Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

Building "Ground Up" Approaches to Care Over the Longer Term: From "Beds" to "Places"

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IRPP Panel on Continuing Care
BC Care Providers Association
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IRPP Study

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Ideas
Analysis
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Since 1972

Integrating Long-Term Care into a Community-Based Continuum

Shifting from "Beds" to "Places"

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To address the growing long-term needs of Canada's aging population, governments should expand community-based care instead of simply increasing the number of residential care beds.

Where We Are Now:

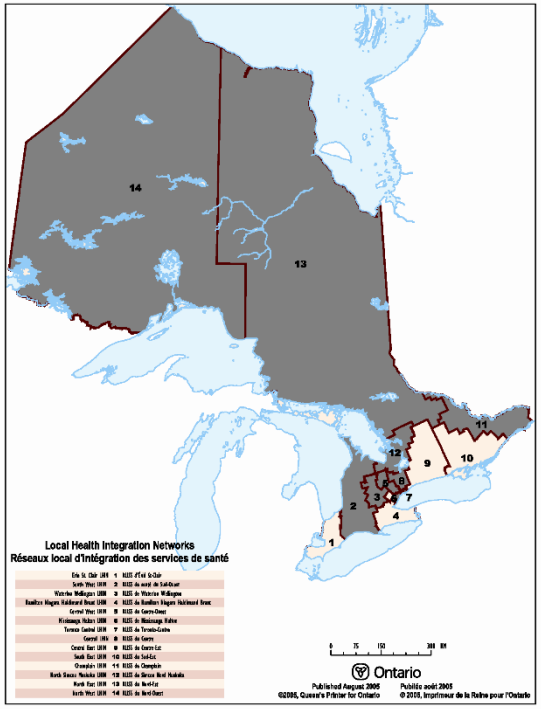
Default to Beds

Ontario Balance of Care (BoC) Studies

The BoC is a policy planning tool adapted from the UK and applied by our team in 12 of 14 LHINs

- Erie St. Clair, South West, Waterloo Wellington, Central East, Central West, Toronto Central, Central, Champlain, North Simcoe Muskoka, North East, North West, South East and North Shore Tribal Council

- Best available data and most knowledgeable local experts

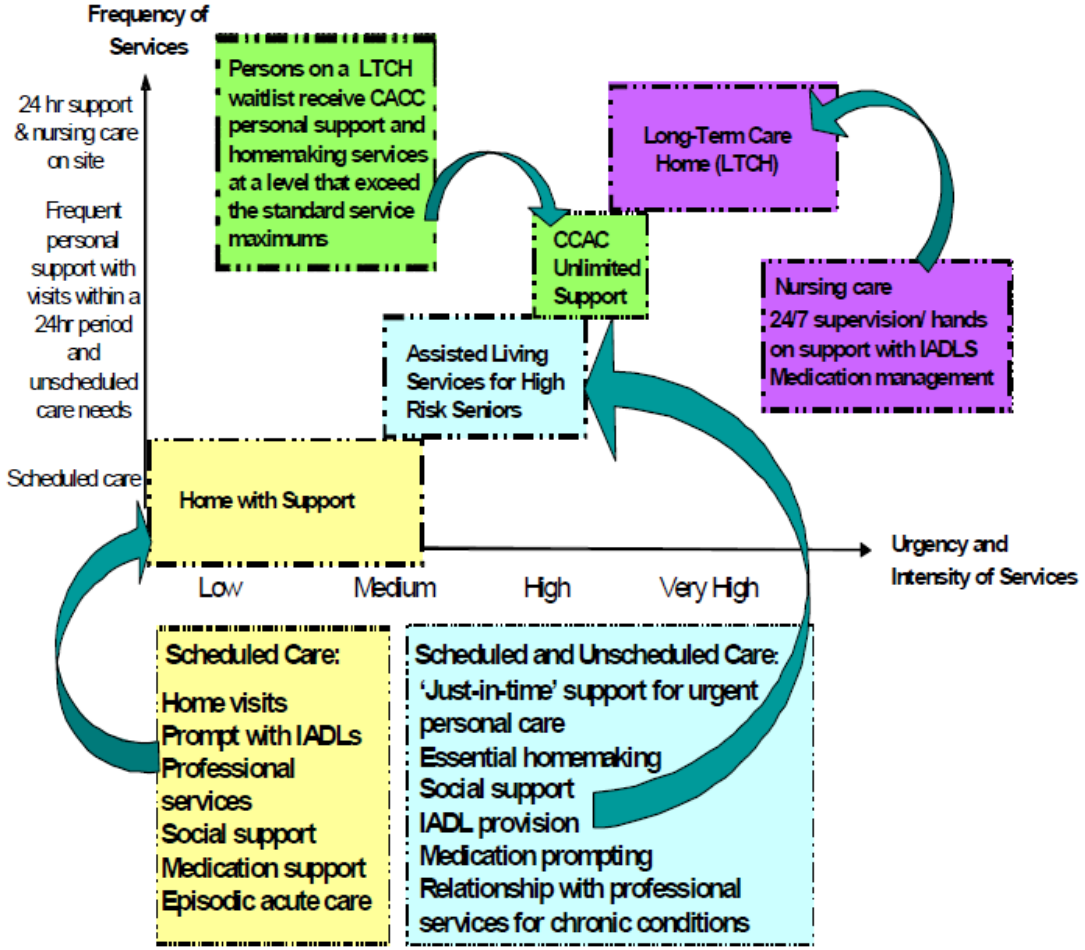


Two Big Questions

- Why is it that most older persons live safely and independently at home, while others require residential care beds?

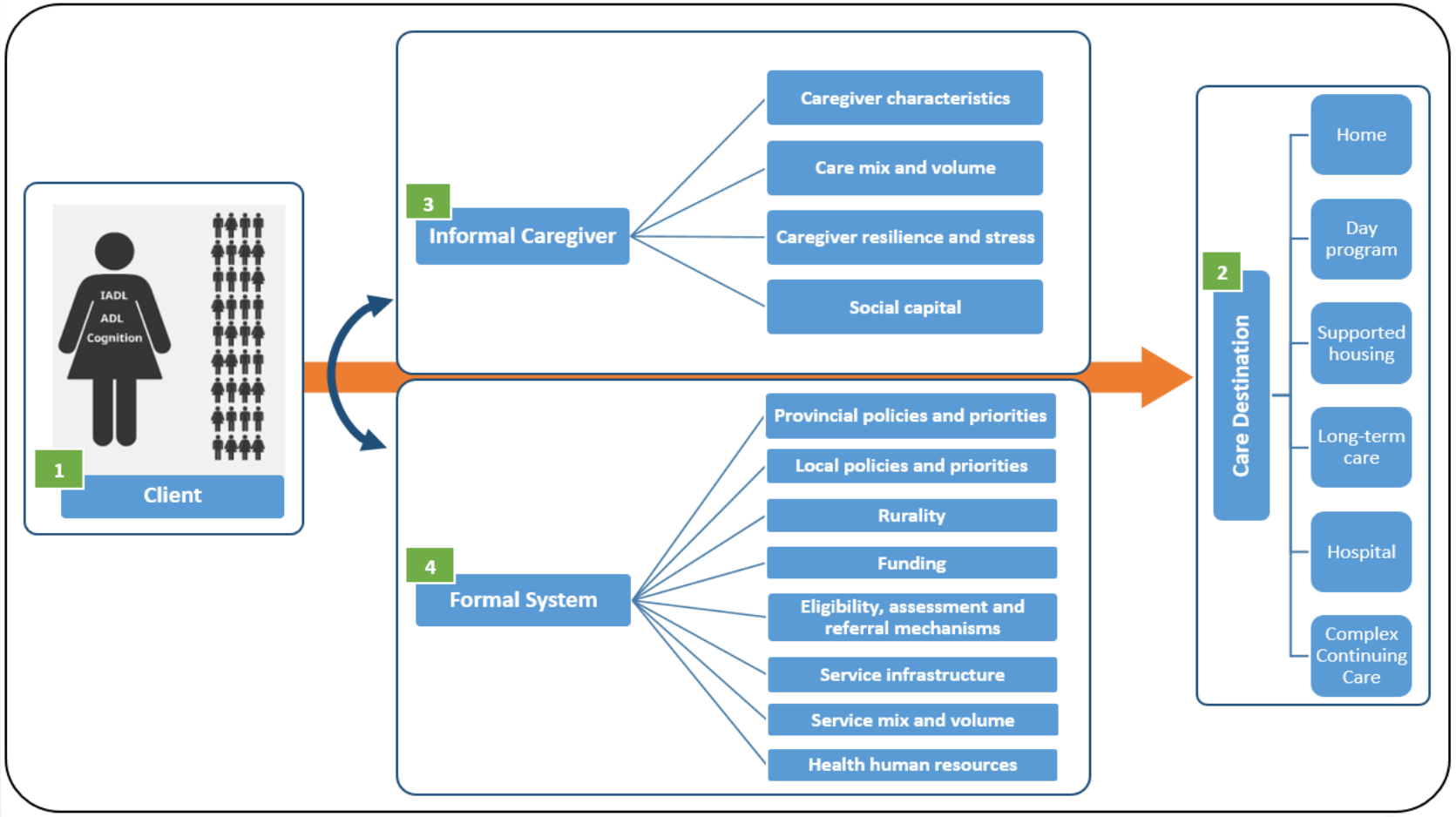
- What are the key characteristics of “ground-up” innovations that can help build a robust continuum of “places” for care over the longer term?

Conventional Wisdom:
Needs Drive Care Setting



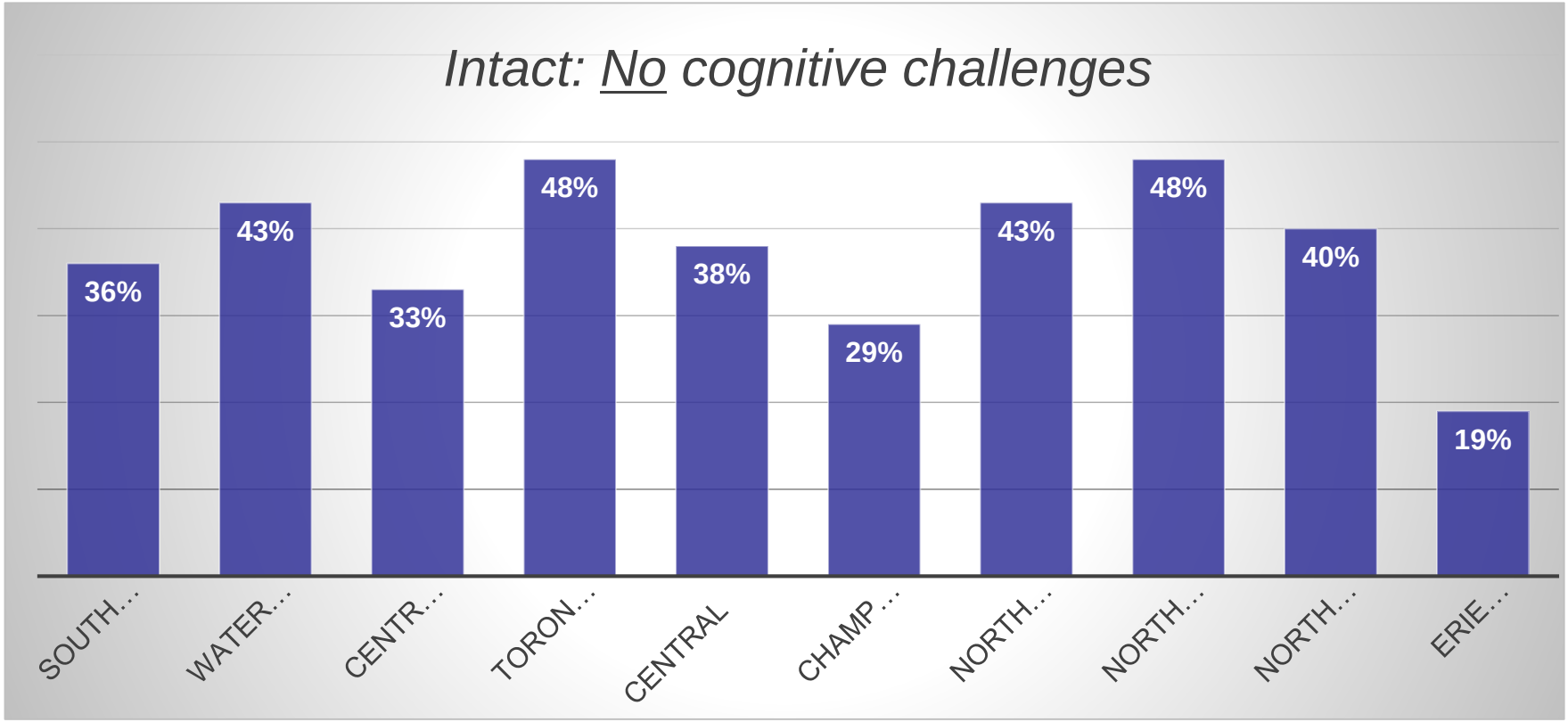
Source: Ontario, Assisted Living Services for High Risk Seniors Policy, 2011 (Updated 2012)

A More Robust Conceptualization:
Needs Only One Factor



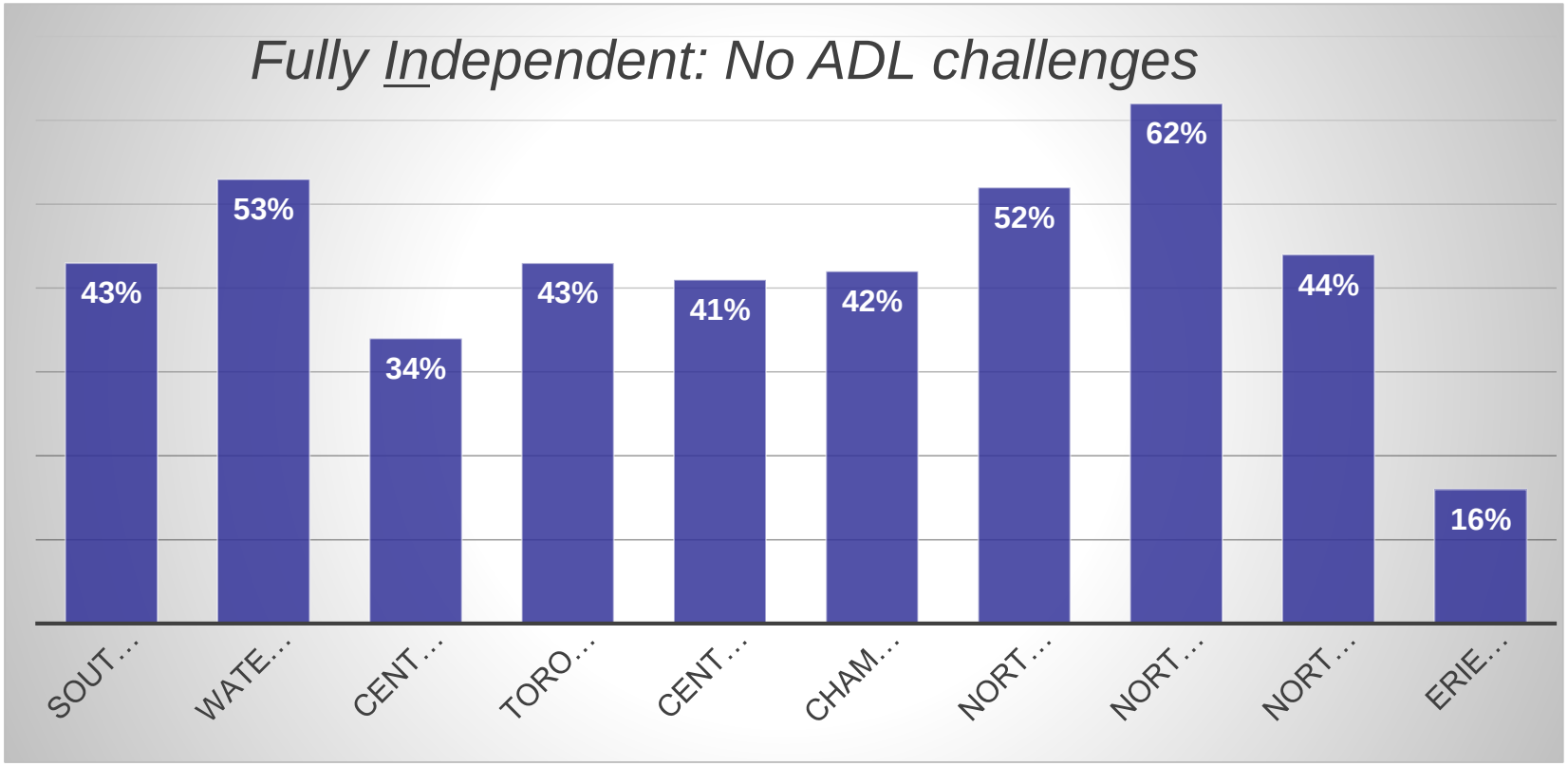
Waiting for LTC: Cognition

Cognitive Performance Scale: Short term memory, cognitive skills for decision-making, expressive communication, eating self performance.



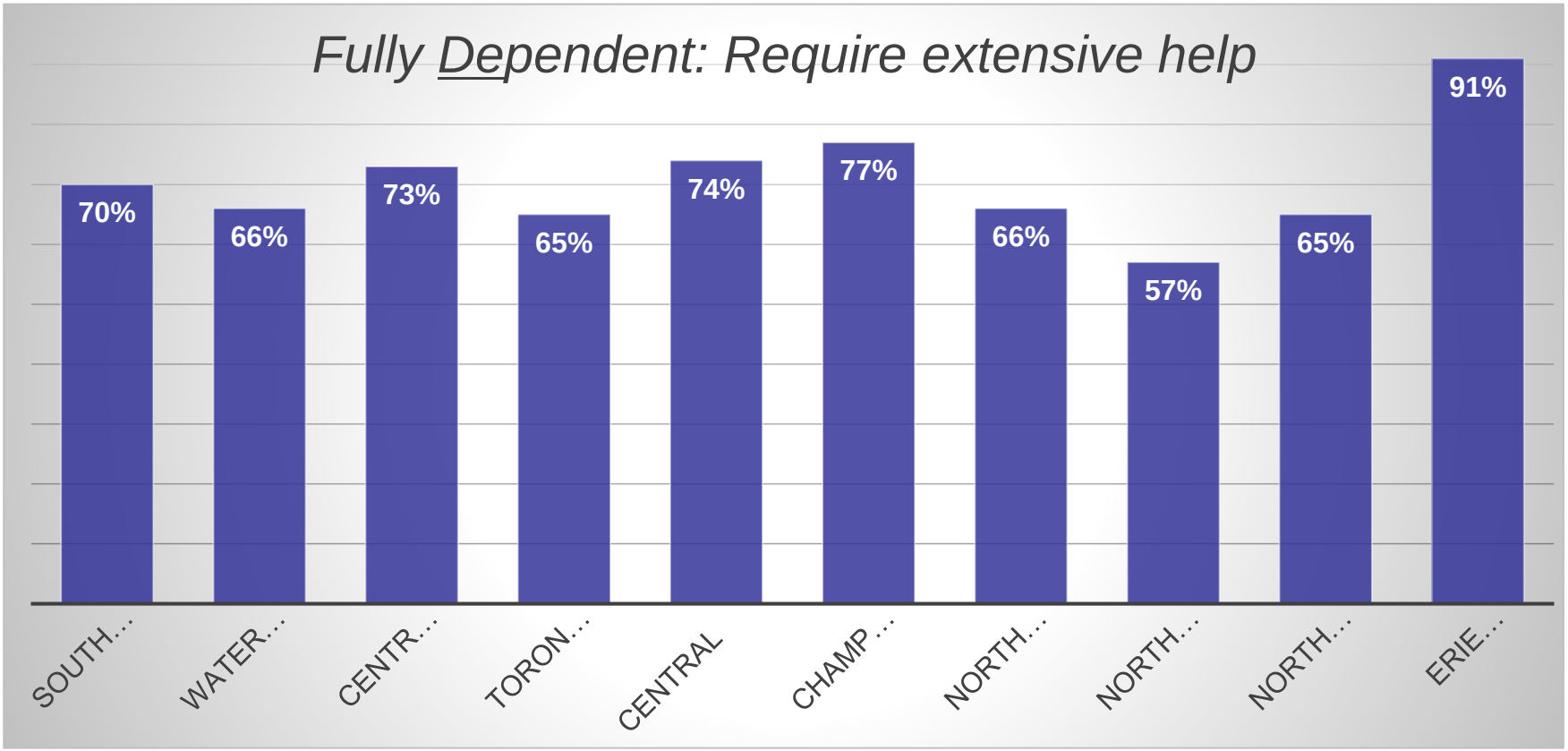
Waiting for LTC: ADL

Self-Performance Hierarchy Scale: eating, personal hygiene, locomotion, toilet use

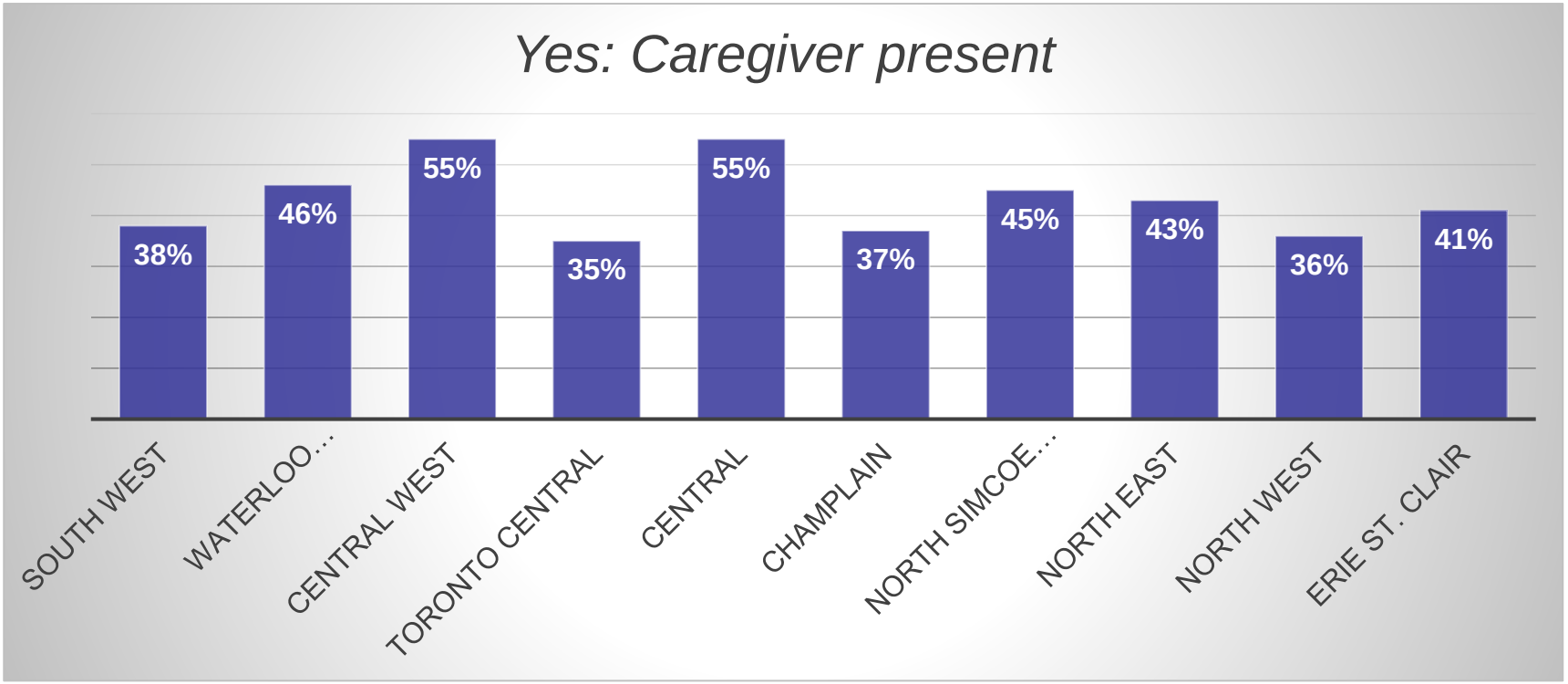


Waiting for LTC: IADL

IADL Difficulty Scale: meal preparation, housekeeping, phone use and medication management



Waiting for LTC: In-Home Caregiver?



Ontario BoC Studies: Key Observations

- "Tipping point" for LTC varies extensively
  - Substantially lower in rural & remote regions where there are few community-based care "places"
- "Unit of care" includes client and informal caregiver
  - Especially critical for persons with dementia
- "Small things" matter
  - Grocery shopping, banking, home maintenance, homemaking, and transportation to medical appointments key (yet first to be cut)
- Even when services present, may not be accessible
  - Multiple entry points, eligibility requirements, service offerings, assessments, user fees – most challenging for older persons with multiple needs and their caregivers

Where We Want to Go:

Toward a Person-Centred Continuum of Care "Places"

Ground-Up Innovations 1:

Jasper Place, North West Ontario

- Seniors supportive housing model
  - RGI housing plus 24/7 on-site coordinated support services
  - NP works to maintain wellness to delay or avoid LTC, does tests on-site to avoid hospital visits, follows clients who require hospital care
  - Past admissions often at lower needs; now more resource intensive, higher needs admissions
    - 30% of clients now MAPLe 4 or 5's
  - Ability to do meet higher needs, or do outreach limited by historically embedded funding ($30/day)
  - No ability to transition clients to physically connected LTC home, or do community outreach

Ground-Up Innovations 2:

SMILE (Seniors Managing Independent Living Easily), South East Ontario

- "Supported self-management" model
  - Focus on frail older persons with complex health and social needs and caregivers living in community
  - Spans urban and rural areas with vastly different needs, formal and informal service capacity
  - Professional case managers use nominal budgets to work with informal caregivers and clients to identify challenges, lever local resources, build comprehensive care packages
  - Emphasizes IADL supports
  - Ability to scale and spread limited by "market share" and by later, higher needs referrals from provincial home care agencies creating politically sensitive "wait lists"

Ground-Up Innovations 3:

Assisted Living in South Western Ontario (ALSO)

- "Hub & spoke" model
  - 9+ different supportive housing buildings, plus mobile and outreach services to create "supportive neighborhoods"
  - Initially designed to support persons with disabilities – expanded to support frail seniors with severe functional impairments
  - Services include: In home personal support/independence training; client intervention; day services, ABI assisted living; VoN nursing; falls prevention
  - Transitioned 200 clients from ALC, CCC, ER and ICU demonstrating "proof of concept"
  - Now has limited "flow-through" because people do not leave reducing ability to demonstrate ongoing impact on ALC beds

Looking Farther Afield:
Neighborhood Networks

- Since 2005, each local area in Leeds, UK, has had its own dedicated Neighborhood Network
  - Local older people and their families get help with the everyday tasks of care, such as free or cheap transport, social activities, shopping, practical help at home, cleaning, gardening and breaks for carers
  - Families and carers get help to juggle the demands of family, work and caring, delay entry into formal care, and reduce reliance on the NHS

Source: http://www.ageuk.org.uk/leeds/about-age-uk-leeds/neighbourhood-networks/

Japan's Open Houses:
Sakura-chan & Suzu-no-ya

- Run by volunteers who offer people with dementia and carers access to all-day support in private homes
  - Volunteer training
  - Caregiver peer support
  - 24/7 help line
  - "Light touch" regulation

Source: CRNCC. http://www.ryerson.ca/content/dam/crncc/enews/pdfs/2015/2015-fall-winter-crncc-enews-vol35.pdf

How We Get There:

Change the Policy Discourse

Three Essential Steps:

Plan for a Person-Centred Continuum of Care Places

- Stop thinking about LTC beds as the ultimate destination for older persons
  - Start thinking about a “person-centred” continuum of “places” for care over the longer term
  - Provide choice of care in the least restrictive setting possible
- Consider what’s needed to keep people as independent as possible for as long as possible
  - Local system capacity to provide needed health and social care
  - Ability and willingness of informal caregivers (and broader social networks) to care

Three Essential Steps:

Build Enabling Policy Frameworks

- Even exemplary local innovations face formidable political and logistical barriers to spreading and scaling-up
  - Clarify that primary purpose of community care is to serve people, not solve health system problems (e.g., ALC)
  - Japan's 2015 Orange Plan (championed by PM himself)
    - Seven "pillars" to guide the creation of dementia-friendly communities
    - Including support family caregivers, encourage cooperation, remove institutional barriers within government and between providers, incent intergenerational projects, and give people with dementia a greater voice

Three Essential Steps:

Fund Based on Need, Not Location

- If you're willing to pay $160/day to keep older persons in LTC, why not pay the same amount to keep them at home which is where most prefer to be?
  - Combine financial and clinical accountability to incent cost-effectiveness rather than cost shifting

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