



Community Alternative to Long-Term Care Launching the Central LHIN IHSP-2

June 2010

Outstanding care – every person, every day

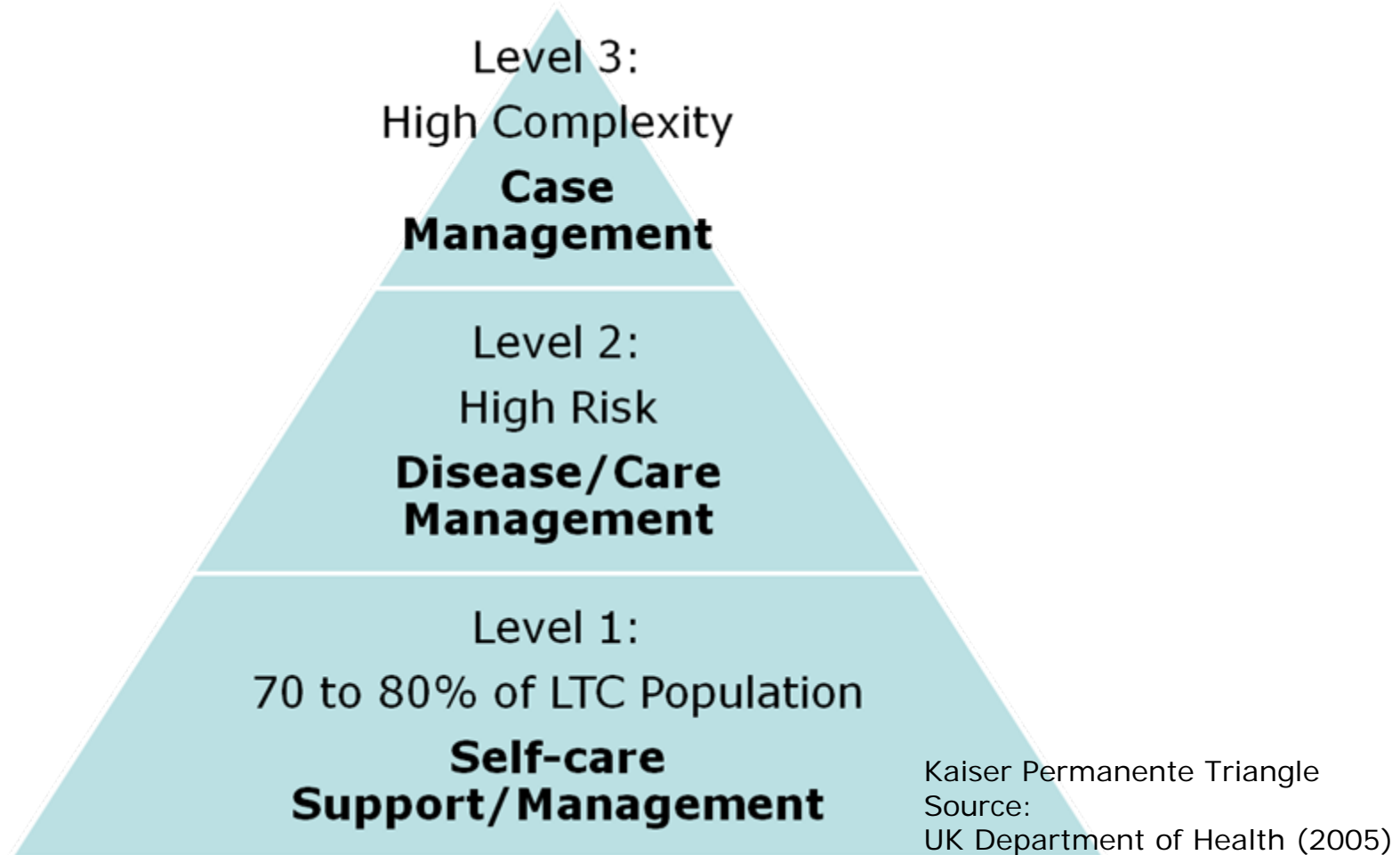
Community Alternatives to Long-Term Care

- 150 clients receiving CCAC and community support in their homes instead of placement in a Long-Term Care Home

Evidence to Action

- A growing body of international research suggests that Home & Community Care plays an important role in maintaining the health, well-being and autonomy of individuals and caregivers, while moderating demand for more costly emergency, hospital and long-term care beds, when:
 - Targeted
 - Case managed
 - Integrated into the broader continuum
- Personal Social Services Research Unit (PSSRU), University of Manchester
 - Dr. David Challis

Targeted, Integrated, Managed Care



Acknowledgements

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- Balance of Care Research Group
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 - Central LHIN/Central CCAC, CIHR Team in Community Care and Health Human Resources, MOHLTC/HMRU

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Central Balance of Care Expert Panel

June 2008

- **Kate Andrews**, Client Care Supervisor/Team Leader, CHATS
- **Jackeline Barragan**, Manager of Community Health Programs, Black Creek Community Health Centre
- **Naomi Cornfield**, Senior Social Worker/Team Leader, Circle of Care
- **Toni Dell'Aquila**, Director of Community Services, Villa Colombo
- **Susan Doyle**, Director of Strategic Program Development, Downsview Service to Seniors
- **Sharri Ann Edmunds**, Supervisor, Home Support, Comcare Health Services
- **Sheryl Ginsler**, Case Manager, Central CCAC
- **Amy Go**, Administrator, Yee Hong
- **Noreen Kallai**, Balance of Care Project Manager
- **Joan Lesmond**, Executive Director, Community Engagement, St. Elizabeth Health Care
- **Narain Motwani**, Manager of Community Support Programs, St. Clair West Services for Seniors
- **Shayes Mozaffari**, Social Worker, Newmarket Health Centre
- **Mary Neill**, Operation Director for Medicine and Emergency, York Central Hospital
- **Stella Ng**, Administrator, Mon Sheong
- **Mindy Packer-Bloom**, Social Worker, The Regional Municipality of York
- **Rudy Pedri**, Manager of Patient Flow and Clinical Utilization, Humber River Regional Hospital
- **Miriam Snider-Petry**, Supervisor, Placement Services, Central CCAC
- **Elizabete Spinasse**, Case Manager Central CCAC
- **Andrea Ubell**, Senior Social Worker, Alzheimer Society, York Region

Partners

- **Phase 1**
 - Central CCAC
 - Circle of Care
 - Downsview Services to Seniors
 - CHATS
- **Phase 2**
 - Carefirst Seniors and Community Services
 - Yee Hong Centre for Geriatric Care
 - Unionville Home Society
 - South Asian Group
 - Alzheimer Society
 - Community Capacity Building Project

Comparative Findings of CCAC Clients: Cognition

Cognitive Performance Scale

Short-term memory, cognitive skills for decision-making, expressive communication, eating self-performance

	Waterloo	Toronto	Central West	Central
Intact	43%	48%	33%	38%
Not Intact	57%	52%	67%	62%
Total	1100	1684	725	2631

Comparative Findings of CCAC Clients: IADL

IADL Difficulty Scale

Meal preparation, housekeeping, phone use, medication management

	Waterloo	Toronto	Central West	Central
Low Difficulty	2%	3%	1%	1%
Medium Difficulty	32%	32%	26%	25%
High Difficulty	66%	65%	73%	74%

Comparative Findings of CCAC Clients: Caregiver Living with Client?

	Waterloo	Toronto	Central West	Central
Yes	46%	35%	56%	55%
No	54%	65%	44%	45%

Central Sub-Groups: First 14 of 36

Sub-Group	Confusion	ADL Difficulty	IADL Difficulty	Live with Caregiver	Frequency (Percent)	Average MAPLe Score
1-Appleton	Intact	Low	Low	Yes	7 (0.3)	1.1
2-Bruni	Intact	Low	Low	No	23 (0.9)	1.4
3-Copper	Intact	Low	Medium	Yes	155 (5.9)	2.3
4-Davis	Intact	Low	Medium	No	257 (9.8)	2.2
5-Eggerton	Intact	Low	High	Yes	92 (3.5)	3.0
6-Fanshaw	Intact	Low	High	No	82 (3.1)	3.1
7-Grimsby	Intact	Medium	Low	Yes	1 (0.0)	3.0
8-Hamilton	Intact	Medium	Low	No	1 (0.0)	3.0
9-Islington	Intact	Medium	Medium	Yes	34 (1.3)	3.5
10-Jones	Intact	Medium	Medium	No	27 (1.0)	3.2
11-Kringle	Intact	Medium	High	Yes	77 (2.9)	3.4
12-Lambert	Intact	Medium	High	No	50 (1.9)	3.3
13-Moore	Intact	High	Low	Yes	0	N/A
14-Nickerson	Intact	High	Low	No	0	N/A

Central Vignette for Copper

- Copper is cognitively intact
- Copper is functionally independent with all ADLs with the exception of bathing (limited assistance is required)
- Copper has no difficulty using the phone, some difficulty managing medications, but great difficulty with meal preparation, housekeeping and transportation
- Copper has a live-in caregiver who provides advice/emotional support and assistance with IADLs

Central Home and Community Care Package for Copper

Service	Frequency (Visits or Hours per Week)
PSW – Bathing, Meal Prep, housekeeping	2hr 2x/week
Transportation	3 rides (return)/week
Meals on wheels	3/week
EPC (Elderly persons center)– wellness programs / congregate dining	2 (half days)/week
OT assessment – assistive devices, ADP application	2 visits total
Caregiver support (in home, Support group or in home counseling, education, social work support)	1 hr/biweekly
Life Line	
Cultural competence (Interpretation/translation)	2%
Client case management: Interdisciplinary Navigation and on- going support	2 hr /month

Central Home and Community Care Costing for Copper

Service	Code	Unit of service	Cost/unit of service to LHIN	Units of service for 13 weeks	Total LHIN cost
PSW		hour	\$27.75	52	\$1,443.00
Transportation	04A	one-way trip	\$22.00	78	\$1,716.00
Meals on Wheels	02A	meal	\$11.00	39	\$429.00
Elderly Persons Centre		visit (half day)	\$10.36	26	\$269.36
Occupational Therapy		visit	\$107.15	2	\$214.30
Caregiver Support	08B	hour	\$48.00	6.5	\$312.00
Emergency Response System	09F	one time	\$343.00	1	\$343.00
Client Case Management	09I	hour	\$42.00	6	\$252.00
CSS Total					\$4,978.66
Cultural Competence (2%)					\$99.57
TOTAL H&CC COST					\$5,078.23
TOTAL LTC (April 2007)					\$7,491.12

Community Alternatives to Long-Term Care

- Up to \$80 per day per client for all services
 - Traditional CCAC services and those provided by the CSAs
 - Amount of MOHLTC funding to Long-Term Care Homes for care
- MOHLTC policy
 - “CCACs cannot offer CSA services”
 - Letter from the Minister authoring Central CCAC to offer
 - Adult Day Programs
 - Homemaking
 - Transportation
 - Client Intervention (Social Work)

. . . so long as their was no cost to the client

Community Alternatives to Long-Term Care

- Funded basket of services
 - Adult Day Program
 - Meals on Wheels
 - Homemaking Support
 - Personal Emergency Response System
 - Caregiver Respite
 - Transportation
- Recently added Medication Management Services as per Aging at Home Project

BOC Service Tracker

BOC Service Tracker - v2.2 - Microsoft Excel

Home Insert Page Layout Formulas Data Review View

Clipboard Font Alignment Number Styles Cells Editing

C111

1	BOC Worksheet													
2	**Worksheet is not to be distributed. It is meant as a working tool for the BOC Case Managers to enter the service information.													
3														
4	Recommended Units	0												
5	Confirmed Units	0												
6	Available Units	80												
7	**Services Not Included in Confirmed Units (SLP, PT, ADP Nursing)	0												
8														
9		Initial Ax	Add-On 1	Add-On 2	Add-On 3	Add-On 4	Add-On 5	Add-On 6						
10		Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed	Recommend Confirmed
11	TYPE OF SERVICE													
12	Services													
13	Bathing													
14	Incontinence													
15	Feeding													
16	Dressing													
17	Mobility Assistance													
18	Transfers													
19	Caregiver Respite													
20														
21	Hours													
22	Hours/Month													
23														
24	Units													
25	Units/Month	0	0	0	0	0	0	0	0	0	0	0	0	0
26														
27														
28	ADLs/Homemaking (098)													
29	Med Cues													

Client & Assessment Info Service Info **Worksheet** Reference Sheet

Ready 100%

start Inbox - Microsoft Out... RE: HELP - Message ... LHIN Microsoft PowerPoint ... Home - Microsoft Inte... Microsoft Excel - BOC... 4:53 PM

Community Alternatives to Long-Term Care Project

Phase 1

- \$3.2 million in 2008/09
- 400 clients
- Geographically based
 - Richmond Hill and Downsview
 - Significant cluster of clients waiting for LTC
 - Existing CSA capacity to build

Phase 2

- \$1.8 million in 2009/10
- 155 clients in Markham
 - South Asian and Chinese communities and agencies
 - Diversity in community agencies
 - ADP and transportation

Long-Term Care Regulation Impacts

- Long-Term Care Placement Regulations take precedence
 - If client turns down placement as a result of BOC they must be removed from the wait list
- July 1, 2010
 - MAPLe score of 1 and 2 no longer eligible for placement
 - Priority to placement of MAPLe 5
 - No accepting to BOC
- Clients on BOC continue to deteriorate
 - e.g. Alzheimer's
 - Impact costs
 - Variations in acceptance of placement alternative

Groundbreaking Initiatives

- Expanded “tool kits”
 - Including transportation, adult day service, meals-on-wheels, personal emergency response systems
- Emphasis on care teams
 - Including doctors
- Greater opportunity for clients to determine mix of services within individualized budgets

Insights

- IADLs not ADLs top wait list drivers in all regions
 - Transportation, nutrition, housekeeping
- “Upward” to “downward” substitution
 - Barriers to accessing “lower level” services have often meant LTC (or hospitals) the default option
- Willingness to work with colleagues across continuum
 - Intensive case management
 - Clinical and financial accountability need to be combined
- Client and caregiver choice of services
 - Many caregivers also frail

Insights (cont'd)

- Ethno-racial diversity key, particularly extent to which different communities choose different housing options, support individuals, see caregiver roles
 - Presence of multi-generational households impacts on demand for formal services, mix of services, service costs
 - May account for relatively high needs on Central LTC wait lists

Relationships and Trust

- Difficult meetings and conversations with Community Support Agencies
 - Passionate about perspectives
 - CCAC accountability beyond normal activities . . . *which are normally the responsibility of CSA*
 - Adult Day Programs
 - Concern about future CCAC/CSA delineation of responsibilities between CCAC BOC Case Manager and CSA BOC Coordinator
 - RAI-HC and RAI-CHA; need to develop processes to share client information and to prevent duplicate assessments
 - Intensive pressure to meet all LHIN requirements
- Memorandum of Understanding (MOU)

What did we learn?

- 72% of clients have a degree of cognitive impairment
- 30% of clients are attending adult day programs
- 35% of clients are receiving transportation as part of the basket of services
 - Most of this is associated with the adult day programs
- 60% of clients are receiving homemaking support
 - Light cleaning, laundry, grocery shopping
 - Service often used as part of caregiver respite
 - *Caregivers are key*
- 23% of clients are accessing Meals-on-Wheels

What did we learn? (cont'd)

- While on Balance of Care:
 - 45 declined a bed offer
 - 27 died at home
 - 33 clients hospitalized
 - 47 clients with ED visits
 - Clients with a MAPLe 5 cannot be sustained at home
 - *Caregiver burnout*

Unintended Consequences

- Clients *move* to geographic area covered by program in order to access Balance of Care
- Advantageous for participating Community Support Agencies
 - Adult day programs
- Brought issue of co-payments to spotlight
- Due to degree of cognitive impairment in BOC clients we are adjusting the adult day program
 - Specific to the dementia client and are working with the local Alzheimer Society

Unintended Consequences (cont'd)

- Enhanced collaboration between CCAC and CSAs
 - Front-line Coordinators and Case Managers working closely to facilitate access to BOC
 - Operations Committee continues to meet to address questions and challenges as the program grows
- Next step is to consider the role of other CCAC services at the adult day programs
 - Is there a role for physiotherapy, occupational therapy, nursing services in an adult day program/clinic model?
 - Cost