

The ALC “Flo” Collaborative

Introduction

Ensuring access to acute care services is a complex issue confronting health care systems world-wide, impacting wait times, clinical outcomes and efficiency. As such, reducing Alternate Level-of-Care (ALC) days is an immediate strategic priority for Ontario. Recently, the Ontario Ministry of Health and Long-Term Care (MOHLTC) announced several short-term strategies to relieve pressures in specified Ontario communities related to long waits for appropriate levels of care, and high inpatient occupancy rates. These strategies address issues in three areas: 1) processes of care delivery; 2) policy barriers; and 3) resource/capacity issues.

The Ontario Health Performance Initiative (OHPI) – a joint initiative of the Health System Strategy and Health System Accountability and Performance Divisions of the Ministry of Health and Long-Term Care – is launching a major quality improvement project, entitled the “Flo” Collaborative (“Flo”), to improve transitions from acute care hospitals to subsequent care destinations for all patients, not only those designated as ALC. The project focuses on process improvement, while recognizing the critical importance of complementary longer-term strategies needed to address capacity issues in the system.

In addition to improving the timeliness and effectiveness of transitions for better care, “Flo” is designed to help achieve one of the Performance Initiative’s key goals of building long-term capability for quality improvement in the province.

Lessons from other jurisdictions world-wide demonstrate that effective and sustainable system transformation results from a variety of key drivers, including leadership commitment and support for improvement, knowledge and expertise in applying quality improvement methods, use of information to stimulate and monitor improvements and incentives for improvement. These critical levers for success are integrated into the design and implementation of the “Flo” Collaborative.

Over the next 18 months, OHPI will use an action-based learning series that brings together quality improvement teams working collaboratively towards a common improvement aim, involving senior leaders from Local Health Integration Networks (LHINs), hospitals and Community Care Access Centres (CCACs), as well as clinical leaders, middle managers, and front-line staff who will focus on improving patient transitions from general medicine



The “Flo” analogy was developed to tell the story of a real patient experiencing an acute event who requires care in an alternate setting following a hospital stay. Flo is an 85-year

old woman admitted to hospital from her home with multiple co-morbidities. Her frailty and declining cognitive status necessitate transfer to a nursing home. Flo continues to need quality care in the right setting and the system needs to support her and her family in getting there.

The “Flo” Collaborative is intended to help Ontario’s health care system continue to provide the care that Flo, and thousands of other people like her require. The aim is to accomplish this by making transitions from acute hospitals to other settings faster, and with fewer hassles, bottlenecks and irritations to Flo, her family and the staff who care for her.

Participating organizations will work together on improving the effectiveness and timeliness of patient transitions across care settings.

units to subsequent care destinations. In areas of the province where the transition of choice is predominantly complex continuing care or rehabilitation, team members from these sectors will also be invited to participate in addition to long-term care, as appropriate.

Participants in the “Flo” Collaborative will use a systematic method for understanding and improving care, beginning initially on one or two medical units, and later on a broader scale, based on specific strategies for effective spread and sustainability.

Partnerships of acute care hospitals and CCACs are invited to apply to participate in the “Flo” Collaborative, based on data demonstrating high numbers of Alternate Level of Care (ALC) days on general medicine units among patients with ALC lengths of stay between 1-30 days.* and LHIN identification of organizations that might benefit most. Hospital/CCAC partners that demonstrate the ability to meet all of the requirements for each of three streams of activity outlined in this document will be selected to participate in the Collaborative.

Additional “Flo” Collaborative Support

OHPI will provide leadership, coordination and content for scheduled “Flo” Collaborative Learning Sessions, conference calls/web casts, and a Quality Congress (designed to celebrate and acknowledge the accomplishments of participating organizations). “Getting Started Kits” will also be developed that will include background materials such as suggested change ideas, self-assessments, and detailed information regarding process and outcome measures. A secure web page will be developed for communication among participating organizations to share successes and challenges and to receive input from experts.

Benefits of Participation

The benefits of participating in the “Flo” Collaborative are numerous, and include the opportunity to:

Engage with other organizations to achieve improvements in patient flow, measured through key metrics, including the ALC indicator in Accountability Agreements;

Integrate and coordinate health services within your LHIN, thereby addressing standards required for organizational accreditation;

Interact with, and learn from, world leaders in quality improvement;

Gain free Improvement Advisor Certification for an individual in your organization, delivered by the Institute for Healthcare Improvement (IHI) and sponsored by the MOHLTC, providing long-term pay-off to your organization;

Provide action-based learning opportunities for front-line and management staff who participate in the Improvement Teams;

Enhance leadership capability for quality improvement through participation in the Leadership Series;

Receive MOHLTC financial support, allocated by the LHINs, at the outset of the project, with the possibility of a secondary allotment contingent on achieving measurable aims; and

Receive support from OHPI, including project coordination, exploratory work to gather and synthesize potentially better practices to help teams redesign care processes, and coaching of Improvement Advisors (IAs) using a train-the-trainer model.

* ALC lengths of stay greater than 30 days are potentially indicative of capacity issues (e.g., no available long-term care beds), rather than issues that could be amenable to process improvements (e.g., early discharge planning, streamlining referrals to CCACs, eliminating redundancies in care processes, and developing strategies to address specific delays, etc).

Outline of The “Flo” Collaborative

The design of this large-scale project is based on evidence relating to key drivers of success for performance improvement, drawn from the literature and international case studies. The Collaborative includes three streams of activity – Improvement Teams, supported by Improvement Advisors and Senior Leaders.

1) Improvement Teams

The Model for Improvement identifies four key elements of successful process improvement: 1) specific and measurable aims; 2) measures of improvement that can be tracked over time; 3) interventions that will result in desired improvement; and 4) a series of testing “cycles” during which teams learn how to apply key change ideas to their own organizations.

Improvement Team Goals

The “Flo” Collaborative is designed as an 18-month learning collaborative that brings together a number of teams from partner hospitals and CCACs to improve the transition from medical units to subsequent care destinations using the Model for Improvement. Teams will map current processes to identify delays and bottlenecks, and through their collective wisdom, will select potentially better practices and will redesign, test, embed and spread improved care processes.

Improvement Team Participants

Hospitals and CCACs must partner together and select a minimum of one, up to a maximum of four, Improvement Teams (depending on the size of the organization, the number of medical units and the availability of resources to support teams).

Team Composition

- Teams must consist of at least six multi-disciplinary front-line care staff (e.g., hospitalists, unit managers, case managers/placement co-ordinators, discharge planners, nurses, social workers, etc);
- Teams must include staff from the hospital, CCAC, and if applicable, external stakeholders from other organizations to help facilitate the improvement work (e.g., representatives from LTC homes in the region);
- Co-Team Leads (one from the hospital, and one from the CCAC) must be identified to lead the Improvement Team work on a daily basis. Ideally, team leaders will be staff who work on the target unit(s) either in a resource or management capacity and have credibility with, and the respect of, the rest of the Team;
- Each Team must have a Senior Champion (e.g., Director of Medicine, Manager of Client Services) to liaise between the Improvement Team(s) and senior management at each organization, and to remove barriers for the Teams, as required;
- Team Leads will need to spend up to a quarter of their time weekly on the “Flo” Collaborative, leading the Team, facilitating Team discussions and leading change.

Organizational Expectations for Improvement Teams

In addition to the participant requirements noted on the previous page, each Team is required:

- To develop a Collaborative Aim Statement and define the measures they will use to assess whether changes are resulting in improvements;
- To meet regularly (e.g., at least weekly) to plan, discuss and monitor improvement efforts and achievements;
- To connect regularly with their Improvement Advisor;
- To report on results for selected measures;
- To attend Learning Sessions (four face-to-face meetings over the course of the Collaborative), with additional members working on improvements during Action Periods between Learning Sessions; and
- To develop and present storyboards illustrating progress and results at each of the four Learning Sessions and at the Quality Congress which will celebrate achievements at the end of the 18-month period.

Critical Improvement Team Stream Events and Timeline

| Event | Participants | Dates |
|--------------------|---|------------------|
| Learning Session 1 | Improvement Teams, Improvement Advisors | Nov. 7-9, 2007 |
| Learning Session 2 | Improvement Teams, Improvement Advisors | Feb. 11-13, 2008 |
| Learning Session 3 | Improvement Teams, Improvement Advisors | June 2-4, 2008 |
| Learning Session 4 | Improvement Teams, Improvement Advisors | Oct. 1-3, 2008 |
| Quality Congress | Improvement Teams, Improvement Advisors, Senior Leaders | Jan. 2009 |

Note that monthly conference calls and/or web-casts will also be scheduled by OHPI to support Improvement Teams.

2) Improvement Advisors

Developing a critical mass of individuals with the necessary knowledge and skills to support and sustain improvement efforts will be critical to accelerating quality improvement across Ontario, and sustaining improvements over the long term. Improvement Advisors, trained by faculty from IHI, will support teams throughout the “Flo” Collaborative.

Improvement Advisor Goals

The aim of the Improvement Advisor Professional Development Program is to expand capability for improvement within participating organizations by developing Improvement Advisors (IAs) effective in facilitating and supporting quality improvement efforts. The curriculum is designed for health care professionals who:

- Are able to dedicate time to improvement projects on a regular basis;
- Are viewed by senior leaders as vital assets for accomplishing strategic organizational goals; and
- Will be leveraged by senior leaders to support quality improvement over the long term within their organizations.

IA training will be reinforced through action-based learning, recognized as an effective educational strategy. This will be achieved by supporting IAs to use their quality improvement training to support Collaborative Improvement Teams in their respective organizations.

Improvement Advisor Participants

Hospitals and CCACs are requested to nominate one to two individuals to receive IA training. While it would be ideal to nominate one from each partner organization, each IA will be able to support one to two Improvement Teams. If there is only one Improvement Team being established, the hospital and CCAC may: 1) nominate one IA, either from the hospital or CCAC; or 2) nominate one from each organization, and allow the LHIN and OHPI to select the individual. The latter approach would help to ensure capability building in both the hospital and CCAC sectors. Stability in the IA role is very important. The participant should not be contemplating leaving the organization, and the organization should not be contemplating changing the IA role such that they are no longer involved in improvement work. Prospective IAs might be drawn from the current quality management portfolio (e.g., manager, analyst, facilitator), utilization management staff, organizational development staff, etc.

Organizational Expectations for Improvement Advisors

The selection of prospective IAs will require significant reflection on the part of partner organizations, including consideration of the time commitment required to support the “Flo” Collaborative. Prospective IAs must attend and participate in each of three, 4.5 day Improvement Advisor Training Workshops, in addition to attending the four “Flo” Collaborative Improvement Team Learning Sessions, the Kick-off Event and the Quality Congress. Improvement Advisors must attend all events, and cannot send someone else in their place. It is anticipated that IAs will spend approximately one third of their time on the “Flo” Collaborative. It is expected that trained IAs will be leveraged by participating organizations to support other improvement efforts in the future, making the current investment in time pay off for participating organizations in the months and years to come.

Critical Improvement Advisor Stream Events and Timeline

| Event | Participants | Dates |
|--------------------------------|---|------------------|
| Kick-off Event | Senior Leaders, Improvement Advisors | Sept. 18, 2007 |
| Improvement Advisors Session 1 | Improvement Advisors | Oct. 15-19, 2007 |
| Learning Session 1 | Improvement Teams, Improvement Advisors | Nov. 7-9, 2007 |
| Improvement Advisors Session 2 | Improvement Advisors | Jan. 7-11, 2008 |
| Learning Session 2 | Improvement Teams, Improvement Advisors | Feb. 11-13, 2008 |
| Improvement Advisors Session 3 | Improvement Advisors | Apr. 21-25, 2008 |
| Learning Session 3 | Improvement Teams, Improvement Advisors | June 2-4, 2008 |
| Learning Session 4 | Improvement Teams, Improvement Advisors | Oct. 1-3, 2008 |
| Graduation (Webex) | Improvement Advisors | July 2008 |
| Holding the Gains (report due) | Improvement Advisors | Dec 2008 |
| Holding the Gains (Webex) | Improvement Advisors | Early Jan. 2009 |
| Quality Congress | Improvement Teams, Improvement Advisors, Senior Leaders | Jan. 2009 |

Note that monthly conference calls and/or web-casts will also be scheduled by the IHI faculty to support the Improvement Advisors.

3) Senior Leadership

One of the key drivers for success is senior executive leadership and commitment to visibly support quality improvement, making the investment in quality improvement a core organizational strategy. System-level improvements can only be realized when participating organizations collectively focus on a strategic initiative, with Improvement Teams working at the front lines of care, actively supported by senior leadership.

Senior Leadership Goals

The Senior Leadership Series aims to engage senior executive leaders, and Boards through CEOs, in action-based learning to facilitate optimal support for their Improvement Teams. The series will bring leaders together in face-to-face sessions under the guidance of content and improvement experts, scheduled between Collaborative action periods. These sessions are deliberately scheduled prior to their Teams' Learning Sessions to ensure that they remain closely connected to the project and "a few steps ahead" to visibly support, communicate with and mobilize resources for teams in a timely and meaningful way.

Specific objectives of this series include the following:

- To provide an opportunity for senior executives in LHINs, hospitals, and CCACs to interact with and learn from leaders from high performing health care organizations in Canada, the USA and Europe that have invested strategically in quality improvement and achieved significant outcomes;
- To support Senior Executives and Boards in making quality improvement a strategic imperative, and applying tangible strategies for leading and supporting Improvement Teams to achieve breakthrough performance in the "Flo" Collaborative; and
- To develop a network of leadership for improvement "champions" in Ontario to help to further integrate and spread a strategic focus on quality into policy and service delivery in Ontario.

As active participants, senior leaders will:

- Learn about and apply leading-edge ideas and experiences from high performing health care systems related to improving flow and strategically investing in, and achieving improvement;
- Learn about and apply practical strategies and tools for leading and supporting quality improvement (e.g., aligning improvement with their overall strategy and measures, bringing their "boards on board", linking finance and quality to measure return on investment, engaging clinical leaders); and
- Share their progress, and benefit from the ideas and support of peer leaders as they develop and test their leadership skills to support "Flo" Teams, as they work to redesign processes for more timely and effective transitions to the community.

Senior Leadership Participants

Each hospital and CCAC team will have a Senior Leader – this is the CEO or Executive Director, or another designate, such as a Vice President or Senior Director – who is a key member of the senior management team and will provide high-level strategic leadership and support for the Collaborative and for quality improvement generally. The Senior Leaders will actively participate in all parts of the Senior

Leadership Series, and will involve Senior Champions, such as the Chief of Medicine, Chief Financial Officer, and a Board Member (e.g., Chair or Chair of Quality Committee) in specific learning sessions and opportunities.

Organizational Expectations for Senior Leaders and Champions

In addition to the above noted expectations, senior leaders and champions will also:

- Actively participate in the Kick-off Event and all face-to-face Senior Leadership Sessions, and engage other leaders and stakeholders based on the content being delivered;
- Assign the right team members, Team Leads and Improvement Advisors to ensure successful implementation and spread for long term sustainability;
- Align the “Flo” project with their organization's strategic aims and measures, and other key organizational practices (e.g., reward and recognition);
- Visibly lead and support Improvement Teams, including setting aims for improvement, regularly monitoring progress, and ensuring two-way communication with Teams throughout the duration of the project;
- Provide and mobilize adequate resources to support teams, especially in the development and application of improvement knowledge and skills;
- Channel attention to the improvement project as part of daily work; and
- Help to celebrate success with their Teams.

Critical Senior Leadership Stream Events and Timeline

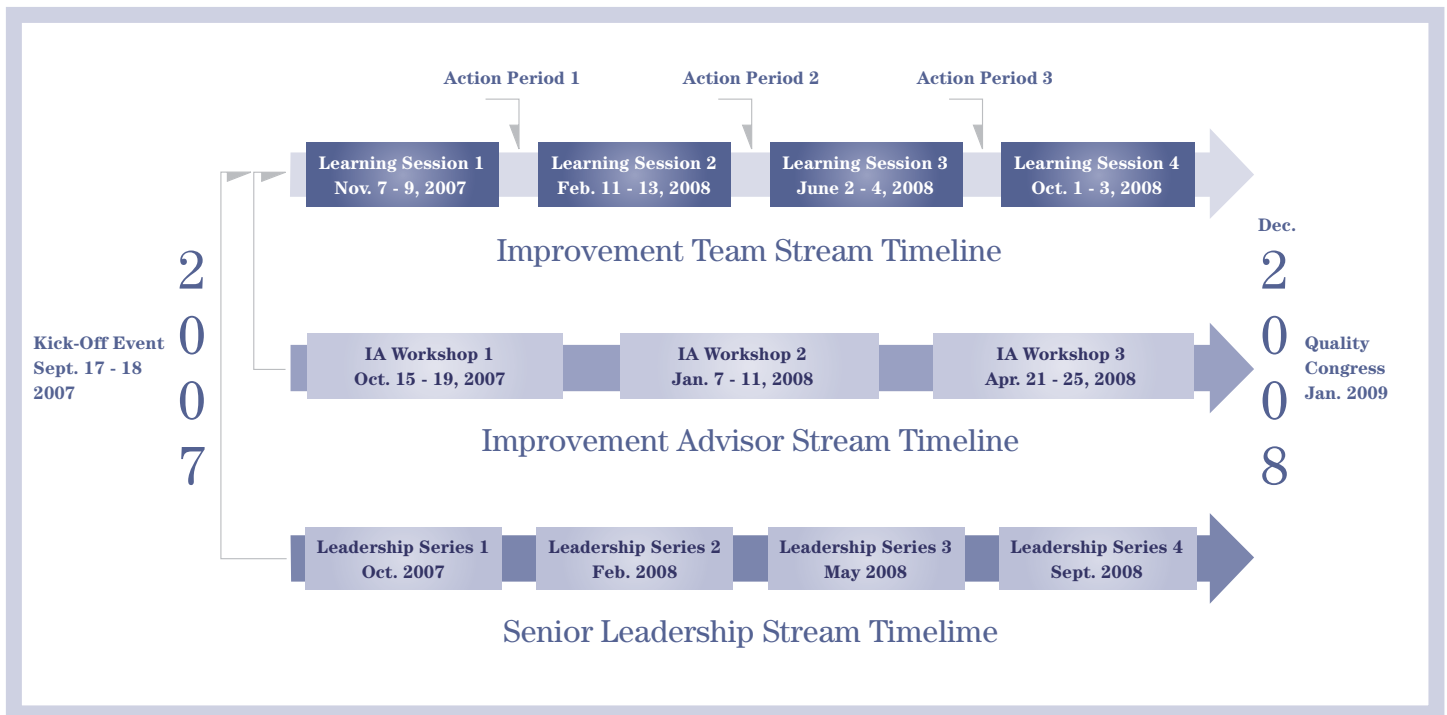
| Event | Participants | Dates |
|------------------|---|---|
| Kick-off Event | Senior Leaders | Sept. 17/07 (Dinner) and Sept 18/07 (1/2 day) |
| Leadership 1 | Senior Leaders | Oct. 2007 |
| Leadership 2 | Senior Leaders | Feb. 2008 |
| Leadership 3 | Senior Leaders | May 2008 |
| Leadership 4 | Senior Leaders | Sept. 2008 |
| Quality Congress | Improvement Teams, Improvement Advisors, Senior Leaders | Jan. 2009 |

Note that these sessions will be scheduled as either half or full day sessions dependent on the topic to be covered. As well, regular conference calls and/or web-casts may be scheduled to support senior leader involvement with the Improvement Teams.

Costs

Hospitals and CCACs are responsible for all travel and accommodation expenses incurred by team members to attend Learning Sessions, and for providing dedicated staff time to implement changes determined necessary to reach desired outcomes. OHPI will provide funding to help defray in-kind costs (ranging from \$60,000 to \$65,000 per partnership to be allocated by the LHIN) at the beginning of the project, with the possibility of a secondary allotment contingent on achieving measurable aims. In addition, OHPI will fund the IA training provided by IHI and all required training materials.

The Flo Collaborative Timelines



About Us

The **Ontario Health Performance Initiative (OHPI)** – a joint initiative of the Health System Strategy and Health System Accountability and Performance Divisions of the Ministry of Health and Long-Term Care – aims to accelerate quality improvement in Ontario to improve system level outcomes in areas of provincial strategic priority. OHPI will accomplish this by working with senior health care leaders to build the case for improvement as a business strategy, by initiating and coordinating improvement projects, and by strengthening capability for improvement among leaders and providers in the system. Using action-based learning, the Performance Initiative will focus its work within large-scale improvement initiatives that are aligned with strategic areas of priority for the province.

If you have further questions based on the information in this package, please contact:

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Ontario
Health Performance Initiative

Accelerating Improvement in Health Care



The Balance of Care

Background to the Problem

Many people prefer to age ‘in place,’ remaining in their homes, rather than moving to a long-term care (LTC) facility. At what point do their care needs become so high that home-based care is no longer feasible? Potential clients for facility-based care have varying needs and conditions, which could be met by different mixes of health and social care resources. A variety of tools have been suggested to assist in allocating resources. This *In Focus* reports on work which has been done in the United Kingdom to develop and test a particular methodology –the Balance of Care (BoC)– to determine the most appropriate care setting and mix of resources required to sustain frail seniors in the community. The key question is, “What proportion of frail seniors deemed eligible for LTC facility placement could be maintained at home if given access to appropriate community-based care packages?”

The Balance of Care (BoC) Model

Pioneered in the UK by Dr. David Challis and his colleagues at the Personal Social Services Research Unit (PSSRU), University of Manchester, the BoC model assumes that the need for LTC facility placement is determined by two major factors: first, the care needs of individuals; and second, the availability of the community-based health and social care required to meet those needs. As the recent Wanless Social Care Review (2006) in the UK emphasized, most seniors prefer to age ‘in place,’ continuing to live in their own homes as independently as possible rather than moving to long-term care (LTC) facilities. For the vast majority of seniors, relatively minimal levels of care will be required to allow them to age in place. For a small minority of frail, often isolated seniors with very heavy,

complex long-term care needs, there will be no reasonable, safe, cost-effective alternative to facility placement. However, between these two clear-cut groups there will be some number of seniors who qualify for a facility placement, but whose care needs could potentially be met in the community if appropriate, cost-effective care packages were available. By assessing the health and social care needs of seniors “at the margins” of facility placement, and matching these needs to available or potential community care packages, the BoC aims both to estimate the proportion of at-risk seniors that could be safely maintained in the community with better outcomes for individuals, carers, and funders, and to identify priorities for investments which might affect the care mix in the future. Such “real world” assessment thus establishes benchmarks for “the correct mix and provision of institutional and community based services in any given geographical area.” (Challis & Hughes, 2002; Hughes and Challis, 2004).

Targeting “At-Risk” Seniors

As noted, the BoC model focuses on seniors “at the margins” - those at risk of losing independence. This is consistent with the current policy focus in the UK on groups with the highest need. A first reason for this focus is ethical: vulnerable, disadvantaged groups should have first access to available resources as a matter of social equity. A second reason relates to care utilization and costs: a relatively small number of very high needs individuals currently use a very large share of costly services, and this number is likely to grow as the population ages. In the UK, for example, it has been estimated that just 5% of inpatients, many with long-term care conditions, account for 42% of all acute care bed days and a disproportionately high number of hospital emergency visits (Department of Health, 2005).

By improving care for these individuals, it is hoped that a range of problems which threaten accessibility and sustainability can also be addressed. In Canada, a similar situation is evident. A collaborative position paper written by key health care stakeholders in the province of Ontario (OACCAC, OANHSS & OLTCA, 2006) noted the absence of an efficient and timely mechanism to provide care in the most cost effective setting; in consequence, many people were occupying costly acute care beds because of this difficulty in accessing the needed resources in other settings. The authors recommended the development of a best practices model for discharge planning, and a single coordinating mechanism to determine the most appropriate setting for people when they are no longer in need of acute care. The BoC is an example of a methodology that might be used to address these issues.

Care/Case Management

The BoC model also points to the crucial role of care/case managers in designing, delivering and monitoring care packages for “at risk” seniors. While most seniors and their carers need relatively little assistance to “navigate” available services and manage their own care, frail seniors with complex, multiple long term conditions are least likely to be able to manage without help. In its model “for improving care for people with long term care conditions,” The UK Department of Health (2005) stresses the importance of using case management “to anticipate, co-ordinate and join up health and social care” for individuals with the highest need both to ensure the best outcomes for individuals, and to ensure the best use of available resources. Instead of integrating health and social services from the “top-down,” case managers use flexible, decentralized budgets, with clear spending limits, to integrate care from the “bottom-up” by building innovative, personalized care packages.

The Balance of Care Method

The BoC method has the following steps:

1. Identify “at risk” seniors: those currently occupying or deemed eligible for a LTC bed.

2. Use assessment data to classify these at-risk seniors into multiple, relatively homogeneous groups. To do this, PSSRU studies have used key variables including gender (female, male); need for help in performing activities of daily living (Barthel scale -- low, medium, high); confusion (MDS cognitive performance scale -- intact, mild impairment, severe impairment); and presence of a carer (yes, no). Note that such information is commonly available in instruments such as the RAI –HC (Resident Assessment Instrument for Home Care).

3. Determine how many of the at-risk seniors fall into each group. PSSRU studies have found that most are concentrated in a few groups.

4. Select groups with more than 5% of the at-risk seniors and create a typical vignette for each group based on a real case (e.g., Mrs. Smith requires some help with ADL, has a mild cognitive impairment, but lives alone and has no regular carer).

5. Have case managers (or expert panels) review case vignettes, construct appropriate care packages and estimate the costs of these packages.

6. Determine which groups of at-risk seniors (and how many individuals in total) could be maintained in the community with less or comparable costs to the system (using facility care as a comparative base), and better or comparable outcomes for seniors and their carers.

In the UK, the BoC has been shown to provide a powerful tool for guiding resource allocation at the system level and testing different scenarios. For example, by repeating steps 5 and 6, first considering only currently available services, and then considering alternative service configurations (e.g., the addition of some number of supportive housing units), it is possible to estimate both current need for LTC beds, and future need if the balance of care at the system level shifts. However, as is the case for evaluation of this type, it does not dictate where any particular individual will actually be placed; other factors such as individual and family preferences must also be considered.

Selected Balance of Care Findings

While there is an extensive BoC literature, a classic study was conducted in the 1980s by PSSRU in conjunction with Gateshead Social Services Department. It compared a group of seniors receiving managed community care packages to another group receiving regular services. Care managers worked with flexible, decentralized budgets with pre-set limits (based on the costs of regular services) to develop creative care packages. For example, they hired homecare helpers who performed such activities as providing companionship, making meals, preparing snacks and hot drinks, giving/checking medication, and assisting seniors with activities of daily living (dressing, and getting in and out of bed). Congregate dining groups were set up in the homes of some of the helpers. Vacuum packed meals (allowing for flexible meal times), automatic kettles, and smoke alarms were purchased for seniors with dementia. Care managers then spent most of their time doing check-ups, reviewing visits, sustaining/nurturing helpers, mobilizing resources and engaging in ongoing information exchange with clients and service providers. Post intervention, the experimental group was more likely to be living at home, had higher life satisfaction, were less likely to be depressed, more likely to perceive an ability to cope, more likely to engage in social activities outside of the home, and less likely to express a need for additional assistance (Challis et al, 1990).

A more recent BoC study, also conducted in Gateshead, looked at 233 new admissions to a care home over a 9 month period. It concluded that between 15% and 28% of admissions could have been cared for in the community if given appropriate, cost-effective managed packages of care (Challis & Hughes, 2002).

In Conclusion

Challis et al (1990), caution that the BoC model should be carefully targeted to seniors at risk of institutionalization. As noted in the CRNCC *In Focus* on Community Support Services, community-based services are not always a cost-effective option. A national long-term care

demonstration project in the United States which extended community services to all seniors rather than targeting them was not cost saving; it generated significant additional costs (Thornton et al, 1988., Kemper, 1988). This is not to suggest that services to less frail seniors may not prove important or desirable. They may be valued by their recipients and their families and be seen as worth the additional money. They may also generate savings over a longer time frame. For example, Research by Hollander & Tessaro (2001) demonstrates that over the longer term, lighter support services for low-risk seniors did produce cost savings in future years by preventing deterioration. However, at least initially, using the BoC methodology would seem most appropriate for those at relatively highest risk of being institutionalized.

Putting Evidence into Action

A Case Study: Applying the BoC Approach in Waterloo, Ontario.

A multi-disciplinary team of researchers based at the University of Toronto and Ryerson University are currently working in partnership with the Waterloo-Wellington Community Support Services Network and representatives from the Local Health Integration Network, the Community Care Access Centre, and a local hospital to see what adjustments are needed to apply the balance of care methodology to Canada. This study is set in Waterloo, Ontario, where close to 900 individuals are currently on wait lists for long-term care (LTC) beds. The study asks, "What proportion of these individuals could be safely and appropriately 'diverted' to community if integrated packages of community care, and/or if enhanced community services (such as supportive housing units) were available?" A cross-sectoral "expert panel" will review the characteristics of individuals on the wait list and determine which individuals would benefit from various community care options. Criteria for selection emphasize better outcomes for individuals and carers, as well as consider the relative costs of community services versus LTC beds. Participants see this approach as particularly valuable as Ontario moves to establish Local Health Integration Networks which will plan and fund hospital, LTC, home care, and community support services at a regional level.

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Last Edited

September 22, 2006

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