TORONTO

STAFF REPORT
INFORMATION ONLY

Balance of Care Research Project

Date:	July 3, 2008
To:	Advisory Committee on Long-Term Care Homes and Services
From:	General Manager, Long-Term Care Homes and Services
Wards:	All
Reference Number:	

SUMMARY

The "Balance of Care" project was a groundbreaking research study launched by the Toronto Central Community Care Access Centre (CCAC) in collaboration with the University of Toronto and Ryerson University which asked: What proportion of individuals currently on the wait lists for long-term care homes in Toronto could be maintained at home if given access to appropriate community-based care packages?

The study adapted a Balance of Care (BoC) approach pioneered by researchers in the United Kingdom (UK) to assess the service mix that would be required to sustain individuals currently at risk of losing their independence. While many individuals deemed eligible for admission to a long-term care home have such high needs that they cannot be safely maintained at home, a growing body of evidence suggests that many others could be appropriately and cost-effectively supported in the community if given access to integrated, managed home and community care packages.

The Long-Term Care Homes and Services Division assisted with the research by providing oversight at a senior level, participating on the steering committee and expert panel, and providing data for service costing.

Key findings of the project suggest that over a third (37 percent) of the applicants on the Toronto CCAC wait list for long-term care homes could cost effectively remain in the community if supported by appropriate community services such as homemaking, meals on wheels, and transportation. A larger percentage of those same applicant (between 49 percent and 53 percent) could remain in the community if more integrated care options such a supportive housing and cluster care were available. However, one in five (20 percent) demonstrated higher levels of need that resulted in long-term care home admission being the best option irrespective of available community services.

By participating in the study, staff from the Long-Term Care Homes and Services Division provided valuable input into the process and expanded evidence supporting the value of community alternatives. Study results also confirmed the importance of the community programs offered by the division and clearly affirmed the worth of both the supportive housing and homemakers and nurses services programs in providing integrated care for an aging population.

Financial Impact

There are no financial implications arising from this report.

ISSUE BACKGROUND

This project was conducted by the Toronto Central CCAC in collaboration with researchers from the University of Toronto and Ryerson University. The study was based on research conducted in the United Kingdom by Dr. David Challis. Dr. Challis' research found that the need for placement into a long-term care home was dependent on two factors: the care needs of the individual and the availability of community-based resources to meet those needs. While some individuals with complex, long-term care needs could only be safely and cost effectively supported in a long-term care home, there was another group who, while eligible for long-term care placement, could be maintained in the community with proper supports.

Prior to initiating the Toronto study, the Steering Committee reviewed the results of a parallel BoC study conducted by the research team in partnership with the Waterloo-Wellington CCAC and service providers from across the care continuum. In that study, the results suggested that up to half of those currently waiting for LTC beds in the Waterloo region could be cared for in the community with better outcomes for individuals and their caregivers and lower or comparable costs for the health care system.

The purpose of the Toronto study was to determine how many individuals on the wait list for long-term care homes could be maintained in the community if appropriate community support was available. The study was conducted in three phases. In the first phase, Toronto Central CCAC RAI-HC data was used to categorize individuals waiting for long-term care into homogenous groups based on activities of daily living (ADL), instrumental activities of daily living (IADL), cognitive ability, and the availability of a caregiver. In phase two, an expert panel of experienced case managers from different health care sectors designed care packages for each of the above groups that would allow the individuals to remain at home. In the third phase, provincial data was used to calculate the costs of the care packages recommended in phase two. When the cost of these packages developed in phase two was less than the cost of a long-term care bed, it was deemed that persons on the wait list could be diverted from a long-term care home into the community. The hypothesis was that most individuals prefer to stay in their own home and in some cases it is less costly to provide support in this setting.

The Long-Term Care Homes and Services Division supported the project in several ways. First, the General Manager was a member of the Steering Committee that provided overall guidance to the project in Toronto. The Manager of Community Programs was a

member of the expert panel that developed the care packages in phase two. City staff assisted with and provided input into the costing exercise in phase three.

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COMMENTS

Dr. Challis developed the BoC approach to inform decision making at the system level about the most appropriate mix of facility-based and community-based resources needed to meet the needs of an aging population. BoC is a system planning tool, not a clinical placement tool.

At a system planning level, there is considerable discussion currently occurring related to alternative level of care (ALC) patients in hospitals, EMS offload delays in emergency departments and appropriate use of long-term care home beds to alleviate hospital pressures. Some long-term care homes have developed convalescent care programs, short-stay programs and low-tolerance long-duration (LTLD) rehabilitation programs to assist in responding to the hospital pressures. The recently announced "Aging at Home Strategy" builds on these initiatives and is intended to develop more robust community alternatives.

The Toronto study suggests that up to 80 percent of the patients in hospitals awaiting a long-term care home admission could be discharged to the community if appropriate, safe, and cost-effective community services were available. The Toronto study suggests that supportive housing is clearly the preferred option, particularly for those with more care needs. This care model is also considered to be more financially viable, due to the ability to pool resources and respond to needs related to activities of daily living (e.g., medication management).

The Toronto study also suggests that in expanding and/or enhancing supportive housing and other community alternatives, consideration be first given to "at risk" populations, for moral and ethical reasons and because they tend to be intensive users of more costly services. A BoC approach however suggests that savings in this area should be redeployed to other areas to achieve a truly balanced system.

Further, a BoC approach suggests that it is imperative to integrate care across the continuum in order to facilitate the most appropriate, cost-effective care substitutions within and across sectors. It is important to establish cross-sector benchmarks (e.g. ALC rates; ER admissions; EMS negative transfers) and balance investments to meet needs. Last, the BoC approach suggests that it is imperative to actively manage services,

prioritizing those at risk, then those in crisis and then those least likely to be able to navigate the system. Care provider partners must be willing to build the system from the ground "up" around the needs of individuals and combine both financial and clinical accountability to avoid cost-shifting.

The study affirmed that the division's current approach and scope of services are accurate, responsive and appropriate. The division provides care for over 2,600 individuals in long-term care homes, approximately 320 individuals in supportive housing settings, over 170 individuals in adult day programs and over 2,200 individuals who are supported in their own homes through the provision of support services such as cleaning, laundry, limited shopping, and assistance with meal preparation. Thus, the City is providing exactly those services that the BoC study recommends as essential to actively manage wait lists for long-term care and to alleviate the hospital pressures in the provision of health care.

There are, of course, other reasons to support individuals in their own homes besides reducing the wait lists for long-term care home placement. First, the BoC study clearly demonstrates that when care in the community is appropriate, the cost of providing in-home support is less than for facility-based options. Next, the stated preference of seniors is to age in place. Ontario announced its "Aging at Home Strategy" in August of 2007 to address the fact that Ontario's population is aging and that the number of seniors will double within the next 16 years. This program, administered through the Local Health Integrated Networks (LHINs) will ensure that resources are available to assist those who wish to remain at home.

The division is pleased to have participated in the BoC study, as a systems planning exercise. The results of the study suggest that Ministry of Health and Long-Term Care investment in community alternatives will be both cost-effective and respond to the preferences of individuals requiring long-term care. Although the division currently offers a care continuum, the BoC study demonstrates the need to expand the supportive housing program and the homemakers and nurses services programs.

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