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Canadian Research Network for Care in the Community

Integrating Community Care: Evidence, Best Practices and Knowledge Networks

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Social Sciences and Humanities Research Council of Canada

University of Toronto

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Leadership & Innovation

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Big Picture Thinking

"The idea of 'stepping back and viewing the big picture' is very important through the policy change process because it keeps you focused on your ultimate goal. Stepping back reminds you that new policy is not your ultimate goal but rather a means to reach your goal. Stepping back makes you see the whole forest, not just individual trees."

OPHA Guide for Policy Change

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Anticipating Change

Wayne Gretsky

- It’s not enough to know where the puck has been -- you have to know where it’s going

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Balancing Goals

- *The top line*: individual needs and preferences
  - Diversity
  - Equity

- *The bottom line*: cost-efficiency, cost-savings, cost containment
  - Access
  - Sustainability

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First Law of Health Economics

- It is always easier to shift costs, than to achieve cost-efficiencies

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Where the Puck is Headed: Home and Community

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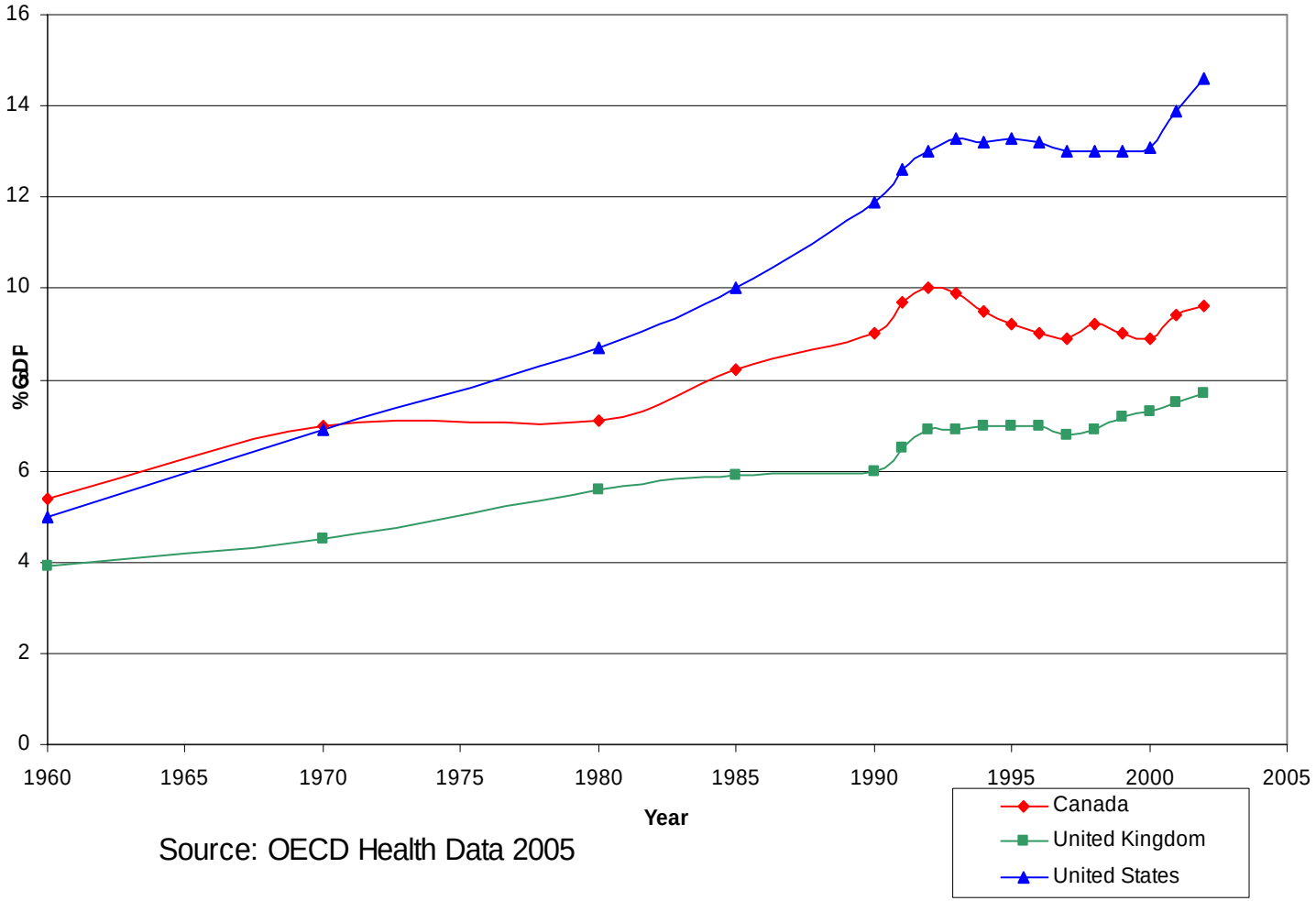
Total Expenditure on Health as %GDP (1960-2002)



Source: OECD Health Data 2005

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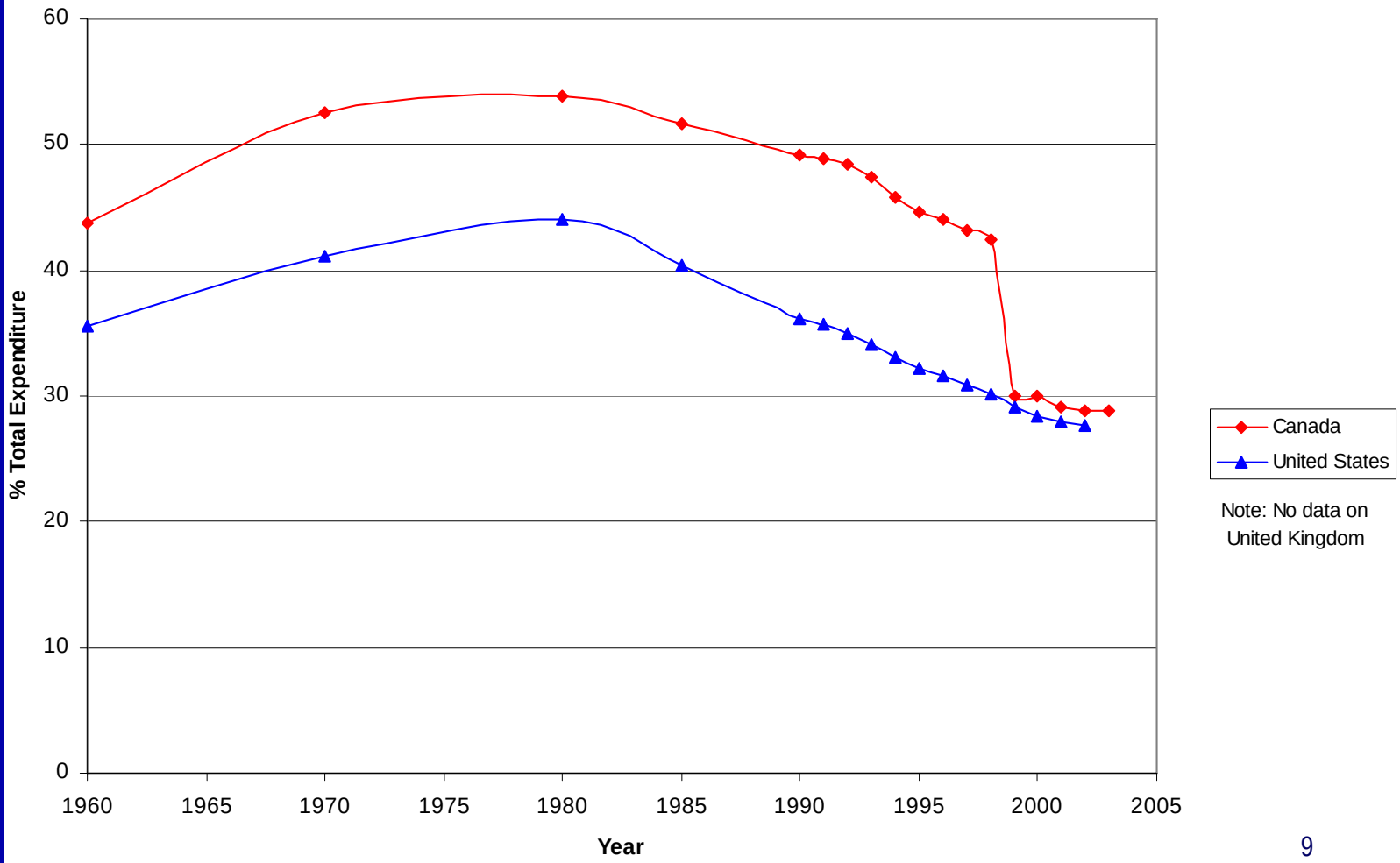
Total Expenditure on In-Patient Care, as % Total Expenditure on Health (1960-2003)



Source: OECD Health Data 2005

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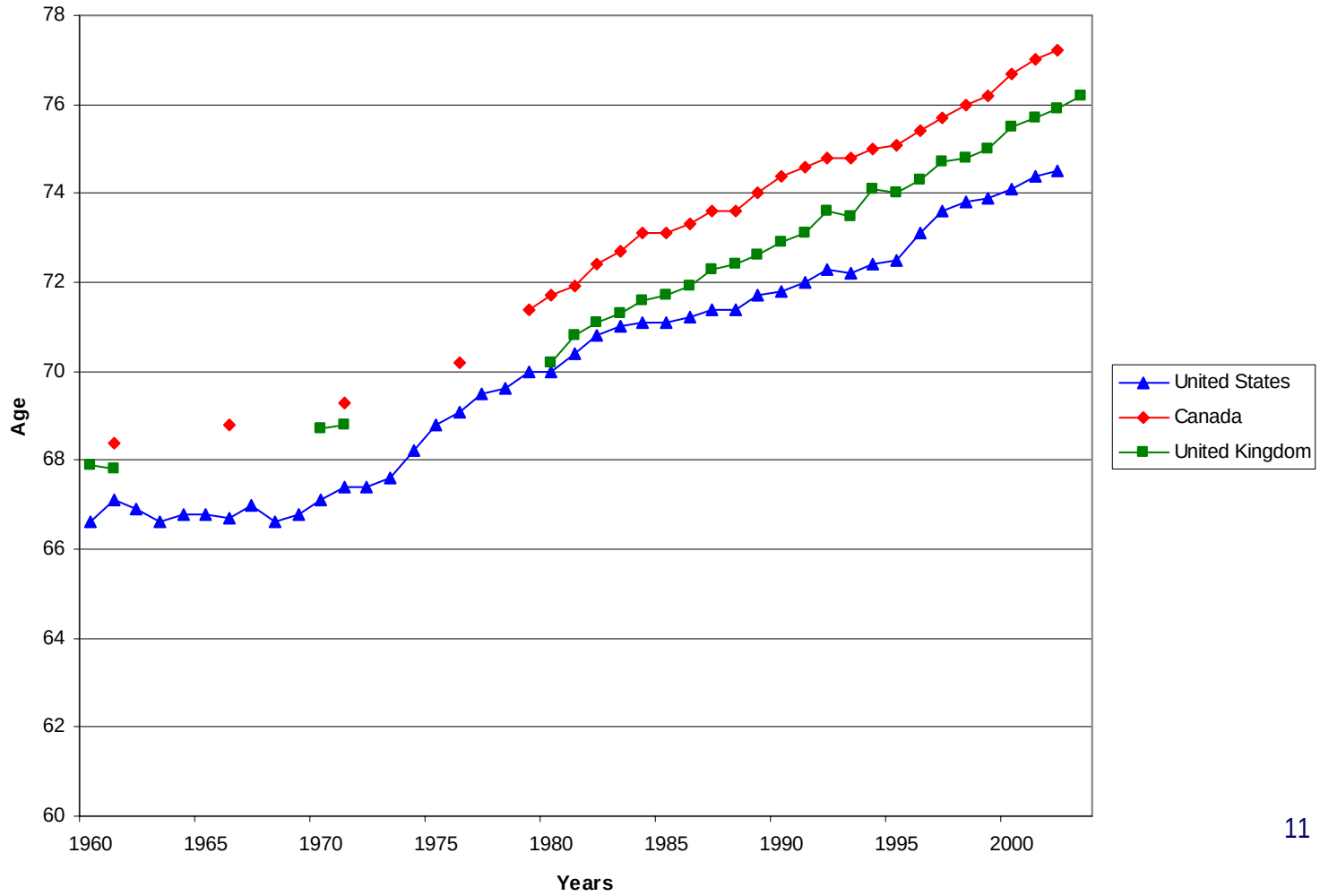
An Aging Population: UK
(Wanless Social Care Review, 2006)

- Costs
  - In 2004/5, local authorities spent £8 billion on social care
  - £ 3.7 billion on benefits
  - £ 3.5 billion on residential and home care
- Needs
  - Next 20 years, number of people 85+ to increase by 2/3, compared to 10% overall
  - Healthy life expectancy gains not kept pace with life expectancy gains
  - In 2002, over people unable to carry out 1 or more ADLs (e.g., washing, dressing)

Life Expectancy of Males at Birth (1960-2002)



Source: OECD Health Data 2005

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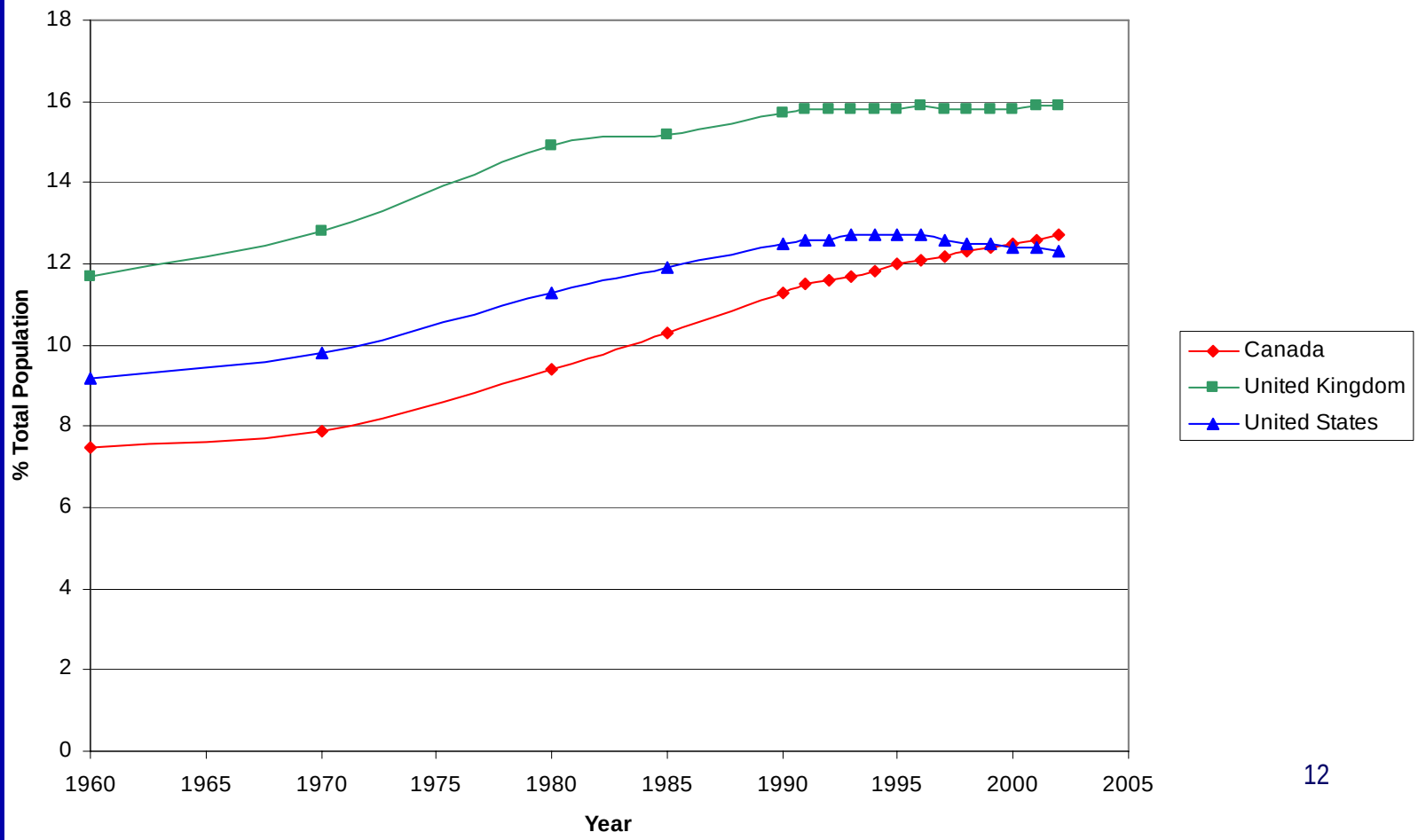
Population 65 Years + as % Total Population (1960-2002)

Source: OECD Health Data 2004



Vital Signs: Targeted, Managed Care

- Just 5% of in-patients account for 42% of acute bed days

- Stratify patients and match care needs
  - Level 1: supported self care
  - Level 2: disease-specific care management
  - Level 3: intensive care management

Supporting People with Long Term Conditions (2005)

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Vital Signs: Cross-Sector Thinking and Action

- The Government has made it one of its top priorities…. to bring down the 'Berlin Wall' that can divide health and social services, and to create a system of integrated care…..

Modernizing Social Services (1988)

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The Case of Ontario, Canada

- Ontario now engaged in a major rethinking of health and social care system (Local Health Integration Networks)
  - Hospitals, home care (nursing, rehab), community support services
  - Integrated budgets
  - Integrated assessment
  - Single point of access

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Complications: A Complex Terrain

- Range of formal/informal services in diverse settings by regulated/non-regulated providers
- Little coordination, integration of services
- No “uniform terms and conditions”
- Multiple needs groups
- Limited consensus on role of the state, individuals, families, communities

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Complications: Managed Competition

- Introduced as mechanism for purchasing services from for-profit and not-for-profit providers,
  - Achieve competitive market advantages, managed for social purposes
- But …
  - Information proprietary
  - Unwillingness to share best practices for fear of losing competitive edge
  - As HHR fled, prices rose

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Complications: Researcher/Practitioner Divides

- Distrust of academic knowledge
  - Every case different
- Unwillingness of researchers to demonstrate relevance
  - Make evidence accessible

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The Evidence

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What Does the International Evidence Tell Us?

- Stand-alone CSS may or may not achieve gains
  - Individuals with widely varying needs
  - Multiple services and informal carers
  - Limited ability to do comparative costing analysis
  - Little systematic outcomes data
  - Different methodologies
  - Different time frames

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What Does the International Evidence Tell Us?

- Targetted CSS within an integrated continuum consistently achieve individual and system goals
  - Maintain the health, well-being and autonomy of individuals and families
  - Reduce demand for more costly emergency, hospital and residential care (e.g., nursing homes)

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US: On Lok/PACE

- On Lok/PACE (Program of All Inclusive Care for the Elderly)
  - Initiated in the early 1970s in San Francisco Chinese community
  - Currently 36+ PACE replication projects in U.S.
- *Service model*
  - Organized around adult day care centre
  - Individuals transported to services
  - Continuum of services including CSS and health care
  - Needs assessed and managed on ongoing basis by multi-disciplinary team

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On Lok/PACE

- *Target group*
  - "At risk" seniors
  - Average 80 years of age (33% are over 85)
  - Average 7.9 medical conditions (including, diabetes, dementia, coronary heart disease, and cerebrovascular diseases)
  - Most live alone
  - 40% poor enough to qualify for public income supplements
  - All clients qualify for admission to nursing homes

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On Lok/PACE

- *Funding model*
  - Government funding for PACE clients averages 95% of the costs of institutional care

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On Lok/PACE

- *Outcomes*
  - Most resources channeled into CSS (e.g. transportation)
  - Just over a fifth (22%) to health care (e.g., hospitals, long-term care, x-rays, lab tests, medications and medical specialists)

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On Lok/PACE

- *Outcomes*
  - Better health status and quality of life, lower mortality rates, increased choice in how time is spent, greater confidence in dealing with life's problems
  - Care costs 21% lower for participants
  - Inpatient care costs (hospital and skilled nursing) 46.1% lower
  - 5-15% cost savings over standard fee for service care

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Balance of Care Model

- Personal Social Services Support Unit (PSSRU), University of Manchester
  - Determine most appropriate mix of institutional and community resources to meet needs of an aging population

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Balance of Care

- *Key questions*
  - Which groups of older people require residential and nursing home care?
  - What combinations of institutional and CSS services are required for specific groups?
  - How can we solve system problems (“bed blockers,” unnecessary hospital/residential admissions)?

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Balance of Care

- Use assessment data to stratify older persons into homogeneous needs groups
- Target those most likely to lose independence
- Employ
  - Ongoing assessment
  - Intensive case management
  - Integrated budgets and clinical responsibility
  - Appropriate health and social care packages

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Balance of Care

- *Outcomes*
  - Reduced facility admissions (15% to 28%)
  - Reduced care costs
  - Enhanced social activity, morale, and satisfaction with life development for older persons, while reducing depression, and stabilizing care needs
  - Reduced stress and the burden of care for informal carers
  - Increased satisfaction for service providers including family physicians

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Having A Great Idea Is Not Enough

- Knowledge mobilization networks an important tool for:
  - Building cross-sectoral political partnerships
  - Translating knowledge into practice

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From Ideas to Action: Mobilizing Knowledge

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Background

- CRNCC grew out of March 2005 symposium: “From Ideas to Action: Community Services in the Continuum of Care”

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Knowledge Impact in Society

- Social Sciences and Humanities Research Council of Canada wanted more *knowledge mobilization* initiatives:
  - "…moving knowledge into active service for the broadest possible common good…"
- Canadian Health Services Research Foundation emphasized vital importance of *knowledge networks* for organizations, institutions, individuals
  - " … crucial support for evidence-based decision-making and best practice."

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Funding: SSHRC and Ryerson University

- $300,000 from SSHRC with $300,000 matching funds from Ryerson University.
- Consolidate and expand efforts to gather, synthesize the best available evidence about home and community care.
- Ensure a stable knowledge exchange infrastructure locally, nationally and internationally.

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CRNCC: Who We Are

- National network of over 200 members of researchers, providers, citizen groups, community organizations, consumers and policy makers.

- Collaborative partnerships with researchers from universities in Canada and the UK (including CHILL).

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Partners and Members Include:

Centre for Health Improvement and Leadership in Lincoln, UK (CHILL)
Canadian Healthcare Association
Canadian Institute for the Blind (CNIB)
Canadian Mental Health Association
Canadian Pensioners Concerned, National
Canadian Red Cross
Centre for Addictions and Mental Health (CAMH)
Children and Youth Home Care Network
Health Canada/Santé Canada - Home and Continuing Care Unit
Ontario Ministry of Health and Long Term Care
Mount Sinai Hospital
Ontario Association of Community Care Access Centres (OACCAC)
Ontario Association of Non-Profit Homes & Services for Seniors (OANHSS)
Ontario Coalition of Senior Citizens' Organizations (OCSCO)
Ontario Community Support Association (OCSA)
Ontario Home Care Association
Ontario Seniors' Secretariat
Personal Social Services Research Unit, University of Manchester
Registered Nurses Association of Ontario
VHA Home Healthcare
VON Canada

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CRNCC Goals: What We Do

- Link people to knowledge about home and community care as an integral part of the continuum of health and social care.
- Raise the profile of home and community care sector within care continuum.
- Build community capacity.
- Provide evidence to facilitate advocacy.

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In Focus Fact Sheets

- *Community Support Services in the Continuum of Care*
  - Short, concise summary in lay language of most recent international evidence
  - Guide to system design
  - Support for advocacy

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Applying The Balance of Care Model

- 700+ seniors on waiting lists for LTC placements in Waterloo-Wellington
- How many could be diverted to care packages in the community?
- Held joint symposium based on Fact Sheet
- Established inter-sectoral working group to assess data, estimate care packages and costs, plan and implement change

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Building Community Capacity

- Example of mobilising knowledge from our United Way study to help Toronto Community Housing (TCHC)
  - Largest social housing provider in North America
  - Home to about 164,000 tenants
  - About 37% are seniors
- Wants to develop a viable aging in place strategy
  - Set standards and benchmarks for non-profit housing in North America

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"When home is community"

Lum, Ruff & Williams (2005)

- Seniors in supportive housing –high risk and eligible for LTC
- 80% women
- 40%, 85+ years
- Low income
- Live alone --more likely to be isolated and to face the mental and physical risks that accompany isolation (like depression)
- Multiple health problems
  - greater incidences of high blood pressure, osteoporosis, arthritis, heart problems, cancer as compared to the general elderly population

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"When home is community"

Lum, Ruff & Williams (2005)

- Minimal services
  - 25% --bathing, eating, toileting, dressing
  - 80% vacuuming, cleaning, laundry
  - Most continued to receive help from family

- Better outcomes for individuals
  - Live independently
  - High social connectedness
  - Self-reported health status "better" than peers
  - Confident about receiving help when needed
  - Less use of 911 and emergency departments

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"When home is community"

Lum, Ruff & Williams (2005)

- Key conclusions
  - Importance of active care management
  - Critical role of community supports provided by community agencies

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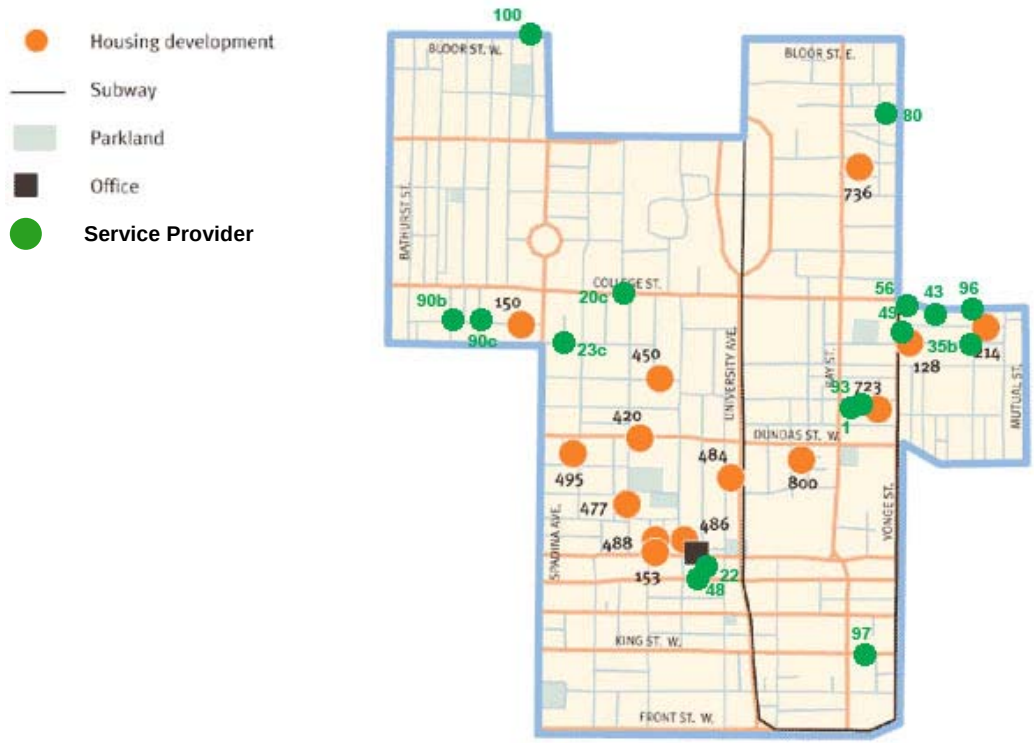
Connecting clients to providers

Spadina-Downtown

Community Housing Unit (CHU) 10

Toronto Community Housing



Basket of services

CHU 10: Spadina/Downtown

	Adult Day Service	Caregiver Support	Respite Service	Foot Care	Friendly Visiting	Home Maintenance	Homemaking	Personal Support	Client Intervention	Meals on Wheels	Misc.	Other Meals	Psycho-geriatric Counselling	Supportive Living	Transportation
1. 2-Spirited People of the 1st Nation 43 Elm Street 416-944-9300		x													
20. Carefirst Seniors and Community Services Association 203 College Street 416-585-2013					x		x	x	x		x	x			x
22. Centre for Independent Living in Toronto 205 Richmond Street West 416-599-2458											x				
23. Centre for Information and Community Services 58 Cecil Street 416-598-2022											x				
35. Family Service Association 355 Church Street 416-595-9618		x							x						
43. Hospice Association of Ontario 27 Carlton Street 416-304-1479											x				
48. LOFT Community Services 205 Richmond Street West 416-979-1994								x				x			
49. McLeod House 423 Yonge Street 416-340-7241														x	
56. NABORS 2 Carlton Street 416-351-0095														x	
80. Society of Sharing: Inner City Volunteers 10 St. Mary Street 416-413-0380					x										x
90. St. Stephen's Community House 91 Bellevue Avenue 416-925-2103 260 Augusta Avenue 416-964-8747	x								x		x				
93. Three Trilliums Community Place 25 Elm Street 416-598-1564								x						x	
96. Toronto People with AIDS Foundation 399 Church Street 416-506-1400											x				
97. Trinity Home Hospice 25 King St W. 416-364-1666		x													
100. Volunteer Centre of Toronto 344 Bloor Street West 416-961-6888		x							x		x				

Sources:
Teplitsky, F., Williams, A. P & Lum, J. M. (2003). *The final frontier: Impacts of health reforms and population change on the community support sector in Toronto*. Toronto: Toronto District Health Council.
Ontario Community Support Association. (n.d.). *Toronto Care Finder Maps*. Retrieved June 7, 2005 from http://www.ocsa.on.ca/whoweare/body_carefinder_toronto_maps.html
Toronto Community Housing Corporation. (n.d.). *Our communities*. Retrieved May 30, 2005 from http://www.torontohousing.ca/our_communities/

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Connecting Clients to Providers

Scarborough North

Community Housing Unit (CHU) 23

Toronto Community Housing

Housing development

Railway

Parkland

Office

Service Provider

Basket of Services

CHU 23: Scarborough North

	Adult Day Service	Caregiver Support	Respite Service	Foot Care	Friendly Visiting	Home Maintenance	Homemaking	Personal Support	Client Intervention	Meals on Wheels	Misc.	Other Meals	Psycho-geriatric Counselling	Supportive Living	Transportation
20. Carefirst Seniors and Community Services Association 3825 Sheppard Avenue East 416-291-1800					x		x	x	x		x	x			x
23. Centre for Information and Community Services 3850 Finch Avenue East 416-292-7510 4002 Sheppard Avenue East 416-299-8118											x				
79. Shepherd Village 3758 Sheppard Avenue East 416-609-5700															
107. Yee Hong Centre for Geriatric Care 2311 McNicoll Avenue 416-321-6333	x	x			x			x		x	x	x			x

Sources:
Teplitsky, F., Williams, A. P & Lum, J. M. (2003). *The final frontier: Impacts of health reforms and population change on the community support sector in Toronto*. Toronto: Toronto District Health Council.
Ontario Community Support Association. (n.d.). *Toronto Care Finder Maps*. Retrieved June 7, 2005 from http://www.ocsa.on.ca/whoweare/body_carefinder_toronto_maps.html
Toronto Community Housing Corporation. (n.d.). *Our communities*. Retrieved May 30, 2005 from http://www.torontohousing.ca/our_communities/

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In Conclusion

- Increasing pressures on national health systems
  - Threaten access and sustainability
- Growing evidence on crucial role of community support services in integrated health and social care systems

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In Conclusion

- Having a good idea is not enough
- Knowledge networks like CRNCC can play an important role in mobilizing knowledge for system change and building cross-sectoral alliances to support change

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