional workshops organized by OANHSS.

• *A Guide to Planning and Conducting Program Evaluation* (Fraser Health, 2009)  

• *Framework for Program Evaluation in Public Health: A Checklist of Steps and Standards*  

• BetterEvaluation: An international collaboration to improve evaluation practice and theory by sharing and generating information about options (methods or processes) and approaches  

**STEP 5: REVIEW AND SIGN-OFF BY THE LHIN**

**LEAD ORGANIZATION: LHIN**

Active LHIN participation in the prior steps should facilitate and speed up this review.

**EXPECTED OUTPUTS AND OUTCOMES:**

• LHIN analysis and support are documented.

• Completed package submitted to the MOHLTC.

**TASKS TO COMPLETE:**

• Review the proposal and document from a regional perspective:
  
  o Opportunities and risks presented by the proposal with mitigation strategies.
  
  o Consultation with the community and stakeholders including the local CCAC to articulate how the Unit will fit into the continuum of care for the community and overall support for the proposal. This could include an independent clinical validation, from at least two clinical experts outside the LTC home, that the proposed model will meet the needs of the identified population.
  
  o Analysis of local pressures on the health care system (such as funding, ALC, and human resources limitations), effects of the program on other health care sectors, and how the proposed SU will impact these pressures.
  
  o A review of the LTC home’s licensing and compliance history under LTCHA to determine whether there are any outstanding issues.
  
  o A review of the budget submission to identify:
    
    ▪ How the Unit will be funded.
    
    ▪ Any additional funding approvals required.
    
    ▪ Any concerns related to the budget as submitted.

• Prepare LHIN support documents for designation to be submitted to the MOHLTC (Director, Licensing and Policy Branch) that includes:
  
  o An assessment identifying the need for the Unit, taking into account the input of the CCAC, the LTC home and others (e.g. clinical experts), with the input from each clearly
noted. Needs analysis should be based on the statistics that highlight a need for such a unit, the number of the prospective residents and why their particular needs cannot be met in a regular LTC long-stay bed.

- An analysis of the advantages and disadvantages of the Unit. Present information about the impact that the designation will have on the availability of long-stay beds in the LHIN’s geographic area (e.g. impact on the LTC home, its residents and the broader community). Other service delivery options considered should be included together with the rationale on why these were not chosen.
- A summary of the LTC home’s readiness for change.
- A description of the resident population to be served by the SU.
- A description of the SU and how it differs in any way from the care and other elements provided to residents in the rest of the LTC home.
- A statement that the LHIN is satisfied that the licensee will be financially capable of providing what the Unit needs, including a detailed estimate of the cost of the Unit, a full budget, information about the sources of the funding, and what additional funding the Unit needs.
- A statement/letter from the licensee that it agrees to the proposed designation.
- A detailed proposal for the monitoring, evaluating, and reporting on the utilization and effectiveness of the SU, demonstrating alignment with relevant provincial evaluation frameworks.
- A summary of the LHIN’s proposal review process.
- A statement that the LHIN is satisfied that the LTC home has the necessary skills and experience to provide the care and services required in the Unit.
- LHIN confirmation that the Unit has a plan for managing resident discharges to regular areas within the LTC home and elsewhere that complies with the requirements of the LTCHA and Regulation.

**BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:**

- Is this a comprehensive (clinically, financially, and organizationally sound) proposal that the LTC home can deliver?
- How does the proposed Unit fit in with the LHIN’s integrated health service plan?
- How will the Unit be funded?
- What is the appropriate length of designation based on the proposal, existing best practice for the service, and LHIN programming priorities – pilot (for how many years?) or non-time limited designation?
- Does the proposal require additional licenses to be allocated/transferred to the LTC home (if required in the proposal)?
STEP 6: REVIEW BY THE MOHLTC

LEAD ORGANIZATION: MOHLTC Licensing and Policy Branch

EXPECTED OUTPUTS AND OUTCOMES:
• MOHLTC grants pilot (time-limited) designation.

TASKS TO COMPLETE:
• Review and analyze the LHIN’s recommendation and the proposal. Ensure that the right departments in the Ministry and other relevant ministry partners contribute (including but not limited to the LHIN Liaison Branch, the Financial Management Branch, and the Health Capital Investment Branch). The review might lead to questions for the Unit proponents (LHIN and LTC home) to seek clarifications.
• The MOHLTC LTC Service Area Office may conduct a pre-occupancy review.
• Make decision about whether to designate the Unit or not.
• If a management contract is required to operate the SU, the MOHLTC must review and approve before the SU opens.
• If included in the proposal, review and approve an increase in the licensed or approved bed capacity.

BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:
• How does the proposed Unit advance the LHIN’s priorities?
• How does the Unit advance the province’s priorities?
• Is the proposal clinically (goals, processes), organizationally, and financially (comprehensive, sustainable budget) sound?
• Does the proposed host LTC home have the capacity to run the unit? Is it currently compliant? Is it currently in good standing?
• How long should the Unit be designated for – pilot or non-time limited?
• Is this a Unit model that could be explored across the province?

STEP 7: AWARD PILOT DESIGNATION

LEAD ORGANIZATION: MOHLTC and LHIN

EXPECTED OUTPUTS AND OUTCOMES:
• The LTC home enters an agreement with the LHIN to operate the SU through a separate agreement or an addendum to an existing agreement.

TASKS TO COMPLETE:
• MOHLTC informs the LHIN and LTC home about the designation decision and the terms and conditions, copying the CCAC and relevant ministry departments.
• If an increase in the licensed or approved bed capacity is needed, the MOHLTC undertakes a licensing review process for the appropriate licences under the LTCHA.

• The LHIN prepares a Specialized Unit Addendum to the Long-Term Care Home Service Accountability Agreement (L-SAA). The operation of the Unit is subject to the terms and conditions in an agreement (the L-SAA or another agreement, as the case may be). The agreement must include any terms and conditions specified by the Director as part of the designation of the Unit.

BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:

• What is the appropriate length of designation based on the proposal, existing best practice for the service, and LHIN programming priorities and budget?

STEP 8: SET UP, OPERATE AND EVALUATE THE SPECIALIZED UNIT

LEAD ORGANIZATION: LTC home and partners
The LHIN remains a key contact throughout the operation of the SU. The LTC home is required to submit reports and the LHIN oversees the external evaluations mandated in the Unit’s evaluation plan.

TASKS TO COMPLETE:

• Prepare and implement a work plan for Unit setup based on the original proposal and the terms and conditions set by the MOHLTC.

• Review and update the multi-stakeholder proposal development advisory group’s terms of reference to ensure that the Unit continues to receive relevant stakeholders’ support.

• Conduct regular data collection, monitoring, and internal/external evaluations as outlined in the evaluation plan. Consistent evaluation and analysis are the most important tools to show that the Unit is of the right size and that the resources are efficiently and effectively allocated.

• Report all additional funding related to the Unit in the LTC home’s annual reconciliation report. Generally this is a separate budget line in the Nursing and Personal Care and/or Program and Support Services envelope(s).

BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:

• Do we have the right stakeholders in our advisory group and do we receive the support we need from each?

• How are we delivering on our goals (process, compliance, and finance indicators) and expected outcomes (client outcome and system transformation outcome indicators)?
**STEP 9: REQUEST RE-DESIGNATION**

**LEAD ORGANIZATION:** LHIN & LTC home

**TASKS TO COMPLETE:**

- If the original designation is time-limited and if the LTC home satisfactorily delivers on the Unit’s goals, as evidenced by the evaluations, the LHIN consults with the LTC home to determine if the designation should be renewed.

- Six months prior to the end of the existing designation, submit a request to the MOHLTC to extend the time period of designation or to seek non-time-limited designation. The submission must include the evaluation reports and the rationale for the renewal.

**BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:**

- How is our original service approach and model standing up to the test of time (Does the care model still fit with best practice? Do processes work? Does demand remain strong? Are short- and long-term client outcomes consistently met? Is this still the best setting to offer the service? How is it contributing to system transformation?)

- How have evaluation findings been integrated into the Unit?

**STEP 10: AWARD RENEWAL PERIOD OR NON-TIME LIMITED DESIGNATION**

**LEAD ORGANIZATION:** MOHLTC

**OUTCOME:** The Unit receives non-time limited designation

**TASKS TO COMPLETE:**

- Determine if the designation should be granted, in consultation with the LHIN and other relevant ministry departments and ministry partners.

**BY THE END OF THIS STEP, YOU SHOULD BE ABLE TO ANSWER THE FOLLOWING KEY QUESTIONS:**

- How does the original service approach and model stand up to the test of time (e.g. Is it still system transformative? Does it still fit with best practice? Is it still the best setting to offer the service? Is the program sustainable? Are short- and long-term client outcomes and organizational goals consistently met? Is it contributing to system transformation?)

- How has the Unit integrated learnings from evaluations and from others’ experiences?

- What are the benefits and risks of moving from pilot to non-time limited designation?

Note: The MOHLTC retains the right to revoke the Unit’s designation, or the LHIN and the LTC home might decide to let the designation expire. In the event that a SU is revoked:

- The MOHLTC is required to provide a six months’ notice of the revocation/expiration to the licensee, LHIN, and CCAC placement coordinator.

- Upon receipt of the notice, the LHIN, LTC home, and the CCAC prepare for the MOHLTC a plan and timeline for the accommodation, care, and services of the residents of the Unit.
• Once the MOHLTC approves the closure plan:
  o The LTC home must implement it by providing each affected resident and their substitute decision maker with a written notification of the change and begin the process of making alternate arrangements.
  o The CCAC informs applicants on the Unit’s waiting list that the designation is being revoked or is expiring, abolishes the separate waiting list and ceases the authorization of admissions to the Unit.

ELEMENTS OF A PROPOSAL

A LTC home interested in operating a SU must submit an application to its LHIN. The proposal is often developed collaboratively by the LTC home, the LHIN, and partners who have supported the type of clients who would benefit from the new Unit. The proposal must contain all the requirements laid out in the LTCHA, Regulation and Policy. This detailed project plan must articulate the model for the SU as well as an implementation plan and schedule.

A review of the 10 Steps for designation outlined in the toolkit above will help the partners to ensure robust information gathering and collaboration for a strong proposal.

DESCRIPTION OF THE LTC HOME HOSTING THE UNIT

• Information about the licensee, LTC home, current beds (including numbers and types of long-stay and short-stay beds), and other SUs in the LTC home.
• Describe how the proposed Unit will fit into the LTC home’s organizational structure.

DESCRIPTION OF THE PROPOSED UNIT AND PROGRAM

• Unique resident population to be served
  o A detailed resident profile and how they are distinguished within the long-term care population (see in the Appendix an example of the admission criteria for a Behavioural Support Unit)
  o Existing and projected demand for the services
  o Admission criteria
  o Information on how the needs of residents in this sub-group are not currently being met
• The number and type of licensed/approved beds to be designated within the unit.
• The term of the proposal (e.g. time-limited or non-time-limited).
• The description of the unique accommodation, care, services, programs and goods to be provided to residents in the Unit, and what will differ in any way from that which is provided in the rest of the LTC home:
  o Type of services and support to be provided - transitional or permanent
• Care delivery approach
  ▪ How the needs of the unit residents will be met
  ▪ Appropriate staff mix and staff levels, and how these differ from other areas of the LTC homes
  ▪ Training requirements (at start up and ongoing)
  ▪ Space, environment/facility, supplies, storage, equipment, and information system requirements
• Describe how the program will fit into the continuum of care for the community and overall support for the proposal from different stakeholders consulted.
• Opportunities and risks presented by the proposed program with mitigation strategies

CAPACITY OF THE LTC HOME TO PROVIDE THE PROGRAM
• The LTC home’s clinical readiness to provide the type of care, accommodation, and services proposed, including expertise with providing the care and services and the existing physical environment
• Human resources plan for staffing within the SU
• Links with and support from stakeholders (this could be in the form of a project charter)
• Senior management support and readiness
• The LTC home’s present and past history of compliance with requirements under the LTCHA
• The LTC home’s financial capability to provide the proposed services

COMPREHENSIVE ADMISSION AND DISCHARGE PLANS
• A policy/plan to communicate with the applicant/family/substitute decision maker about the Unit prior to and during a stay in the Unit.
• Include the requirement (based on regulation) to discharge the resident when:
  o He/she no longer requires or benefits from being in the Unit, and alternate arrangements have been made
  o When an appropriate bed becomes available in another area of the LTC home for a resident who was admitted from the regular waiting list.
• If applicable, an explanation of how the Unit will manage discharges to other areas of the LTC home or other LTC homes
• A process for ongoing collaboration with the CCAC for managing discharge to other settings (e.g. home, community, or other LTC home).
• A plan for knowledge transfer and provision of any available supports to the receiving LTC home/other destination (prior to and post discharge).
FINANCIAL PLAN

• Detailed budget (of start-up and/or ongoing funding) that aligns with the MOHLTC’s financial policies and provincial program guidelines. Only the incremental costs associated with the SU should be included.

• Costing estimates should be supported with assumptions, such as the number and type of FTEs and strong justification that is consistent with the proposal details, including the care plan.
  o Include all details that the LHIN and the MOHLTC need to assess if the budget items and costs match and support the care model. These should also be rolled up into higher level categories. Ultimately, the funder needs to know that the proposed budget is realistic and is neither too little nor is it inflated.
  o Start-up budget items may include but are not limited to: renovations to the physical environment, purchase of specialized equipment, training and recruitment of staff.
  o Operating budget items may include but are not limited to: incremental staff increases, supplies or other equipment needs, ongoing training of new and existing staff.

• Funding sources and approvals required.

• Plans to ensure that 97% or higher occupancy is achieved within 90 days of designation.

COMMUNICATIONS PLAN

• Describe how to reach clients, families, substitute decision maker, and circle of care members, covering the whole care cycle in the Unit from intake to discharge

• Address how the LTC home will work with the local CCAC and referring hospitals to:
  o Create an awareness of the Unit,
  o Ensure that the CCAC has a full understanding of the Unit’s goals and profile of the resident population served, and
  o Ensure that there’s an appropriate flow of information between the LTC home, the CCAC, and other relevant partners.

MONITORING AND EVALUATION PLAN

• The Unit will continue to collect all regular LTC indicators. Looking at these for the Unit and comparing them with the results of the host LTC home’s general population could be useful for adjust programming. Comparing results for the home before and after the establishment of the Unit can also illuminate the benefits of the specialized programming.

• In addition, the proposal must address Unit-specific resident-centered outcomes, program goals, system impacts appropriate for the target client group and the proposed program, including but not limited to:
  o Indicators, monitoring and evaluation methods for implementation/process, output and outcome evaluation
- Resident outcomes (how assessed goals were or were not met)
- Benefits to residents and, if applicable, family members
- Any challenges experienced by the residents and family members, if applicable
- Information on how residents who did not meet the goals of the program were assisted
- Resident and family satisfaction
- Assessment of the staffing model (how the staffing compares with best practices, if these exist, and/or whether the proposed model has required adjustments to better meet resident needs)
- Program operational measures (e.g. wait times, length of wait list, length of stay, SU ALC length of stay)
- System measures (e.g. impact on ALC days, emergency department visits after discharge and during admission, readmissions to the Unit, comparing cost of taking care of a resident in the Unit, in a hospital, or in the community)
- Data related to Unit admission and discharge (e.g. calls from interested persons, waitlist management, referral/admission/discharge times)
- Financial and budget data (including an assessment of the cost to run the SU as compared to regular areas of the LTC home, and a separate accounting of start-up costs and regular operating costs)
- An assessment of resident outcomes beyond the SU: once goals are met, the status of residents returned to a regular long-stay bed or other setting (e.g. did the individual remain stable in the destination home or did the individual experience regression, additional ER visits or hospitalizations that should have been minimized through the supports provided in the SU).

• Plan on how to report on the utilization and effectiveness of the Unit.

• If a proposal is for a type of SU that is already in existence, there should be a clear indication that the proposed monitoring, evaluation, and reporting on the utilization and effectiveness of the new Unit would follow or was built on the existing Unit’s framework. This will ensure data consistency, which in turn will enable comparisons, promotion of best practices, and better informed consideration of future policy directions.

• The proposal should also provide an overview of data sources (e.g., RAI MDS, electronic patient record, and resident/family surveys) and mechanisms to collect data (e.g. could include qualitative methods, such as interviews).
## APPENDIX

### COORDINATES OF EXISTING SPECIALIZED UNITS IN ONTARIO’S LTC HOMES (FEBRUARY 2016)

<table>
<thead>
<tr>
<th>No. for Map 1</th>
<th>LTC Home’s Name</th>
<th>Coordinates</th>
<th>Type of Unit</th>
<th>Date of Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Baycrest Jewish Home for the Aged</td>
<td>3560 Bathurst Street, Toronto, ON, M6A 2E1 Tel: (416) 785-2500 <a href="http://www.baycrest.org/care/care-programs/behavioural-support-for-seniors-program-bssp/">http://www.baycrest.org/care/care-programs/behavioural-support-for-seniors-program-bssp/</a></td>
<td>Behaviour Support Unit</td>
<td>September 2012</td>
</tr>
<tr>
<td>2</td>
<td>Cummer Lodge</td>
<td>205 Cummer Ave., North York, ON, M2M 2E8 Tel: (416) 392-9500 <a href="http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=81dd3293dc3ef310VgnVCM1000071d60f89RCRD">http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=81dd3293dc3ef310VgnVCM1000071d60f89RCRD</a></td>
<td>Behaviour Support Unit</td>
<td>September 2012</td>
</tr>
<tr>
<td>3</td>
<td>Hogarth Riverview Manor</td>
<td>300 Lillie St. North, Thunder Bay, ON, P7C 4Y7 Tel: (807) 625-1110 <a href="http://www.sjcg.net/services/long-term-care/homes/hrm.aspx">http://www.sjcg.net/services/long-term-care/homes/hrm.aspx</a></td>
<td>Behaviour Support Unit</td>
<td>Spring 2013</td>
</tr>
<tr>
<td>4</td>
<td>Linhaven Home for the Aged (T. Roy Adams Regional Centre for Dementia Care)</td>
<td>403 Ontario Street, St. Catharines, ON, L2N 1L5 Tel: (905) 934-3364 <a href="http://www.niagararegion.ca/living/seniors/long-term-care/locations/linhaven.aspx">http://www.niagararegion.ca/living/seniors/long-term-care/locations/linhaven.aspx</a></td>
<td>Behaviour Support Unit</td>
<td>2012</td>
</tr>
<tr>
<td>8</td>
<td>Sheridan Villa</td>
<td>2460 Truscott Dr., Mississauga, ON, L5J 3Z8 Tel: (905) 791-8668 <a href="http://peelregion.ca/ltc/sheridan/index.htm">http://peelregion.ca/ltc/sheridan/index.htm</a> or see the presentation “Behaviour Support Project” by the Region of Peel Long Term Care Division on <a href="http://brainexchange.ca">Brainexchange.ca</a></td>
<td>Behaviour Support Unit</td>
<td>September 2010</td>
</tr>
</tbody>
</table>
ACCESS AND REFERRALS TO THE BAYCREST TRANSITIONAL BEHAVIOURAL SUPPORT UNIT

BAYCREST BEHAVIOURAL SUPPORT FOR SENIORS PROGRAM:

Source: http://www.baycrest.org/care/care-programs/behavioural-support-for-seniors-program-bssp/ (Last accessed on February 27, 2016)

From the Factsheet on the Transitional Behavioural Support Unit (TBSU):

Access and Referrals:
The Toronto Central Community Care Access Centre (TCCAC) is responsible for assessing and determining eligibility of all clients for long-term care homes and, as such, referrals to the TBSU are processed through the TCCAC. Clients will be screened for eligibility according to the following criteria:

- Medically stable
- Eligible for LTC placement as determined by TCCAC
- Primary diagnosis of progressive dementia with behaviours that cannot be managed in current environment; other individuals with unprovoked responsive behaviours will be considered on a case by case basis
- Delirium has been ruled out
- Available community and/or hospital-based specialized psychogeriatric resources have been trialed and evaluated to be inappropriate or unsuccessful
- Behavioural pharmacological review and reconciliation of medications (e.g. CCAC Medication Management program) has been completed
REFERRAL SOURCE FACT SHEET FOR SHERIDAN VILLA SPECIAL BEHAVIOUR SUPPORT UNIT

WHAT IS IT?
The Special Behaviour Support Unit (SBSU) is a TREATMENT TRANSITIONAL unit for clients who have a primary diagnosis of dementia with significant behavioural disturbances. Being treated in the SBSU is one option in a continuum of care for clients with dementia. The SBSU is not intended to be a resource for emergency treatment or intervention.

WHAT IS THE GOAL OF THE SBSU?
The residents of this unit will be treated by an interdisciplinary group of staff and community partners working together to stabilize the resident’s behaviours to a point where they can be managed in a normalized long-term care setting.

HOW WILL I KNOW IF A CLIENT IS ELIGIBLE?
Residents will be admitted to the unit based on the following eligibility criteria:
- Eligible for long-term care placement
- Primary diagnosis of progressive dementia with significant behavioural disturbance
- Medically stable with medical needs that can be managed on the unit
- Ambulatory (self-mobile), Ambulatory with aide, or requires one or two person transfer
- Behaviours that cannot be managed in the current environment and require specialized resources outside of those offered in a normal long-term care setting
- Available community specialized geriatric resources have not been successful at treating or managing the condition
- Available community, tertiary, and/or hospital-based specialized geriatric resources have been tried, but the individual requires a further period of treatment and stabilization before transfer to a normalized long-term care home (LTCH).

WHO WOULD NOT BE CONSIDERED FOR THE SBSU?
- Individuals who require hospital-based care
- Individuals with major psychiatric disorder as the primary cause of cognitive impairment
- Individuals who have acquired brain injury.

HOW DO I APPLY ON BEHALF OF A CLIENT?
Contact the CCAC at 1-877-336-9090.

This program receives additional funding from the Mississauga Halton Local Health Integration Network.
ADMISSION CRITERIA FOR BELLEVILLE BEHAVIOURAL SUPPORTS TRANSITION UNIT (BSTU)

Note that the BSTU is housed in a hospital; it is NOT a designated Specialized Unit in a LTC home. [http://www.qhc.on.ca/behavioural-supports-transition-unit.php](http://www.qhc.on.ca/behavioural-supports-transition-unit.php)

The BSTU is a resource for individuals living in South Eastern Ontario who may currently be at home, in a retirement home, long-term care home, or admitted in a hospital who meet all of the following criteria:

- Age-related cognitive impairment and responsive behaviours which could include people with Alzheimer’s Disease, vascular dementia, frontal-temporal dementia, Lewy Body disease, alcohol-related dementia, mixed dementias, or unspecified dementia;
- Behavioural health needs that currently exceed available resources such as those available through the Alzheimer’s Society, Community Care Access Centre, and/or community-based Behavioural Support Services/Seniors Mental Health Services; and
- Medical comorbidities (other health issues) that can typically be managed in a home or other community setting.

People not typically serviced by the BSTU include:

- Those requiring initial workup and treatment of acute delirium;
- Those with responsive behaviours NOT due to age-related cognitive impairments;
- Those who have been stabilized in other Units;
- Those requiring dialysis may be considered on a case-by-case basis; or
- Those experiencing psychiatric issues, such as: severe and/or frequent behaviours requiring high-intensity support, admission under the Mental Health Act, severe mental illness, or those requiring on-going ECT treatments.
ADMISSION, REFERRAL & DISCHARGE PATHWAY: T. ROY ADAMS CENTRE FOR DEMENTIA CARE, LINHAVEN HOME FOR THE AGED

INITIAL INQUIRY/REFERRAL CCAC

Inquiry to CCAC initiates information exchange with CM placement team assigned to Adams Centre ATDT

NOT INTERESTED

process stops

INTERESTED

CM sends out info package
CM receives and records initial client information
Eligibility & assessment proceedings

NOT ELIGIBLE

Referred to other community support services i.e., St. Joseph's, St. Peters, ACO, Society, PRC, GMHO, SCP, CCAC

CCAC CM

- Provides information about specialized dementia services
- Initiates screening for Admission

CCAC establishes eligibility according to Provincial eligibility criteria and Ministry of Health Long-Term Care guidelines & Adams Centre Admission Criteria

File is forwarded to ATDT for review to determine suitability

ADMITTED

CCAC contacts family/referral source to:
- Offer the bed
- Arrange pre-admission consultation with Adams Centre staff
- Arrange admission date

Accepted

CCAC contacts family/referral source to:
- Notify of refusal to share all relevant information
- Determine appropriate referrals to assist with presenting issues of concern
- Facilitate consultation with specialized service providers across the continuum of care

Refused/Referred

CCAC contacts family/referral source to:
- Notify of refusal to share all relevant information
- Arrange admission date

Acceptance is determined upon:
- Consideration of client's cognitive complexity & frequency of client behaviours
- Degree of risk to self & others
- Ability of staff to respond to client need
- Ability of physicial environment to respond to client need

Suitable

ATDT receives client file with all associated assessment and referral information

Guided by Admission Criteria:
ADT revalues eligibility:
1. Diagnosis of dementia
2. Medically stable
3. Behaviourally Stable

ATDT assesses suitability:
1. Complexity of identified behaviours
2. Frequency of identified behaviours
3. Effectiveness of existing interventions

Degree of risk is assessed

Exits acceptance is determined upon:
- Consideration of client's cognitive complexity & frequency of client behaviours
- Degree of risk to self & others
- Ability of staff to respond to client need
- Ability of physical environment to respond to client need

Ongoing communications/care conferences between the Adams Centre RN and the receiving/referring facility and/or family will facilitate a successful transition/discharge and will be scheduled upon admission to the Adams Centre, at 60 days and 2 weeks prior to discharge

Discharge Summary: the Adams Centre RN will provide a discharge summary for the receiving location staff

Discharge process includes:
- A discharge summary presented to the ATDT indicating the client has achieved goals/expectations & is ready for discharge

Consultation & Collaboration with all partners in care across the continuum of care is valued and encouraged

Our goal: To provide Transitional Support and facilitate a successful discharge:
- To coordinate care & provide continuity as individuals transition from the Adams Centre to 'home' in a LTC home or in the community
- Based on comprehensive assessment and 'discharge plan' that identifies the individual's goals & interventions

Provides on-sit support & education to staff at the receiving/referring facility, which will enable them to fully understand and implement the discharge plan and individualized plan of care

Involves a synopsis of the diagnosis, describing the presenting features of the diagnosis and the specifics of the individual's plan of care

Provides family support

Provides liaison with other partners in care
A SNAPSHOT OF THE DESIGNATION PROCESS

<table>
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<tr>
<th>WHO LEADS?</th>
<th>STEPS TO DESIGNATION</th>
<th>KEY QUESTIONS TO ANSWER</th>
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</table>
| LHIN possibly with Home | Service gap analysis | • What are the biggest service gaps in our region?  
• Demand: What are the characteristics of a client who would benefit from this service? What demand do we see in our region? What trends could affect demand (scenario analysis)?  
• What do best practices for this service tell us about the pros and cons of using a Specialized Unit to fill this service gap? Who is serving these clients in our region? |
| LHIN & Home(s) | Partnership strengthening | • Which Home(s) in the region has experience with serving the target population?  
• Who are the key stakeholders for this service to have around the table (LHIN, CCAC, clinical partners, primary expected referring sources, advocacy groups)? |
| LHIN & Home | Readiness for change assessment | • How will we deliver the service (full clinical and business case)? Do we have the right partners?  
• Do we have the licenses to dedicate and the demand to reach 100% occupancy in 3 months?  
• How does the proposed Unit advance the LHIN’s priorities? |
| Home, LHIN & partners | Proposal development | • Is this a comprehensive (clinically & financially sound) proposal that the Home can deliver?  
• How does the proposed Unit fit in with the LHIN’s integrated health service plan?  
• How will the Unit be funded? |
| LHIN | LHIN review and sign off | • How does the proposed Unit advance the LHIN’s priorities?  
• How does the Unit advance the province’s priorities?  
• Is the plan clinically (goals, processes) & financially (comprehensive, sustainable budget) sound? |
| MOHTLC | MOHTLC review | • What is the appropriate length of designation based on the proposal, existing best practice for the service and LHIN programming priorities and budget? |
| MOHTLC & LHIN | Pilot designation | • How are we delivering on our goals (process, compliance and finance indicators) and expected outcomes (client outcome and system transformation outcome indicators)?  
• How is our original service approach standing up to the test of time (Still fits with best practice? Our processes work? Demand remains strong? Our short- and long-term client outcomes consistently met? Still best setting to offer service? How system transformative?)  
• How have we integrated evaluation findings into our Unit’s operation?  
• How is the original service approach standing up to the test of time (Still system transformative?  
Still fits with best practice? Still best setting to offer service? Is program sustainable? Are short- and long-term client outcomes and organizational goals consistently met?)  
• How did the Unit integrate learnings from evaluations and from others’ experiences?  
• What are the benefits and risks of moving from pilot to non-time limited designation? |
| Home & partners | Unit set up, operation and evaluation | • How is the original service approach standing up to the test of time (Still fits with best practice? Our processes work? Demand remains strong? Our short- and long-term client outcomes consistently met? Still best setting to offer service? How system transformative?)  
• How have we integrated evaluation findings into our Unit’s operation?  
• How is the original service approach standing up to the test of time (Still system transformative?  
Still fits with best practice? Still best setting to offer service? Is program sustainable? Are short- and long-term client outcomes and organizational goals consistently met?)  
• How did the Unit integrate learnings from evaluations and from others’ experiences?  
• What are the benefits and risks of moving from pilot to non-time limited designation? |
| LHIN & Home | Re-designation request | • How is the original service approach standing up to the test of time (Still fits with best practice? Our processes work? Demand remains strong? Our short- and long-term client outcomes consistently met? Still best setting to offer service? How system transformative?)  
• How have we integrated evaluation findings into our Unit’s operation?  
• How is the original service approach standing up to the test of time (Still system transformative?  
Still fits with best practice? Still best setting to offer service? Is program sustainable? Are short- and long-term client outcomes and organizational goals consistently met?)  
• How did the Unit integrate learnings from evaluations and from others’ experiences?  
• What are the benefits and risks of moving from pilot to non-time limited designation? |
| MOHLTC | Non-time limited designation |

For more details see *Ensuring the Care Is There: Meeting the Needs of Ontario’s Long-Term Care Residents*. Submission by the OANHSS to the Ontario Standing Committee on Finance and Economic Affairs January 2016; *This is Long Term Care 2015* by the Ontario Long Term Care Association.

At the writing of this toolkit, province-wide discussions were underway about the possibility of “Transfer direct responsibility for service management and delivery from the Community Care Access Centres (CCACs) to the LHINs.” (*Patients first: A proposal to strengthen patient-centred health care in Ontario*). Discussion paper. MOHLTC, December 17, 2015.

For details on the research project see Porteous et al. (2016) *Facilitating Long-Term Care (LTC) System Change – Specialized Units in LTC Homes*. Webinar presented by the Bruyère Centre for Learning, Research and Innovation in Long-term Care on February 11, 2016. Slides and webcast are available at cli-ltc.ca. The research team included: Amy Porteous, from Bruyère Continuing Care and Peter Walker, Melissa Donskov, Tracy Luciani and Zsófia Orosz from the Bruyère Research Institute.

For experiences in different jurisdictions in Canada and examples of approaches around the world, see Orosz, Z. (2014) *Specialized Units: Reviewing the experience of offering specialized care in Ontario’s long-term care homes*. A report to the Bruyère Centre for Learning, Research and Innovation, Ottawa:ON. Available upon request.

*Preyra Solutions Group (2014) 15 Ways to Improve Long-Term Care Planning*. A discussion paper for the Ontario Long-Term Care Association.

*Ontario’s Action Plan for Seniors* (2013) committed to enhance specialized care in LTC homes to help individuals with complex needs: *Enhanced Long-Term Care: ... Also to be included in this proposed amendment will be other improvements, such as staff training and developmental opportunities that focus on improving resident safety, preventing abuse and neglect, and advancing quality of care for residents with responsive behaviours or other specialized care needs, including residents with palliative or end-of-life care needs* (Action Plan for Seniors, p. 11). This commitment built on a number of past reports, including the Walker report (*Caring for our Aging Population and Addressing Alternative Level of Care*). MOHLTC 2011 and the Sinha Report 2013. Analysis by the Ontario Association of Non-Profit Homes and Services for Seniors and by Ontario Long Term Care Association have also recognised the role these Units play in the continuum of care (see most recently in *Action for Seniors: Four priorities to keep Ontario from failing its seniors in long-term care 2016* Ontario Pre-Budget Submission by the Ontario Long term Care Association [http://www.oltca.com/OLTCA/Documents/Reports/2016OLTCABudgetSubmission.pdf] and *Ensuring the Care Is There: Meeting the Needs of Ontario’s Long-Term Care Residents*. Submission by the OANHSS to the Ontario Standing Committee on Finance and Economic Affairs January 2016. [https://www.oanhss.org/MediaCentre2/PositionPapers/Feb_2016_Ensuring_the_Care.aspx](https://www.oanhss.org/MediaCentre2/PositionPapers/Feb_2016_Ensuring_the_Care.aspx).

For more details on the 2013 changes see *OHA Backgrounder: Amendments to Regulation 79/10 under the Long-Term Care Homes Act* (October 2013)

**References**