Chapter 3
Section
3.08

Ministry of Health and Long-Term Care

# Long-term-care Home Placement Process

## Background

Long-term-care homes (LTC homes) provide care, services and accommodation to people who require the availability of 24-hour nursing care, supervision in a secure setting, or frequent assistance with activities of daily living such as dressing and bathing. LTC homes are sometimes referred to as nursing homes or homes for the aged. They may be for-profit, not-for-profit, or municipally run organizations, and often have waiting lists for their beds.

In July 2010, the *Long-Term Care Homes Act, 2007* (Act) came into effect upon finalization of related regulations. This Act replaced the *Nursing Homes Act*, the *Charitable Institutions Act* and the *Homes for Aged and Rest Homes Act*. It governs the process for placing people in LTC homes, and authorizes the province's 14 Community Care Access Centres (CCACs) to manage this process (see Figure 1 for CCAC boundaries). Accordingly, the CCACs determine eligibility for admission, prioritize eligible individuals on LTC homes' wait lists and arrange placement when a bed becomes available. In the 2011/12 fiscal year, the CCACs placed more than 25,000 people in Ontario's 640 LTC homes, which have a total of 76,000 long-term-care beds that are over 97% occupied. About 85% of the people placed were aged 75 and older.

Each CCAC reports to one of 14 Local Health Integration Networks (LHINs). In the 2011/12 fiscal year, the Ministry of Health and Long-Term Care (Ministry) provided $2.1 billion of funding to the CCACs through the LHINs. This funding covered the CCACs' LTC home placement services, as well as their other activities, including the provision of home care and community support services. Information was not available on the cost of LTC home placement alone. The Ministry, to which the LHINs are accountable, is responsible for ensuring that CCACs comply with provisions for LTC home placement under the Act.

## Audit Objective and Scope

The objective of our audit was to assess whether the processes in place at selected CCACs were effective for placing individuals in LTC homes in a consistent and timely manner, based on their needs and in accordance with ministry and legislative requirements.

We conducted our audit work at three Community Care Access Centres of different sizes: Central East CCAC (responsible for 9,700 LTC home beds, with head office in Whitby); North East CCAC (responsible for 5,000 LTC home beds, with head

**Figure 1: Community Care Access Centre Boundaries**
Source of data: Ontario Association of Community Care Access Centres

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

office in Sudbury); and Waterloo Wellington CCAC (responsible for 3,800 LTC home beds, with head office in Kitchener). Senior Ministry and CCAC management reviewed and generally agreed to our audit objective and associated audit criteria.

The scope of our audit included a review and analysis of relevant files and administrative policies and procedures, as well as interviews with appropriate CCAC and ministry staff. We also reviewed relevant research, including best practices for the LTC home placement process in other jurisdictions. In addition, we obtained the perspective of the Ontario Association of Community Care Access Centres, which represents the 14 CCACs; the Ontario Long-term Care Association and the Ontario Association of Non-profit Homes and Services for Seniors, which between them represent the majority of LTC homes in the province; and the Advocacy Centre for the Elderly, which represents low-income seniors. We also used computerized data extraction techniques to analyze data from the Ministry's Client Profile Database, which includes LTC home placement information received from the CCACs.

We did not rely on reports from the Ministry's internal audit service team because it had not conducted any work on the CCACs' LTC home placement processes.

## Summary

Since 2005 the number of Ontarians aged 75 and over has increased by more than 20%, which has undoubtedly been a key reason why the median time that people wait for accommodation in an LTC home has almost tripled—from 36 days in the 2004/05 fiscal year to 98 days in the 2011/12 fiscal year. Although wait times have decreased somewhat since July 2010, when tighter eligibility criteria in the *Long-Term Care Homes Act* took effect, Ontario's population of people aged 75 and up is expected to grow by almost 30% between 2012 and 2021, creating additional pressures to meet the needs of people who require long-term care. As well, beginning in 2021, the first of the baby boomer generation—those born between 1946 and 1964—will start to turn 75, at which point the

demand for long-term care is expected to become even greater.

While CCACs are responsible for the process of placing individuals in LTC homes, numerous factors outside their control affect wait times for placement. In particular, the Ministry of Health and Long-Term Care (Ministry) is responsible for the number of available LTC home beds; individuals are allowed to select the LTC home(s) that they are willing to be placed in; and LTC homes may reject applications if they believe their home lacks the nursing expertise or physical facilities needed to meet the applicant's care requirements.

Numerous studies have shown that remaining in hospital longer than medically necessary is detrimental to a patient's health, yet many people wait in hospital for an LTC home bed to become available, which occupies a hospital bed that is often needed by other patients who have more complex health-care needs. As well, occupying a hospital bed is more expensive than community-based alternatives. This situation is exacerbated because people can wait in hospital for the LTC home(s) of their choice, even if the chosen home(s) have a lengthy wait list. We noted that during the 2011/12 fiscal year, 19% of clients waiting in hospital had applied to only one LTC home. Our research indicated that, to minimize the time such patients spend waiting in hospital, other provinces have stricter policies: five provinces require patients to go to the first vacant bed in any LTC home; and two require patients to go to any home with an available bed within 60 and 100 kilometres, respectively.

Given our aging population, developing alternatives to long-term care and implementing more efficient processes for placing people in an LTC home in a consistent and timely manner is critical. The Ministry has recognized this and has supported a number of initiatives to help reduce or delay the need for long-term care, and improve the placement process when a bed in an LTC home is needed. For example, all CCACs use a provincially standardized process to determine client eligibility, including considering alternatives to long-term care. This process also helps determine each client's wait-list priority; however, more needs to be done to ensure that crisis cases are prioritized consistently.

All three of the CCACs that we visited were managing various areas of their LTC home placement process well. However, all also had areas where improvements could be made, although any changes made in these areas would likely not significantly improve LTC home wait times. Some of our more significant observations are as follows:

- The provincial agency Health Quality Ontario indicated that nearly 20% of the CCACs' home-care clients who were subsequently placed in LTC homes could have remained in the community, and a Ministry-commissioned study noted that 37% of clients waiting in hospital for an LTC home bed had care needs that were no more urgent or complex than those of people being cared for at home.
- Not all people eligible for an LTC home require such care; for example, all veterans and spouses of current residents are eligible regardless of their health-care needs.
- In the 2011/12 fiscal year, CCACs province-wide completed a total of about 36,000 formal client reassessments, which are required to be completed in six-month intervals and within three months of LTC home placement. However, conducting a quick "touch-base" with clients and their families might more quickly and cost effectively provide information on whether a client's condition has changed enough to warrant a formal reassessment rather than conducting reassessments every six months.
- March 2012 LTC home wait-list data indicated crisis clients had waited a median of 94 days up to that point; moderate-needs clients had waited 10–14 months; and most other eligible clients had been on the wait list for years. Further, during the 2011/12 fiscal year, 15% of clients died before receiving LTC home accommodation.

- While 36% of clients were placed in their first choice of homes, others generally accepted the offered home but remained on the wait list for their preferred home(s). In fact, in March 2012, 40% of people on the wait list already resided in long-term care. At least half of admissions to more than 70 LTC homes during the 2011/12 fiscal year were for crisis clients, who typically get priority for the home of their choice. Consequently, non-crisis clients may find it difficult to access accommodation in the newer or more popular homes.
- The CCACs visited did not periodically review client placement decisions to ensure that the highest-priority person meeting an available bed's criteria was offered the bed. Nor did the CCAC systems retain wait-list information so that these decisions could be reviewed after the fact.
- Applicants living in some areas of the province get into LTC homes more quickly. At one CCAC, 90% of clients were placed within a low of 317 days, whereas at another CCAC, it took about 1,100 days until 90% of clients were placed.
- While LTC homes can designate up to 60% of their beds as preferred accommodation (that is, private or semi-private), only 40% of clients apply for these more costly beds. Therefore, regardless of care needs, clients who can afford to pay for preferred accommodation tend to get placed more quickly than other clients.
- Although information on LTC home wait times by priority level or accommodation type (that is, private, semi-private and basic) would help people consider where to apply, only one CCAC we visited made some of this information available publicly.

## OVERALL MINISTRY RESPONSE

The Ministry of Health and Long-Term Care (Ministry) welcomes the advice contained in this value-for-money audit. The audit recognizes a 20% increase since 2005 of Ontarians aged 75 and over, which has impacted wait times for admission to long-term-care (LTC) homes.

The *Long-Term Care Homes Act, 2007* was proclaimed into force in July 2010 and recognizes the principle of access based on assessed need and LTC homes as places where residents live with dignity, security, safety and comfort. The Ministry is pleased that the Auditor has recognized that the Community Care Access Centres (CCACs), the designated placement coordinator for LTC home admission, are managing various areas of the LTC home placement process well.

Ontario's Action Plan for Health Care is a reflection of the government's commitment to better patient care. At the heart of the plan is a commitment to ensure that patients receive timely access to the most appropriate care in the most appropriate place. It is about getting the greatest value for patients from the system and ensuring seniors receive the care they need as close to home as possible.

The Ministry is committed to supporting seniors to remain in their community. For example:

- The Ontario government's Aging at Home Strategy, announced in August 2007, invested close to $1.1 billion over four years in the delivery of an integrated continuum of community-based services so seniors can stay healthy and live more independently in their homes.
- Increased investments were made in CCACs to support the transition of patients from hospital to home or community settings.
- In January 2011 the Assisted Living Services for High-Risk Seniors policy was introduced to address the needs of high-risk seniors who reside at home and require the availability

of personal support and homemaking services on a 24-hour basis to avoid premature admission to an LTC home.

The The Ministry is working on launching a Seniors Strategy with a focus on supporting seniors to stay healthy and to stay at home longer, reducing the strain on hospitals and LTC homes. The Ministry will continue to work with the Local Health Integration Networks, CCACs and the LTC home sector to identify opportunities to improve the LTC home placement process.

# Detailed Audit Observations

## OVERVIEW OF PLACEMENT PROCESS

In general, the key steps followed to place a client in an LTC home involve: the CCAC determining a client's eligibility and priority for LTC home accommodation through a formal assessment process; clients applying to one or more LTC homes; clients accepted by the LTC homes being put on a wait list if a bed is not available; and clients at the top of a wait list being offered a bed. Figure 2 illustrates these key steps.

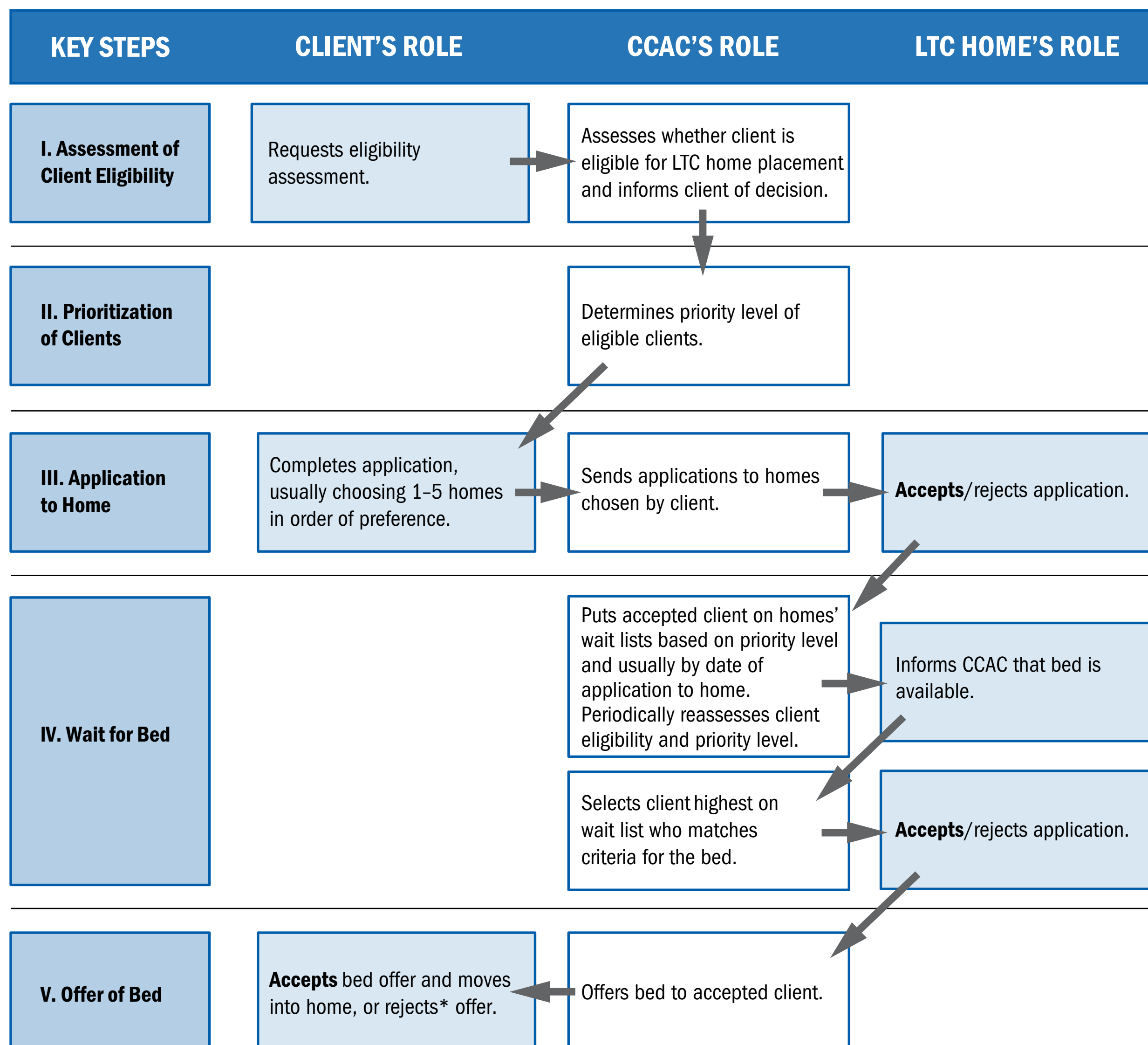
## INITIATIVES

The Ministry has supported a number of initiatives to help the LTC home placement process work consistently, fairly and in the most timely manner possible:

- From 2007 to 2012, the Aging at Home program helped seniors stay in their homes longer through home-care assistance and thereby postponed or reduced the need for long-term-care accommodation. Although this initiative has ended, the Ministry indicated that the LHINs are continuing to implement community-based programs and services that support seniors, including programs and services designed to relieve pressures on hospitals and LTC homes by helping to find the appropriate health-care setting for clients.
- In 2008, LHINs working with CCACs introduced the Wait at Home approach to provide CCAC-organized homemaking and personal support services to higher-needs clients who required more help than that provided in regular home-care hours. This enabled clients to wait in their homes for a long-term-care vacancy rather than waiting in hospital.
- In July 2010, the *Long-Term Care Homes Act* took effect. Among other things, it introduced stricter eligibility criteria for LTC home placement. For example, it no longer permitted people access based solely on whether they would be financially, emotionally or physically harmed if they stayed in their current residence. It also increased the number of LTC homes to which an individual may apply from three to five, and decreased the wait to reapply from six months to 12 weeks in cases where the client refuses a bed at an LTC home to which they applied.
- The provincially standardized Resident Assessment Instrument for Home Care, which is used to consistently determine clients' eligibility for long-term care and prioritize clients on the basis of urgency, is continuing to be refined.
- The piloting of Resource Matching and Referral systems, which help match hospital patients to the earliest available appropriate LTC home bed, is expected to shorten the placement process. At the time of our audit, two LHINs were testing their own systems in conjunction with their associated CCACs; the remaining LHINs were expected to pilot similar systems during the 2013/14 fiscal year.
- A document management system supported by the Ontario Association of Community Care Access Centres has been implemented by six CCACs, and the Association indicated that the remaining CCACs would also be

## Figure 2: Key Steps in Long-term-care Home Placement

Prepared by the Office of the Auditor General of Ontario




* Clients who reject a bed offer are generally removed from all LTC home wait lists, but may reapply after 12 weeks. Hospitalized clients who reject a bed offer stay on the LTC home wait lists, but hospitals have the option of charging these patients a hospital-determined fee to continue waiting in hospital for an LTC home bed.

implementing this system. This system enables CCACs and LTC homes to send and receive clients' medical and placement information electronically.

- Over the next 10 years, older LTC homes containing 35,000 beds will be renovated. The Ministry indicated that the renovations will provide more modern and comfortable living, as well as improved access, including greater wheelchair access for residents, and therefore make these homes a viable option for many more people.
- A toll-free Long-term Care Action Line has been established to allow citizens to phone the Ministry with concerns and complaints about LTC homes and the placement process.

## WAIT-LIST MANAGEMENT

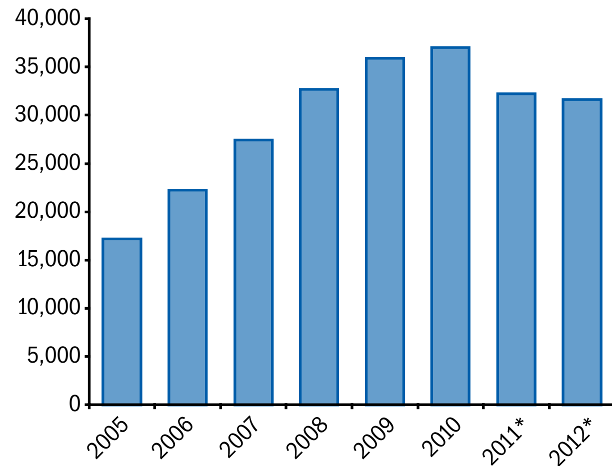
The number of people across the province waiting for an LTC home bed increased by almost 85% between March 2005 and March 2012, as shown in Figure 3, while the number of LTC home beds increased by about 3%. However, the number of people waiting decreased by almost 15% between March 2010 and March 2012. This was primarily due to the stricter eligibility criteria in the new Act.

Of the 32,000 people on the wait list as of March 31, 2012, about 19,000 (or about 60%) were waiting for placement in an LTC home. The remaining 13,000 (or about 40%) already resided in long-term care, but were waiting for another, more preferred, home.

On average, because residents tend to be older and often in poor health, they live in LTC homes for about three years. Therefore, although the numbers may vary among homes, about one-third of the 76,000 LTC home beds in Ontario become available each year.

**Figure 3: People Waiting for a Long-term-care Home Bed, 2005–2012**

Source of data: Ministry of Health and Long-Term Care




Note: Data as of March 31 each year.

* Reduction due primarily to tightened LTC home eligibility rules.

### Determining Client Eligibility

To be eligible for an LTC home, individuals must be at least 18 years old and insured under the Ontario Health Insurance Plan. In addition, they generally must require the availability of 24-hour nursing care, supervision in a secure setting, or frequent assistance with activities of daily living such as dressing and bathing.

#### Timing until Assessment

Potentially eligible candidates come to the attention of CCACs in a number of ways: people may apply for long-term care on their own or on someone's behalf; the physician of a hospitalized individual may refer him or her to a CCAC; or CCAC staff may refer an existing client.

If the individual is not an existing client, the CCAC generally conducts a preliminary assessment within a few days to determine how urgently a full eligibility assessment for long-term care should be completed. If the preliminary assessment indicates that the client is likely to require home care for more than 60 days or admission to an LTC home, ministry policy requires the CCAC to complete an eligibility assessment within the next 14 days. However, if the client seeking LTC home admission is already receiving CCAC services, there is no similar requirement. To help reduce the time patients spend waiting in a hospital bed, two of the CCACs we visited had established stricter internal policies on the timeframe to assess them—three days at one and five days at the other—regardless of whether they were already receiving CCAC services.

According to ministry information for the 2011/12 fiscal year, province-wide the CCACs completed almost 80% of the assessments for hospitalized individuals within 14 days of receiving the request for LTC home accommodation; for people applying from home, 60% were assessed within 14 days and 90% were assessed within 54 days.

#### Reviewing Alternatives

To enable people to live at home as long as possible, the Act requires that CCACs review all community-based alternatives before determining that a client

is eligible for long-term care. For people who do not need the full range of LTC home services, alternatives might include more day or respite programs, or supportive-housing and assisted-living options—for example, people live in their own apartment in a building that has on-site care available.

Almost all cases we reviewed at the CCACs visited indicated that at least some alternatives to an LTC home were investigated. However, satisfaction surveys conducted by those CCACs indicated that between 30% and 44% of clients did not feel they were informed of all the available alternatives (the CCACs each surveyed a relatively small number of LTC home placement clients). One CCAC indicated that many clients received CCAC care at home over an extended period, and that alternatives were explored during that time.

According to a 2012 report by Health Quality Ontario, a provincial agency that monitors and reports on health care, in the 2010/11 fiscal year nearly 20% of the CCACs' home-care clients who were subsequently placed in long-term care could have stayed in their homes or been placed elsewhere in the community. In 2011, a Ministry-commissioned report, *Caring for Our Aging Population and Addressing Alternate Level of Care,* indicated that 37% of clients waiting in hospital for an LTC home bed have care needs that are no more urgent or complex than those of many people being cared for successfully at home. This report also suggested that LTC homes should focus more of their capacity on restorative and transitional care programs (which promote, for example, the recovery of strength, endurance and functioning) that might assist clients in moving out of hospital more quickly and potentially returning to their own home rather than residing in an LTC home. However, these programs represented only about 2% of the LTC home system capacity at the time of the report.

## Assessing Client Needs

CCAC staff—generally a case manager or a placement co-ordinator—determine clients' eligibility for an LTC home using the provincially standardized Resident Assessment Instrument for Home Care (RAI-HC). This assesses, among other things, the client's level of functioning, behaviour patterns and requirements for personal care. It includes a Method for Assigning Priority Levels (MAPLe), which helps determine the urgency of the client's need for long-term care. A rating score is generated based on the results of the assessments.

A client whose RAI-HC score is 7 or less is usually not considered eligible for an LTC home, while a client with a score of 11 or more is considered eligible. Determining eligibility of clients with scores of 8 to 10 is generally based on the MAPLe score and the case manager's professional judgment of the extent of caregiver burden present in the client's situation. At two of the three CCACs we visited, a senior manager was required to review the decision if a client had a score of 8 to 10, and eligibility was often based largely on caregiver burden. The third CCAC had no formal secondary review process, but indicated that it was implementing one.

As part of the eligibility determination process, the Act requires that a physician or registered nurse complete a health assessment. This five-page assessment provides information on, among other things, the client's condition, including any medications. The three CCACs told us that these assessments do not add much value to the eligibility process, as they are often not fully completed by the client's physician and duplicate information obtained through the RAI-HC. The Ministry indicated that the health assessment is an intentional secondary review to better ensure that all client information is accurate. We were informed that, in 2010, the Provincial Placement Committee (a group comprising representatives from each CCAC and the Ontario Association of CCACs) recommended discontinuing these health assessments. However, they were still required at the time of our audit.

According to information we received from the Ministry, in the 2011/12 fiscal year the CCACs conducted more than 40,000 eligibility assessments of more than 36,000 individuals province-wide; some

people are assessed more than once, for instance if they change their minds about long-term care. The CCACs determined that more than 33,000 applicants were eligible for an LTC home. At the three CCACs we visited, the percentage of applicants who met the placement eligibility criteria ranged from 88% to 93% that year. Rejected applicants may appeal their case to the Health Services Appeal and Review Board, an independent quasi-judicial tribunal established by the Ministry. The three CCACs informed us that appeals rarely occur.

## Determining Initial Priority Level of Clients

In the event that accommodation is not available immediately, names are added to the LTC home's wait list based on each client's priority level. The Act stipulates the priority levels and the eligibility for each level. The CCACs are responsible for determining at which priority level clients should be placed. The Ministry and CCACs told us that the highest priority levels are seldom used—only 33 such clients were on the wait list as of March 31, 2012. These priority levels include a category for veterans (who are eligible for veterans' beds, which are less than 1% of all LTC home beds), and a category for clients requiring readmission to an LTC home after being discharged involuntarily, such as following an extended hospitalization. Figure 4 outlines the other, more commonly used priority levels.

Not all the priority levels are based exclusively on medical need—for example, the federally supported veterans' beds in LTC homes are available to veterans, even if they have no health-care needs or would not otherwise be eligible. These beds therefore may not be available for clients with care needs. Similarly, under priority levels 3B and 4B, spouses of current residents wishing to live in the same LTC home do not require any care needs to be eligible. And, while category 2 clients must have care needs, these clients are prioritized within level 2 based on their spouse/partner's date of admission to the home, even though their care needs may not be as high as others'. Therefore, in many of these cases, clients with lesser care needs may be ranked ahead of clients with higher care needs.

If a person's condition deteriorates, he or she may be re-prioritized to a higher level. However, clients will be placed on the 3A and 4A wait list using their original 3B or 4B wait-list date—and therefore possibly ahead of other 3A or 4A clients who have been waiting at a higher-needs priority level for a longer time.

All three of the CCACs used judgment in determining which clients were a crisis priority, including a determination of the caregiver's burden. Caregiver burden considerations can potentially give one client priority over another whose needs are more urgent and whose caregiver burden is at least as arduous but whose caregivers are less insistent. To reduce the risk of inappropriately designating clients as crisis, one CCAC required a senior manager to review each crisis designation and sign a crisis approval form. In most of the files we reviewed, the senior manager had signed this form. Another CCAC required a second case manager to review each crisis designation. However, 50% of the files we reviewed did not indicate whether this review had been completed. The third CCAC did not require crisis designations to be reviewed by a second person, but said that more borderline cases could be discussed between case managers.

We noted that two of the CCACs used additional factors, which were not specifically based on needs, for designating clients as crisis. For example, one CCAC's policy included designating clients as crisis if they had waited three years in an LTC home that was not their first choice. Another CCAC, which had a program to enable hospitalized clients to wait at home for an LTC placement, designated such clients as crisis once they had waited at home for 30 days, mostly because of difficulties the clients had with coping at home.

Patients waiting in hospital for an LTC home bed are generally prioritized as a 3A or 4A, with no priority over people waiting in the community. We noted that one other province gives a higher

### Figure 4: Commonly Used Long-term-care Home Priority Levels

Source of data: *Long-Term Care Homes Act* and Ministry of Health and Long-Term Care

| Description | Priority Level | Eligibility Criteria | Ranking within Priority Level |
|---|---|---|---|
| Crisis | 1 | • Client requires immediate placement, such as a client with dementia whose primary caregiver dies<br>• Client waiting in a hospital that the LHIN has declared "in crisis" to free up beds when the hospital is experiencing severe capacity pressures | By urgency of client's need for placement |
| Reunification with spouse/partner who already resides in the LTC home | 2 | Client is eligible based on care needs and wishes to reside in the same LTC home as spouse/partner | By date of spouse/partner's admission to the home |
| Clients who are of, or whose spouse/partner is of, the same religion, ethnic origin or linguistic origin that the LTC home specializes in | 3A | Client or spouse/partner has applicable background, and client:<br>• has higher care needs*;<br>• is waiting in hospital; or<br>• is residing in another LTC home, but this is their first choice of LTC homes | By date of application to LTC home |
| | 3B | Client or spouse/partner has applicable background, and client:<br>• does not meet eligibility for 3A, but is otherwise eligible based on care needs;<br>• is residing in another LTC home and has applied for a bed in this home, but this is not their first choice of homes; or<br>• does not have care needs, but wishes to reside with spouse/partner who is already in the home | By date of application to LTC home |
| Other clients | 4A | Client not eligible for any other higher priority level who:<br>• has higher care needs*;<br>• is waiting in hospital; or<br>• is residing in another LTC home, but this is their first choice of LTC homes | By date of application to LTC home |
| | 4B | Client not eligible for any other higher priority level who:<br>• is eligible based on care needs;<br>• is residing in another LTC home and has applied for a bed in this home, but this is not their first choice of homes; or<br>• does not have care needs, but wishes to reside with spouse/partner who is already in the home | By date of application to LTC home |

* The Provincial Placement Committee's guideline indicates that clients with higher care needs are generally those with a RAI-HC score of 16 or higher, or those with both a RAI-HC score of 11 to 15 and a MAPLe score of 4 or higher.

wait-list priority to people who are waiting in the hospital, in order to more quickly free up hospital beds for other patients. In Ontario, in order to free up hospital beds more quickly when a hospital is experiencing severe capacity pressures, the LHIN can declare the hospital to be "in crisis," and all patients waiting for an LTC home in this particular hospital are generally given crisis priority. When these patients move up to the crisis priority level, it causes other 3A/4A patients, both in other hospitals as well as in the community, to wait longer for an LTC home. In 2011, two of the CCACs we visited

had a combined total of nine hospitals declared in crisis; and one of the hospitals was designated as being in crisis for most of that year.

The Act requires that crisis clients be prioritized on the basis of urgency of need. However, the CCACs we visited told us that all crisis clients have high needs, so it is often hard to distinguish whose needs are more urgent.

One of the CCACs prioritized crisis clients on the basis of their total wait time for an LTC home. Another CCAC prioritized most crisis clients on their total wait time as well, but also maintained a “high-crisis” list that gave top priority to clients with the most urgent needs waiting in the community. The third CCAC generally gave priority to crisis clients according to their wait time in just the crisis category.

After crisis clients, spouses and partners—including relatives or friends—of current LTC home clients are the next-highest-level priority. During our audit, the Ministry clarified its definition of partner to include only those individuals who had lived with the client during the year preceding the client’s application to an LTC home. All three CCACs visited had adopted this clarified definition.

The Act gives clients seeking LTC homes that serve their religion, ethnic origin or linguistic origin a category 3 priority level. Although no documentation is required to be placed in this priority level, it is important for CCACs to accurately identify clients who are entitled to this priority. However, for three of the specialty homes at one CCAC, 26 clients, accounting for 75% of all the clients ranked at the priority level 4A/4B, actually qualified for the higher 3A/3B priority level. We brought these cases to the attention of the CCAC, which reclassified them to priority level 3A/3B. While all the clients moved up the wait list, nine of the clients moved up the wait list by more than 600 people. This CCAC indicated that, because no one moved to the top position on the wait list, none of these clients had missed a bed offer.

## Placing Clients on the Wait List

### Client Application to Homes

The Act requires CCACs to provide clients with information on the implications of different LTC home choices, and, if the client wishes, assistance in selecting homes. Clients eligible for an LTC home generally select a maximum of five homes, with crisis clients permitted to select an unlimited number of homes. Clients complete an application for the home(s) to which they wish to apply; if more than one is selected, they rank them in order of preference. This application is provided to the CCAC. However, there is no deadline for completing the application. This gives clients and their family time to consider their options carefully. However, for hospital patients it can also extend the time that they occupy a hospital bed.

Under the Act, clients have the right to voluntarily choose which LTC home(s) they want to apply to; in February 2011, and again in May 2012, the Ministry clarified with the LHINs that clients cannot be required to choose from a pre-selected list of homes. In essence, clients can only be placed in a home that is acceptable to them. However, we noted that one CCAC had a policy of asking crisis clients to select homes with current vacancies or short waiting lists if the applicant’s selected home(s) could not accommodate immediate admission. If the client did not agree to do this—perhaps because of distance from family or because the homes were older facilities—he or she might lose the crisis designation, and be moved to a lower priority level by the CCAC. We noted that another CCAC had a policy in place until October 2011 that required crisis clients to choose all homes within 70 kilometres of their residence, or similarly risk losing their crisis designation. However, the Ministry required this CCAC to change the policy, stating that the crisis designation is based on the clients’ condition or circumstances, not on their willingness to consider alternative LTC home choices. This CCAC indicated that it focuses on clients requiring immediate placement when designating clients as crisis.

Numerous studies have shown that remaining in hospital longer than medically necessary, including waiting in hospital for an LTC home, can be detrimental to a person's health for various reasons, among them the potential for a hospital-acquired infection such as *C. difficile*, and, for older patients, a decline in physical and mental abilities due to lack of activity. As well, it is much more costly for a person to wait in hospital than in an LTC home or at home with appropriate home-care support, and it might prevent another person requiring hospital care from occupying that bed. We determined using ministry data that, during the 2011/12 fiscal year, 19% of clients waiting in hospital had applied to only one home. In fact, at one CCAC we visited, 35% of clients waiting in hospital had applied to only one LTC home. While this practice would tend to increase the time clients wait in hospital for a bed in their preferred home, we noted that the median wait time province-wide for 3A and 4A hospitalized clients was about half that of people waiting in the community. This may be due to hospitals encouraging clients to apply to homes with vacant beds.

Rather than allowing patients to wait in hospital for their preferred home, our research indicated that many other provinces have stricter policies: five provinces require the patient to go to the first vacant bed in any LTC home; and two provinces require patients to go to any LTC home within 60 and 100 kilometres, generally of their home, respectively.

### Acceptance/Rejection by LTC Homes

The CCAC forwards client applications, including information on the client's care needs, to the applicable LTC homes. At the three CCACs visited, this information was usually faxed. At the time of our audit, the Ontario Association for Community Care Access Centres was piloting a system at six CCACs for the electronic transmission of documents to and from LTC homes.

Under the Act, LTC homes generally have five business days to accept or reject an application. If the home requires more information from the CCAC, the home has three additional days after it receives the information to make its decision. According to ministry data, in the 2011/12 fiscal year LTC homes province-wide made a decision on 65% of the applications within five business days. LTC homes responded to 90% of applications within 28 days.

We were informed that LTC homes rarely reject clients unless they have very high care needs; in the 2011/12 fiscal year, only about 1% of clients' applications were rejected. An accepted client can move into the LTC home immediately if a bed is available. However, in most cases the client is added to the home's wait list based on the client's priority level because no bed is currently available.

## Reassessing Clients

In some cases a client's condition can deteriorate significantly while waiting for an LTC home bed. These changes might merit adjusting the client's priority level to a higher level, such as a crisis priority. As well, when beds become available, LTC homes require up-to-date information about the care needs of the clients who are moving in.

CCACs may be made aware of changes in a client's condition by various means, for instance when the client's family contacts the CCAC or when the CCAC conducts a reassessment. The Act requires that clients have an assessment or reassessment within three months of their placement in long-term care, which helps ensure LTC homes have up-to-date information to prepare for the client's needs. This involves completing all aspects of the initial eligibility assessment again, including the RAI-HC assessment and the health assessment (generally obtained from the client's physician). As well, ministry policy states that a reassessment of the RAI-HC should be completed every six months. This applies to clients requiring care at home, to ensure their care plans meet their needs, as well as to clients not receiving care at home and hospitalized clients. CCACs province-wide completed a

combined total of about 36,000 reassessments of clients on LTC home wait lists in the 2011/12 fiscal year.

The CCACs visited confirmed that it is challenging to complete all required reassessments, and therefore they used their resources as follows:

- Two CCACs ensured that assessments/reassessments for the 10 highest-priority clients on each home's wait list had been completed in the past three months. As well, one CCAC indicated that clients with conditions that were likely to change would be reassessed every six months, while the other CCAC indicated that it conducted as many six-month reassessments as possible.
- The third CCAC's approach was to reassess 3A/4A clients every three months and 3B/4B clients every six months. (Clients ranked 3A/4A at each home are eligible for beds before 3B/4B clients.)

For hospitalized clients and clients not receiving CCAC care at home, conducting a quick "touch-base" with clients and other appropriate persons, including families, could more quickly provide the CCAC with information on whether a client's condition has changed, and therefore whether a more formal reassessment is needed to determine, for example, whether a client's priority level might have also changed. Furthermore, identifying and reassessing clients who are likely to be placed within the next three months, such as those nearing the top of the wait lists, might provide LTC homes with the information needed to prepare for clients without requiring that the CCAC repeatedly conduct a formal reassessment of all individuals every six months.

As well, a quick "touch-base" might identify clients already in an LTC home who stayed on wait lists for other more preferred homes, but who have subsequently decided to remain where they are. One CCAC indicated that it followed up with clients after six weeks, and all three CCACs indicated that they followed up annually, for example, as part of client reassessments. However, one CCAC visited did a one-time check of clients already in an LTC home who were on the wait list for another home, resulting in about 10% of those clients being removed from the wait lists.

## Placing Clients in LTC Homes

When a bed becomes available, the LTC home notifies the CCAC and provides information on the type of bed. This information includes whether the bed is basic (varies from one or two people per room in newer homes, to three or four people in older homes) or preferred (that is, semi-private or private) to match the client's request; whether a bed in a shared room is appropriate for a male or female; and whether the bed is in a locked area and appropriate for clients requiring secure accommodation.

Once notified, the CCAC selects the client at the top of that home's wait list who matches the specifications of the available bed. To better match hospital patients to the first available appropriate LTC home bed, Resource Matching and Referral systems were being piloted in two LHINs, and the remaining LHINs were expected to pilot similar systems during the 2013/14 fiscal year. The CCAC then sends current information on the selected client to the LTC home. The LTC home reviews the information and may accept or reject the client. Rejections from LTC homes at this stage are generally because the client's needs have changed significantly since the home accepted the initial application. If the applicant is rejected, the client is notified and the CCAC generally removes this client from the home's wait list and proceeds to the next person. Rejected clients may apply to another home.

If the client is accepted, the CCAC contacts the individual and offers him or her the bed. Under the Act, the client has 24 hours to respond. If the client accepts the bed offer, the Act requires that he or she move into the LTC home within five days. Our review of ministry data indicated that 83% of beds offered to clients were accepted province-wide in the 2011/12 fiscal year. Furthermore, 36% of the clients who were placed got their first choice

of homes. Other people who had not selected the home as their first choice nonetheless were offered the bed, and, after accepting, generally remained on the wait list for their preferred home(s).

If a client applying from the community rejects a bed, he or she is generally removed from all LTC home wait lists for a period of 12 weeks. If the client was waiting in hospital, he or she may remain on the wait list for LTC homes, but under the *Public Hospitals Act* the hospital has the option of charging the client a hospital-determined fee to continue waiting in a hospital bed.

In the latter half of the 2010/11 fiscal year, two of the CCACs visited incorporated a process into their information system to assist in tracking the status of available LTC home beds, including when the bed became available, to whom the bed was offered, the date the bed was offered, and whether the client accepted or rejected the bed. The third CCAC used spreadsheets to track this information but indicated that it was implementing an integrated system similar to that of the other CCACs.

We noted that CCACs did not periodically review client placement decisions in order to ensure the highest-priority person was offered the available bed. Furthermore, the information system used by the CCACs did not have the capability to retrieve what an LTC home's wait list looked like on a specific date, and therefore CCACs could not review these decisions after the fact.

## RECOMMENDATION 1

To better ensure that higher-needs clients are identified and placed in long-term-care homes (LTC homes) as soon as possible, Community Care Access Centres (CCACs) should:

- develop a consistent province-wide process for ranking clients within the crisis priority level;
- in consultation with the Ministry, consider conducting a periodic "touch-base" to determine whether wait-listed clients' condition or circumstances have changed and therefore require a reassessment of their needs, rather than conducting formal reassessments of all clients every six months as is currently required; and
- conduct periodic independent reviews of placement decisions to ensure that the highest-priority client matching the bed specifications (such as male versus female, and private versus semi-private and basic accommodation) is offered the first available LTC home bed.

## CCAC RESPONSE

All of the CCACs visited agreed with this recommendation and indicated that they would:

- work with the Provincial Placement Working Group (a group comprising representatives from each CCAC and the Ontario Association of CCACs) to develop a consistent province-wide process for ranking clients within the crisis priority level;
- work with the Ministry of Health and Long-Term Care to create a province-wide standardization of the current CCAC processes to include a periodic "touch-base" to determine whether wait-listed clients' conditions or circumstances have changed and whether a formal reassessment is required; and
- in conjunction with the Ontario Association of CCACs, develop the necessary reports to conduct periodic independent reviews of placement decisions to ensure that the highest-priority client matching the bed specifications is offered the available LTC home bed.

## RECOMMENDATION 2

To help clients move out of hospital more quickly and to help manage growing wait lists, the Ministry of Health and Long-Term Care

Chapter 3 • VFM Section 3.08

(Ministry) should consider options employed by other jurisdictions, as well as making more community alternatives to long-term-care (LTC) homes available and having LTC homes provide more restorative and transitional care programs to improve, among other things, clients' functioning.

As well, to better ensure that clients assessed as eligible for an LTC home are placed as soon as possible, the Ministry should streamline the client health assessment (to avoid duplicating information that is already obtained as part of the eligibility assessment and to avoid potentially delaying the process).

## MINISTRY RESPONSE

The Ministry values the Auditor General's recommendation and will continue to demonstrate its commitment to supporting seniors to remain in their community through more community alternatives. For example:

- As part of Ontario's Action Plan for Health Care the Ministry has announced a Seniors Strategy focusing on supporting seniors to stay healthy and live at home longer through enhanced preventative care and home-care services, thereby reducing pressures on LTC homes and hospitals. The strategy will help inform decisions regarding the role of restorative and short-stay programs in LTC homes and the future development of community alternatives closer to home.
- The 2012/13 Community Sector Investment in home care and community services announced in the 2012 Ontario Budget was allocated to the Local Health Integration Networks (LHINs) in August 2012 to increase investments in home care and community services to support seniors and other Ontarians at home and to reduce the numbers of emergency room visits, patients waiting in hospital for an alternative level of care, and avoidable hospital readmissions. The government also signalled its intent to increase financial support to the community sector for three fiscal years.
- Regulatory amendments made in June 2008 and September 2009 enabled innovation and flexibility in the delivery of Community Care Access Centre (CCAC) home-care and community services. Service maximums for personal support/homemaking and nursing were increased, and new services and service locations were introduced.

The current health assessment requirements were a response to concerns relating to the content and timing of assessments during the placement process that were identified as a result of a Coroner's Inquest into the deaths of two residents at the hands of another resident on his first day of admission (Casa Verde Nursing Home). In some instances duplication is a necessary part of verifying information about a client's status and is a critical component of a comprehensive assessment. The Ministry will work with the CCACs and LTC homes to review the health assessment process and will look for opportunities to reduce unnecessary duplication in the process.

## WAIT TIMES

According to ministry data, 50% of clients province-wide (excluding crisis, spousal/partner reunifications and persons waiting for a transfer to another home) were placed in an LTC home within 98 days in the 2011/12 fiscal year, with 75% of clients placed within 10 months and 90% of clients placed within about two years. This reflects the wait from the time a CCAC received a client's request to be assessed for an LTC home until the client was placed in a home. The median wait for all clients not yet in an LTC home, including crisis and spousal/partner reunification, drops to 85 days,

primarily due to 90% of crisis clients being placed within three months of being designated as crisis. During the 2011/12 fiscal year, 15% of clients died before receiving LTC home accommodation.

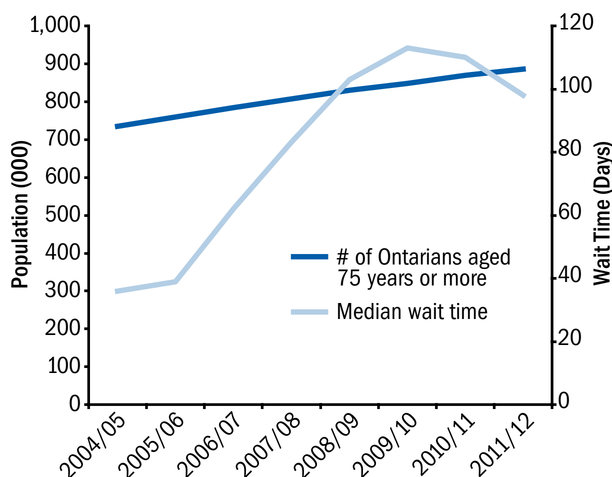
## Wait Time Trends

As Figure 5 shows, the median wait times have almost tripled from 36 days in the 2004/05 fiscal year to 98 days in the 2011/12 fiscal year. An increase in the number of LTC home beds of 3% during that period has not kept pace with the rising demand from an aging population. However, the wait time has decreased since 2009/10, due in part to tighter eligibility requirements under the new Act that took effect in July 2010.

About 85% of LTC home residents are aged 75 and over, and between 2005 and 2012 the number of Ontarians aged 75 and older increased by more than 20%. According to Statistics Canada, between 2012 and 2021, Ontario's population aged 75 and older is expected to increase by almost 30%. This trend will likely increase the demand for long-term care, although enhanced community alternatives could meet some of these needs. As well, beginning in 2021, the first of the baby boomer generation—those born between 1946 and 1964—will start to turn 75, at which point the demand for long-term care is expected to become even greater.

**Figure 5: Long-term-care Home Median Wait Times* and the Number of Ontarians Aged 75 and Older, 2004/05–2011/12**

Source of data: Ministry of Health and Long-Term Care and Statistics Canada




* Excludes crisis, spousal-partner reunifications and transfers between LTC homes.

## Wait Times by CCAC and Client Priority

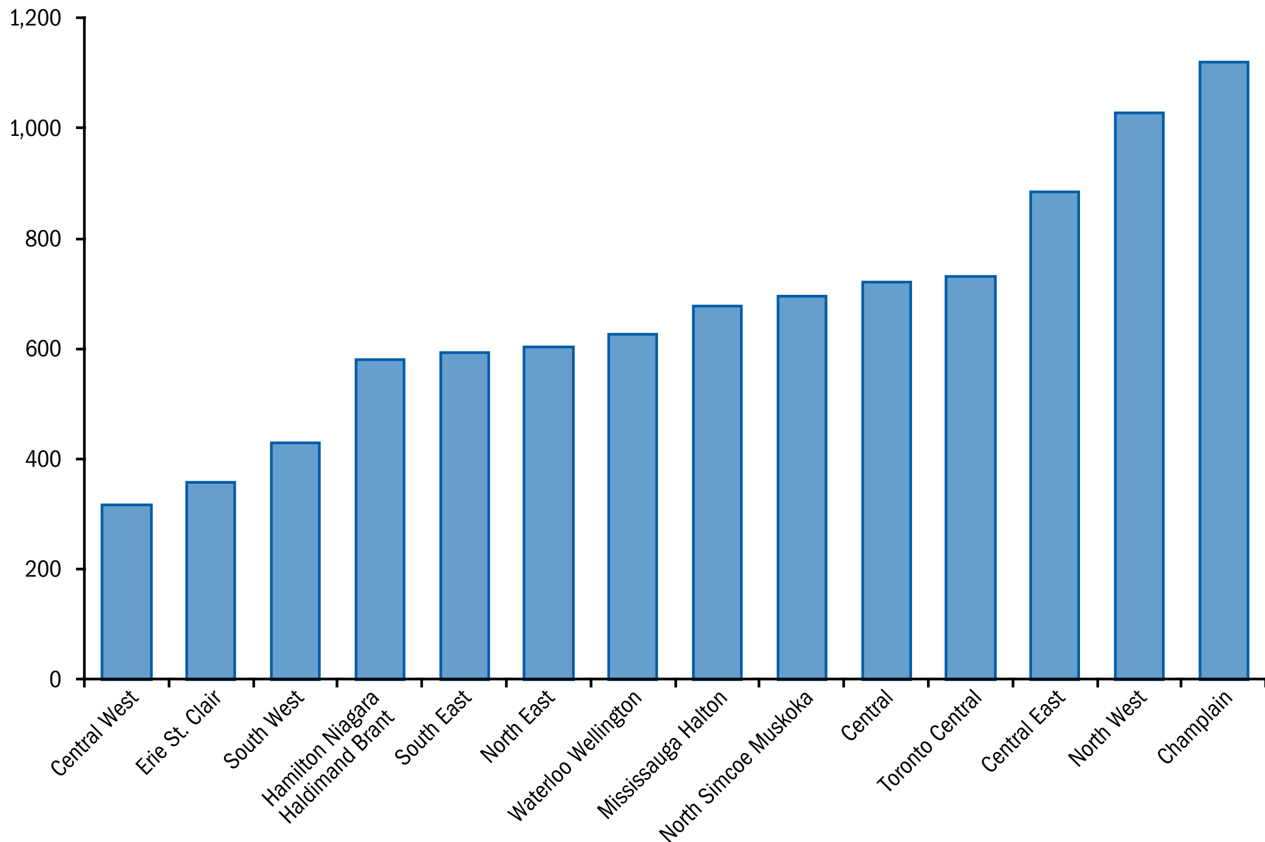
Ministry data indicates that applicants who live in some areas of the province get into LTC homes more quickly. In particular, median wait times for LTC homes in the 2011/12 fiscal year ranged from a low of 50 days at the Erie St. Clair CCAC to a high of 187 days at the North West CCAC. (Overall, 90% of clients were placed within a low of 317 days at the Central West CCAC to within a high of about 1,100 days at the Champlain CCAC, as shown in Figure 6.) Part of this variance reflects differences among CCACs in the demand for long-term care due to population health and age characteristics in that region of the province, as well as the number, age and location of LTC home beds.

According to the Ontario Hospital Association, as of March 31, 2012, about 1,000 people were waiting province-wide in an acute-care hospital bed for a bed in an LTC home; another 1,000 were waiting in other types of hospital beds, such as rehabilitation or mental health beds. We noted that the number of people waiting in hospital for an LTC home bed had decreased by about 25% since March 2010. However, for those still waiting, the wait time until placement had significantly increased. Ministry information indicated that, in the 2011/12 fiscal year, about half of the acute-care patients were placed within about two months (within one month in the 2009/10 fiscal year), with 90% placed within 495 days (within 128 days in 2009/10). Wait times in hospital tend to be longer for harder-to-care-for patients, for example, people who have dementia, are significantly overweight, or require frequent medical treatments such as dialysis.

The Act requires CCACs to provide an "estimated wait time" to clients who request information on their expected wait. The CCACs visited said that clients have become upset if their actual wait time

Figure 6: Number of Days Within Which 90% of Each CCAC's Clients Were Placed, 2011

Source of data: Ministry of Health and Long-Term Care




exceeded the estimate. Therefore, the CCACs generally tell clients how long the top person on the wait list, at the same priority level as the client, has been waiting so far. We reviewed ministry wait-list data as of March 31, 2012, to see how long clients had been waiting. For those in the crisis category, including those who previously waited at a lower priority level, their median total wait time up to that point was 94 days. People in categories 3A and 4A had been waiting a median of 423 and 309 days, respectively, with people in categories 3B and 4B (considered to have lower needs than 3A and 4A clients) waiting a median of 712 and 587 days, respectively.

In the 2011/12 fiscal year, about 5,600 (or 22%) of the LTC home placements were for clients in the crisis priority level and another 71% were from the generally higher-need categories 3A and 4A. As shown in Figure 7, based on the number of people waiting and the number actually placed in the prior year, the expected time to placement for people in the lower priority levels could often be many years.

As well, the high priority given to crisis clients may make it difficult for non-crisis clients to get into some homes. For example, ministry data shows that at more than 70 LTC homes, at least half of admissions during the 2011/12 fiscal year were crisis clients. In fact, at one CCAC visited, crisis clients made up two-thirds of placements to the four most popular LTC homes—that is, the homes with the longest wait lists. Furthermore, ministry data showed that more than 40% of crisis placements in the 2011/12 fiscal year were people whose priority level was escalated to crisis (for example, due to their condition deteriorating or circumstances changing, such as increased caregiver burden) in order to place them quickly after they had waited at a lower priority level, in some cases for an extended period of time.

**Figure 7: Number of Clients Waiting for Long-term Care, Number of Placements and Expected Average Time to Placement for Commonly Used Priority Levels**

Prepared by the Office of the Auditor General of Ontario

| Priority Level | # of People Waiting as of March 31, 2012 | # of People Placed During the 2011/12 Fiscal Year | Expected Time to Placement |
|---|---|---|---|
| 1 — Crisis | 1,400 | 5,600 | 3 months |
| 2 — Spousal/partner reunification | 200 | 900 | 2.5 months |
| 3A — Religious, ethnic, linguistic home (higher needs) | 3,100 | 900 | 3.5 years |
| 3B — Religious, ethnic, linguistic home | 1,400 | 100 | 14 years |
| 4A — Other (higher needs) | 19,700 | 17,000 | 1 year |
| 4B — Other | 5,800 | 800 | 7 years |
| **Total** | **31,600** | **25,300** | |



## Impact of Client Choices on Wait Times

Although the Ministry provides funding to LTC homes, residents must make a co-payment for their accommodation costs. As of July 2012, the monthly co-payment ranged from a low of almost $1,700 per month for basic accommodation to a high of over $2,200 for private accommodation. The co-payment for semi-private and private accommodation in newer homes (that is, the approximately 55% of long-term-care beds that generally meet or exceed the Ministry's 1999 LTC home design standards) is about $30 to $50 more respectively per month than for older homes. Financial assistance is available from the Ministry if a resident is unable to pay, but only for basic accommodation.

The Act allows LTC homes to designate up to 60% of their beds as preferred—private or semi-private—accommodation, which means a minimum of 40% of their beds must be basic accommodation. However, almost 60% of clients applying for an LTC home bed requested basic accommodation. Therefore, clients who can afford to pay for preferred accommodation may get placed faster than clients applying for basic accommodation, regardless of their medical needs.

Furthermore, people pay the same rate for basic accommodation in homes of any age, even though basic accommodation in a newer home has only one or two people per room, compared with up to four people per room in an older home. Partially as a result of this, newer homes tend to have longer wait lists (many over 1,000 people), while less desirable homes may have empty beds for lengthier periods of time. Therefore, clients selecting less desirable LTC homes that have available beds or short wait lists can get placed more quickly.

## Public Reporting of Wait Times

Health Quality Ontario publishes the overall provincial LTC home wait time annually. However, no information was reported on regional wait times or, more specifically, the wait times for each LTC home. Reporting wait times for particular homes is somewhat complex because wait times vary based on a number of factors, including the priority level of the client and the type of accommodation chosen.

In August 2012, one of the CCACs we visited began publicly disclosing on its website information on wait times for each LTC home in its region, including the number of clients waiting for each type of accommodation, the average number of days that clients have waited so far, and the average number of beds that became available monthly. We believe this is a good initiative for providing public wait time information.

## RECOMMENDATION 3

To better ensure that clients have sufficient information on the long-term-care (LTC) home placement process and wait times for LTC home admission, the Ministry of Health and Long-Term Care (Ministry), in conjunction with the Community Care Access Centres (CCACs), should:

- provide the public with detailed information on the LTC home admission process and the policies in place to ensure the process is administered equitably;
- examine options for encouraging greater utilization of basic accommodation in less desirable homes; and
- promote the public disclosure of information that would help people choose which LTC homes to apply to, such as wait times by home, by type of accommodation—private, semi-private and basic—as provided on one CCAC's website, and wait time by priority level.

## MINISTRY RESPONSE

The Ministry agrees with the principles identified in the recommendation and will work with the CCACs, through the Ontario Association of Community Care Access Centres, to continue to promote ongoing and timely communication of appropriate information regarding the LTC home placement process. The Ministry will continue to work in partnership with CCACs in the ongoing review of these policies and processes. Further, the Ministry regularly reviews the policies and processes to ensure maximum utilization of all levels of accommodation in all homes.

## CCAC RESPONSE

Although this recommendation was not directed toward the CCACs, one CCAC highlighted its support for the disclosure of information that would help people choose which long-term-care homes to apply to, such as average wait times by home.

## OVERSIGHT

The Ministry is responsible for ensuring compliance with the *Long-Term Care Homes Act* (Act), which includes the LTC home placement process. The Ministry indicated it commenced monitoring the placement process in fall 2011, primarily by following up on complaints it received directly. We noted that the three CCACs visited all had processes in place for handling complaints. They indicated that very few complaints—on average, fewer than 20 per year—had been received about their LTC home placement process. Although one CCAC provided some general complaint statistics to its LHIN, no other information on complaints was regularly provided by the CCACs to either the LHINs or the Ministry.

Otherwise, the Ministry has delegated the oversight of the CCACs to the LHINs. The *Local Health System Integration Act* restricts LHINs' access to information on individual clients. However, through the LHINs' performance agreements with the CCACs, the LHINs receive information on the percentage of higher-needs clients who are placed in LTC homes. Furthermore, the CCACs visited all provided additional information to their LHINs regarding the LTC home placement process, such as the number of crisis placements by location in which the client was waiting and the number of placements by hospital.

Although the Ministry agreed with the recommendation in our 2010 Discharge of Hospital Patients report, regarding the need to establish benchmark standards for completing each stage in the LTC home placement process (such as times to determine client eligibility, for hospital clients to complete applications, to get clients onto a wait list, and to place clients), there are still few benchmark standards for this process. (See the Discharge of Hospital Patients follow-up section in Chapter 4 for additional information on the current status of this recommendation.) Other performance measures that would provide the Ministry or LHINs with information about the effectiveness of the LTC

placement process could include wait times for clients requesting preferred versus basic accommodation; wait times for clients waiting in hospital versus at home; percentage of clients who die while awaiting placement; and percentage of clients who receive their requested transfer to another LTC home.

## RECOMMENDATION 4

To enhance the oversight of the long-term-care (LTC) home placement process, the Ministry of Health and Long-Term Care (Ministry), in conjunction with the Local Health Integration Networks (LHINs) and Community Care Access Centres (CCACs), should:

- develop consistent performance measures for monitoring the process, such as wait times for clients waiting in hospital versus at home, wait times for clients requesting preferred (that is, private or semi-private) versus basic accommodation, and the percentage of clients who receive their requested transfer to another LTC home; and
- develop target guidelines for completing each stage of the LTC home placement process, such as the times to determine client eligibility, for hospital clients to complete placement applications, and for clients to get onto a wait list.

## MINISTRY RESPONSE

The Ministry will continue to review the data requirements as necessary to provide regular reporting on and monitoring of performance measures.