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Canadian research network for care in the community

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Leading knowledge exchange on home and community care

Supporting People & Sustaining Medicare: The Role of Home and Community Care

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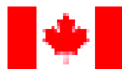


Social Sciences and Humanities Research Council of Canada

The Medicare Conundrum

- While universal Medicare remains a defining characteristic of Canadian identity and top policy issue, “sustainability” a key concern

- Health care costs rising steadily across all OECD countries
  - In 2005, Canada spent 10.4% of GDP on health

A Narrow Policy Response

- Continuing preoccupation with hospital and doctor “mainstream” (wait lists)

- Home and community care which can prevent/delay illness & dependency, or substitute for care in a hospital or long-term care facility, remains low on the radar

Home & Community Care (H&CC): A Complex Terrain

- Home care
  - Mostly professional, often post-acute, health care services (e.g., nursing, rehabilitation, social work)
- Community support services
  - Mostly non-professional services including:
  - Assistance with personal activities of daily living (ADL) -- eating, bathing, grooming, walking, dressing, toileting, personal hygiene
  - Assistance with instrumental activities of daily living (IADL) – preparing meals, vacuuming, laundry, changing bed linens, bathroom and kitchen cleaning, managing finances, using the telephone, shopping, transportation

Diverse Needs Groups

- Individuals with such high needs that they are “at risk” of losing independence and requiring care in an institution …
  - As well as those who require minimal assistance with activities of daily living
- Most are seniors …
  - But other needs groups, including persons with disabilities and a growing number of medically-fragile children and their families, also utilize H&CC

Beyond Medicare's Frontier …

- H&CC outside the Canada Health Act
  - Not "medically necessary" doctor and hospital services
  - No entitlement -- provinces choose coverage
  - No "uniform terms and conditions"
- Limited consensus on role of the public state, private markets, individuals, families, communities

…But Critical to Medicare's Future

- Continued preoccupation with acute care, failure to see H&CC as part of continuum, fails to address roots of ALC beds, ER backlogs, LTC facility wait lists

The ALC Problem

- Estimated 2800+ individuals currently waiting for alternate level of care in Ontario
  - 16% of all acute care beds in the province
- System flow problem
  - 25 – 50% waiting for LTC beds
  - Estimated 700 patients in ER waiting for acute care beds

The ALC Problem – NE LHIN Is Not Alone

- In NE LHIN (2004/05) 185 acute care beds filled by ALC patients more suited for service elsewhere
- In 2006, ALC occupancy rate in acute care beds in Ottawa hospitals in excess of 19% and rising

ALC Beds – Bad for People & Bad for the System

- ALC patients not getting care in right place
- Acute care capacity diminished which can lead to ER overcrowding
- Hospitals expend considerable effort managing ALC patients
- ALC patients experience significant wait times for appropriate care or need to move away from families, informal support

Alternate Level of Care – Challenges and Opportunities. OACCAC, OANHSS, OHA, OLTCA, March 2006

Toward a System Perspective

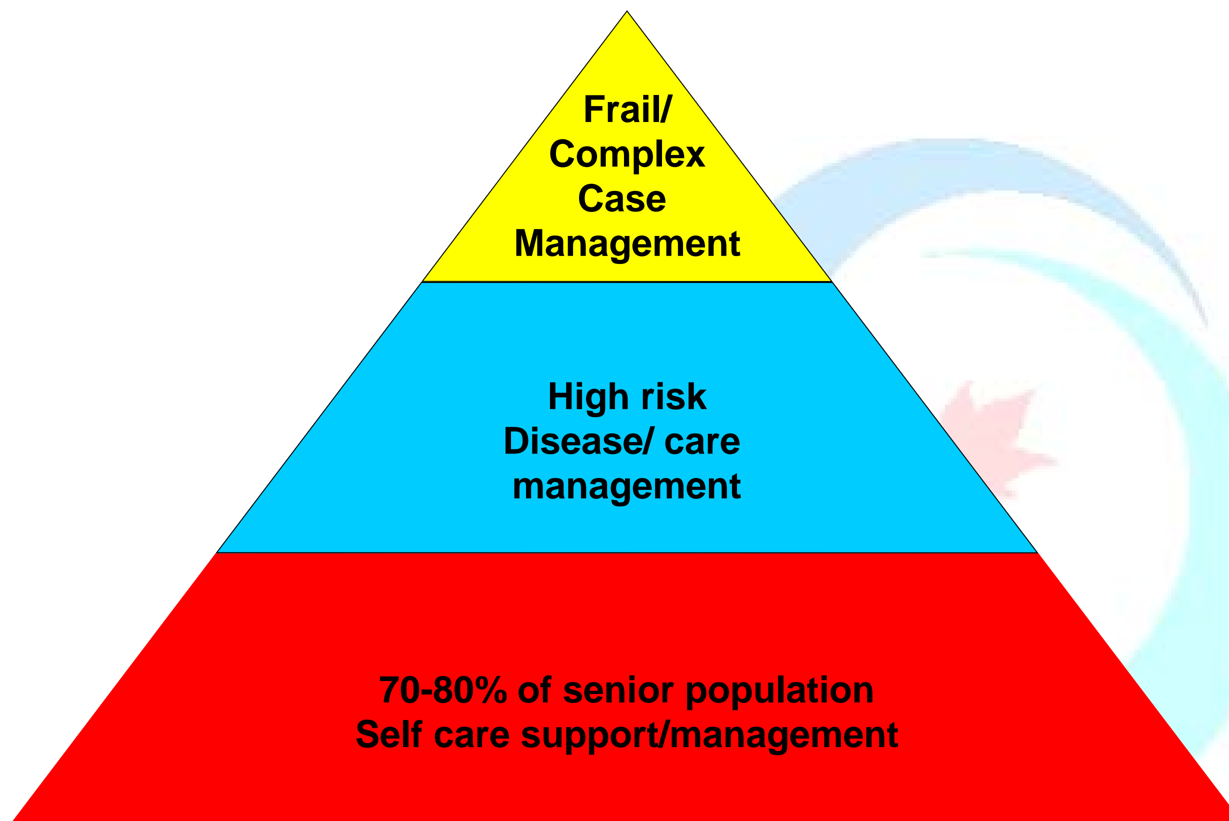
- "The OHA recommends that the ALC issue be addressed from a health system perspective, and involve additional investments in the acute care, long-term care, home care, complex continuing care and rehabilitation sectors and in supporting housing beyond what is currently planned .. Concerted action is needed to ensure that patients, particularly elderly patients, receive the care that they need, where and when they need it …"

  Hillary Short, President and CEO, Ontario Hospital Association, March 22, 2007

Credible and Growing Evidence

- Targeted, managed home & community care within an integrated continuum consistently meet individual & system goals
  - Maintain the health, well-being and autonomy of individuals and carers
  - Help solve key health system problems (e.g., high numbers of ALC beds, ER and LTC waits)
- Little evidence for fragmented services

Targeting and Managing Needs



Kaiser Permanente Triangle

Source: UK Department of Health (2005)

The Evidence

Vital Signs: Veterans' Independence Program

VIP is a comprehensive suite of services to 103,000 clients – mix of approaches

- **Personal Care** (e.g. bathing, dressing)
- **Health and Support Services** (e.g. nurses to administer medication, occupational therapists)
- **Access to Nutrition (**e.g. Meals-on-Wheels)
- **Housekeeping** (e.g. laundry, vacuuming, meal preparation)
- **Grounds Maintenance** to assist with grass cutting and snow removal

Thanks to Dr. David Pedlar – go to www.CRNCC.ca

Veterans' Independence Program

- **Ambulatory Health** outside the home (e.g. adult day care, health assessments, diagnostic services, and travel costs to access these services)
- **Transportation** (e.g. for attending senior citizen centers and churches, shopping, banking, and visiting friends)
- **Home Adaptations** (e.g. bathrooms, kitchens, doorways can be modified to provide access for basic everyday activities like food preparation, personal hygiene, sleep)
- **Nursing Home Care** in the client's community may be provided if / when the client can no longer remain at home.

Veterans' Independence Program

- **Problem**: growing wait lists for LTC beds
- **Intervention**: home care option offered to wait listed clients – care managers have integrated client budgets encouraging appropriate care across continuum
- **Result**: most on LTC wait lists preferred to stay at home with added support -- grounds maintenance, housekeeping, most used
- **Impact**: program implemented nationally in 2003, now under evaluation

Vital Signs: Vancouver Coastal Health

- Mix of in-house and contracted services
- 24,500 staff
- Over 5000 volunteers
- 17 Municipalities/Regional Districts
- 15 First Nation Communities
- 56 Residential Care Facilities (6343 beds)
- 14 Acute Care Facilities (1848 beds)
- 14 Assisted Living sites (620 units)
- Community programs and services

Thanks to Nancy Rigg – go to www.CRNCC.ca

Vancouver Coastal Health

- Initially targeted highest needs groups
  - Complex care seniors, ABI, adults with disabilities
- Linked community care funding to system outcomes
  - E.g. ALC bed reductions
- Shifted focus away from LTC beds …
  - To assisted living (supportive housing) and home care

Vancouver Coastal Health

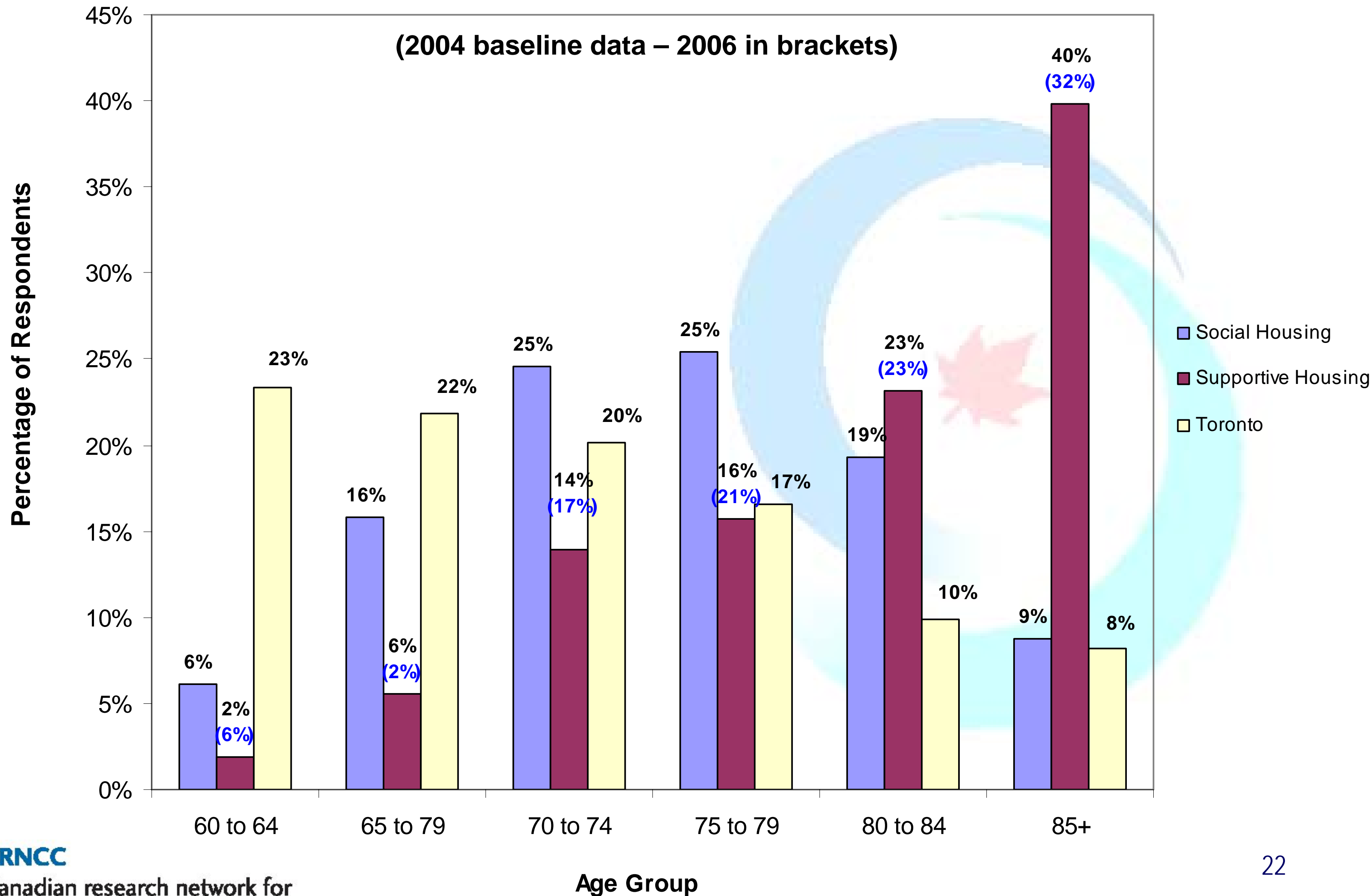
- ALC days reduced from 12% to 6%
  - Freed up system resources for community care
  - Seniors lose 5% capacity each day in hospital
- 17 in-patient ED beds saved
  - Introduced geri-triage nurses
- Residential care bed numbers reduced
  - 500 beds closed although 25 to 30% of community clients met residential care thresholds

Vital Signs: Toronto Supportive Housing Study

- Comparative study of seniors in social housing and supportive housing
  - Three pairs of buildings, 3 areas of Toronto
    - 2004-5: 226 seniors interviewed
    - 2006-7: interviewed 113 of these same seniors
  - Comparable incomes (rent geared-to-income), living arrangements, access to H&CC
  - Key difference: in social housing H&CC may be available – in supportive housing, H&CC case managed

Source: Lum, Ruff & Williams, 2005 -- *go to* www.CRNCC.ca

Age



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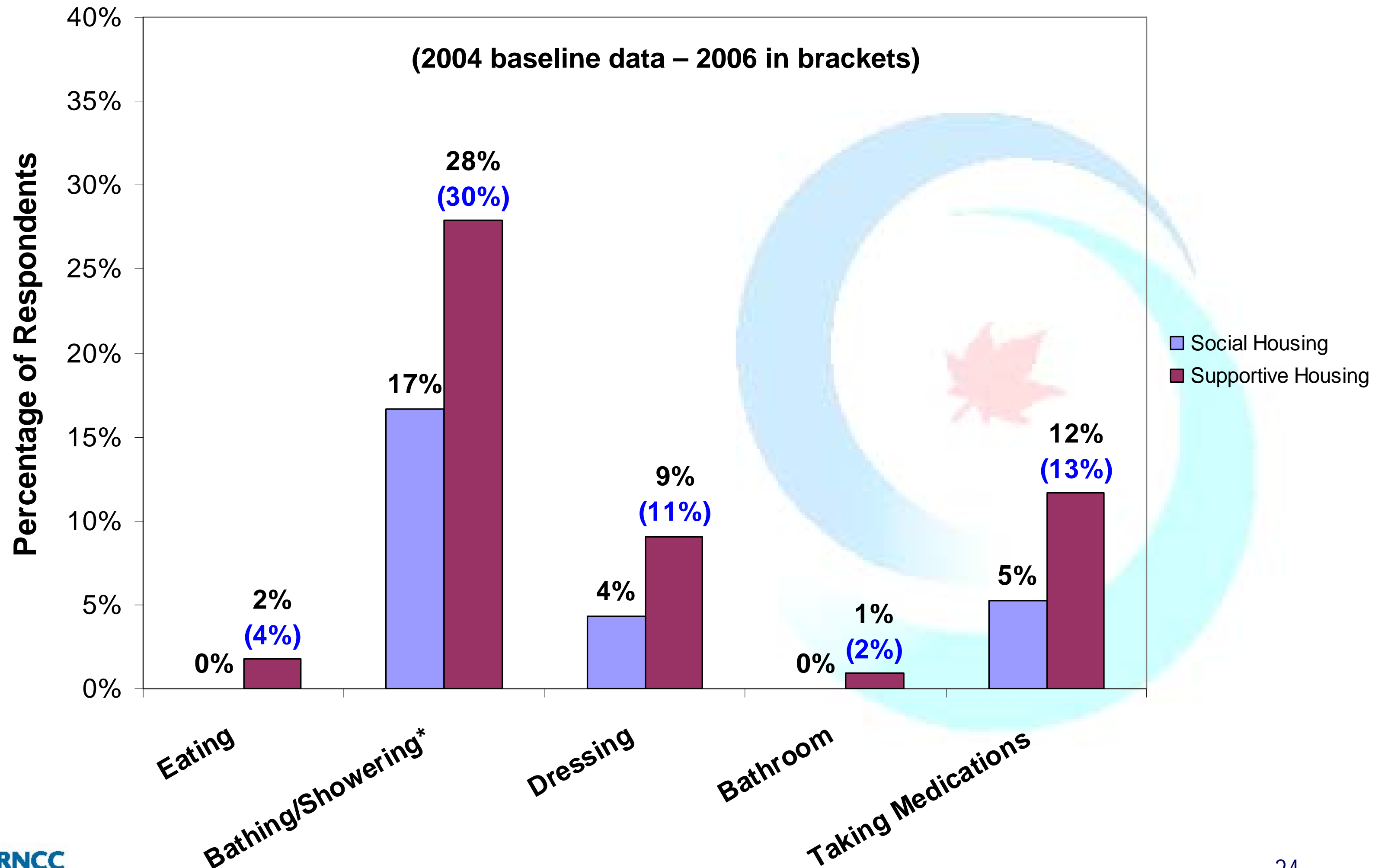
Health Risks

Disease	Social Housing	Supportive Housing	Seniors Population in Canada (1996)
Arthritis	**61%**	**69% (66%)**	**42%**
High Blood Pressure	**56%**	**59% (60%)**	**33%**
Back Problems	**60%**	**51% (43%)**	**-**
Heart Problems	**36%**	**38% (34%)**	**16%**
Osteoporosis	21%	44% (42%)	-
Diabetes	23%	16% (23%)	-
Stroke	10%	10% (19%)	-
Tumour/ cancer	8%	15% (9%)	-

(2004 baseline data – 2006 in brackets)

Supports for ADL



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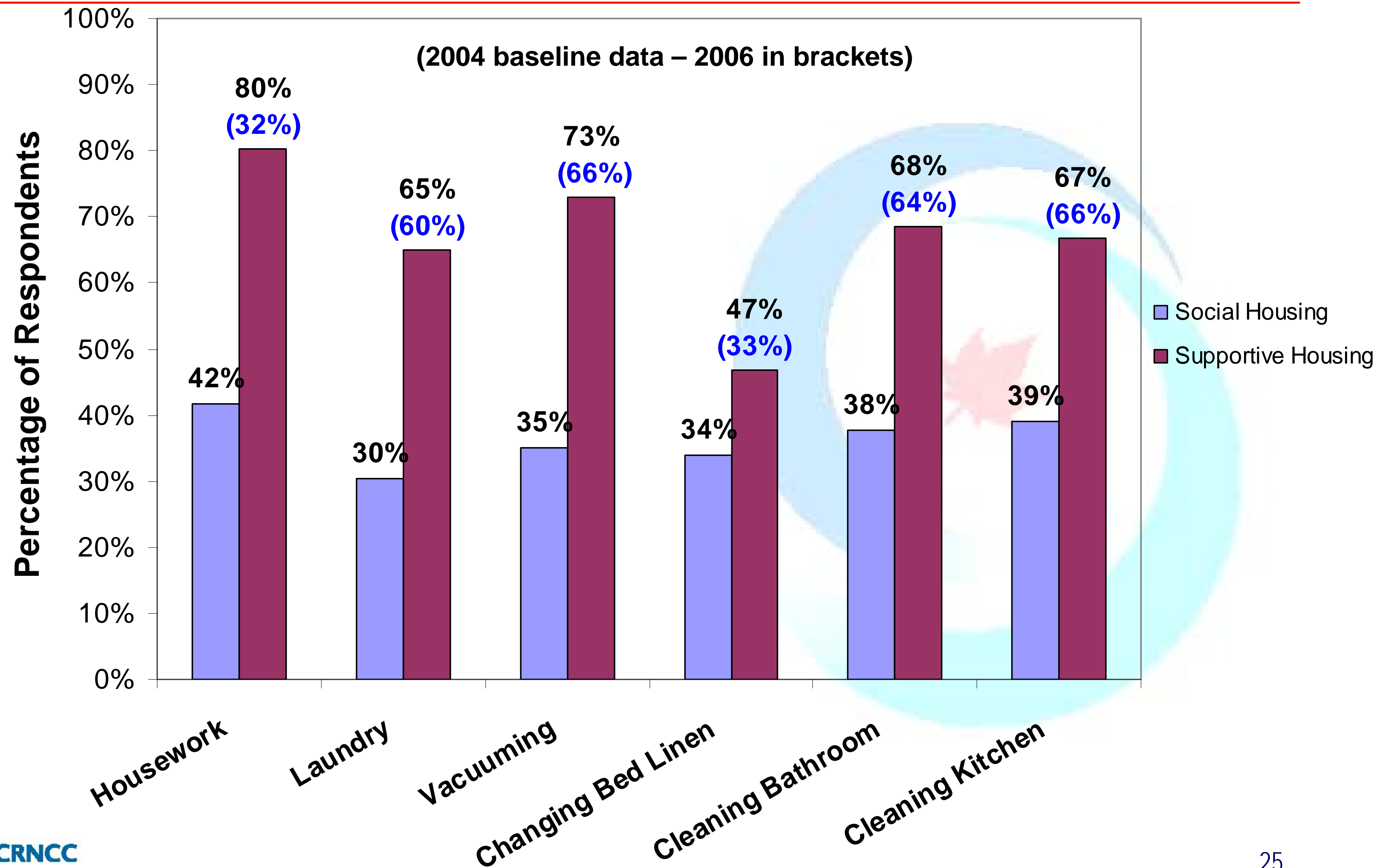
Supports for IADL



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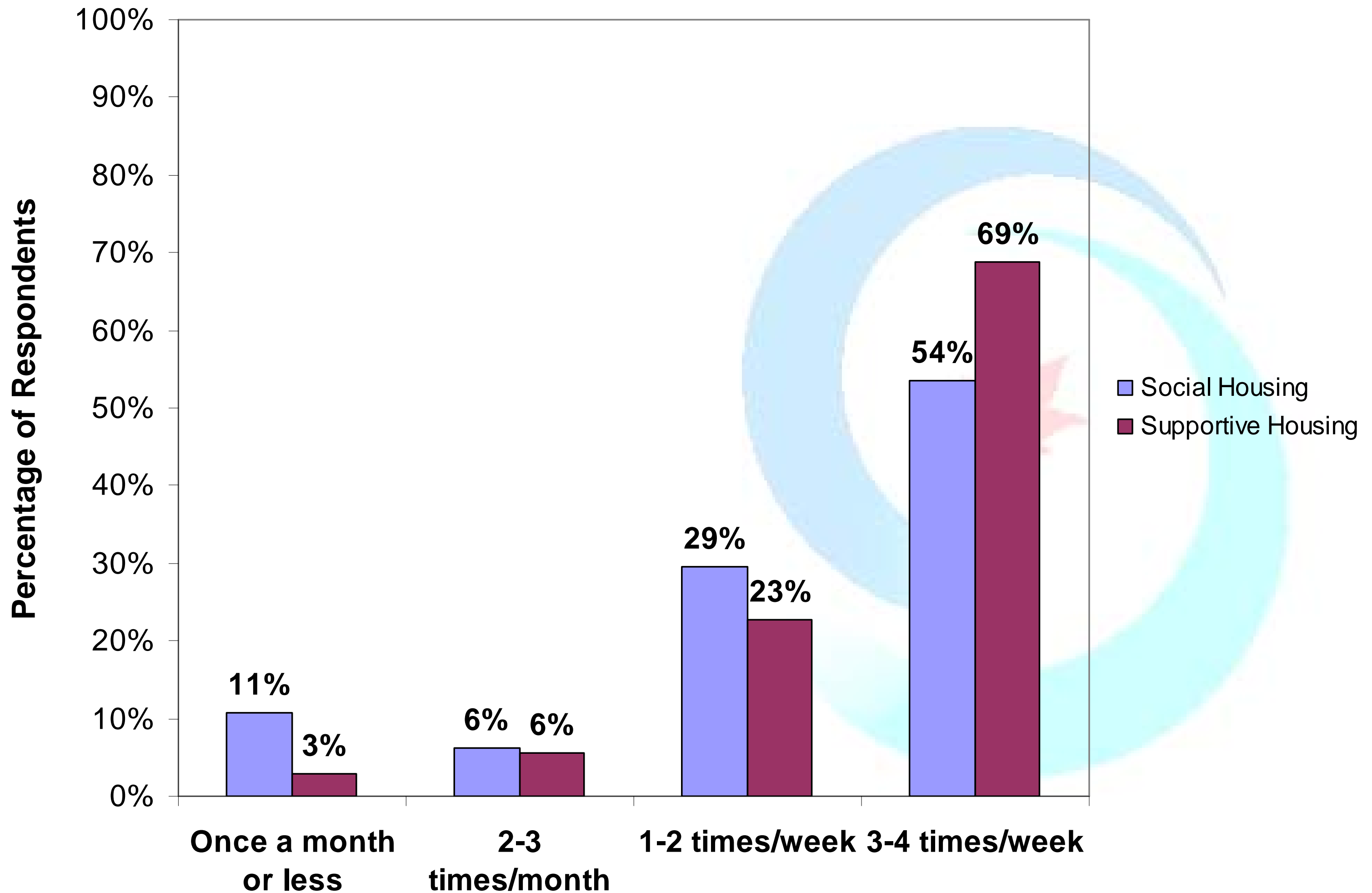
Social Connectedness:
CSA, Family and Friends (2004 data)



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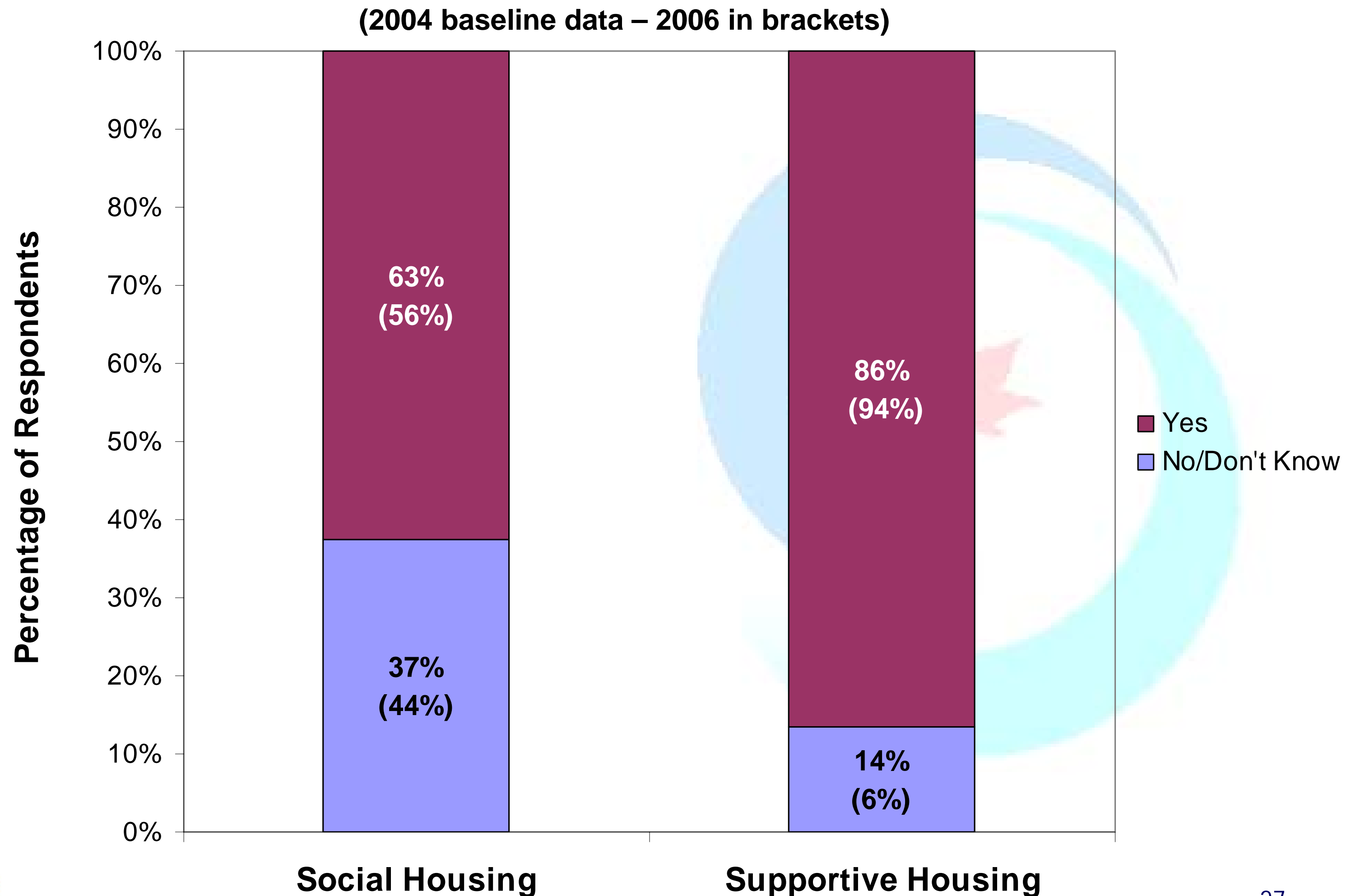
Mental Health:

Confidence in Getting Help When Needed



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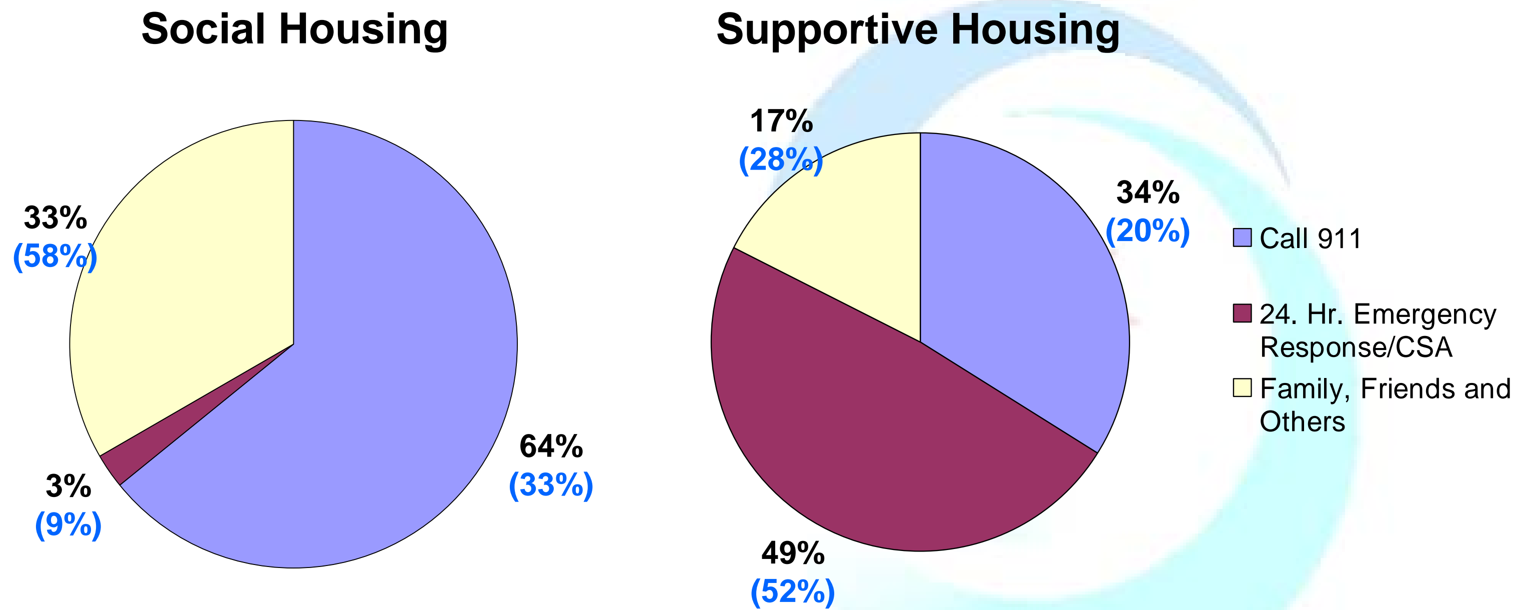
Crisis Management



(2004 baseline data – 2006 in brackets)

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Vital Signs: Balance of Care

Personal Social Services Research Unit (PSSRU), University of Manchester

- Balance of Care approach aims at determining most appropriate mix of institutional and community resources at the local level to meet the needs of an aging population

Source: Dr. David Challis -- *go to www.CRNCC.ca*

Balance of Care: Key Assumptions

What determines optimal balance of institutional (LTC beds) and H&CC?

- Demand side
  - Level of need
  - Support for family carers
- Supply side
  - Access to safe, appropriate cost-effective H&CC within continuum

Can't shift demand side, but can shift balance on the supply side

Waterloo, Ontario: LTC Wait Lists

- CCAC wait list
  - 390 Waiting in Community
  - 74 Waiting in Hospitals
  - 77 Waiting in Out of Region
  - 344 Waiting in LTC facilities

- *What number could be "diverted" safely, cost-effectively to community care …*
  - *With currently available services?*
  - *If enhanced services available?*

A Day in the Life of Community LTC Services: Results of a One-Day Census of Waterloo Region and Wellington-Dufferin Counties (2004)

- Recognized interdependence between institutional and community care

  "Unless additional beds are put into operation, careful consideration will need to be given to developing and enhancing community-based services options …"

A Needs Analysis for Supportive Housing for the Elderly in Waterloo Region, Wellington County and Dufferin County (2003)

- In 2003, no SH units for seniors in region

  How could SH impact on individuals, carers and the system as a whole?

  Note: two recent planning reports (Closson, Handler) recommend investment in SH as a solution for acute care hospital and LTC problems

Characteristics of Individuals on LTC Wait List in Waterloo

Confusion (Cognitive Performance Scale – short term memory, cognitive skills for decision-making, expressive communication, eating self-performance)

- Intact = 224 (28%)
- Mild-Moderate = 521 (64%)
- Severe = 66 (8%)

Characteristics of Individuals on LTC Wait List in Waterloo

Dependency (ADL: Self-Performance Hierarchy Scale – eating, personal hygiene, toilet use)

- Low (Independent) = 433 (53%)
- Moderate = 307 (38%)
- High = 71 (9%)

Characteristics of Individuals on LTC Wait List in Waterloo

Lighter Care Needs (IADL Difficulty Scale – meal preparation, housekeeping, phone use)

- Low (none required) = 18 (2%)
- Moderate = 116 (14%)
- High = 677 (84%)

Vignette

“Mrs. Smith was referred to LTC from the community. She has a mild-moderate cognitive impairment. She does not require assistance with ADLs such as personal hygiene and eating, but she does require assistance with IADLs such as housekeeping and meal preparation. She has a family caregiver.

86 cases (11%) fall into this category

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Key Messages

The Evidence is Growing and Credible

- H&CC can play a key role in maintaining the health, well-being and autonomy of individuals and carers, and moderating demand for costly acute and institutional care if:
  - Targeted
  - Managed
  - Integrated into the broader continuum

H&CC Can Moderate ALC Problems

- By maintaining “at risk” individuals safely and cost-effectively “closer to home”
- By diverting “social admits” from ERs
- By offering appropriate, managed H&CC packages after discharge

LHINs Have a Crucial Role to Play

- LHINS are a platform for transforming a collection of fragmented services into a person-centred, balanced, managed continuum
  - From "ratcheting-up" to acute and LTC as the only manageable option
  - To "ratcheting-down" to the most appropriate care "closer to home" that supports individuals and sustains Medicare

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