



Community Support Services

What are Community Support Services (CSS)?

CSS encompass a range of health and social services aimed at helping people who need assistance with activities of daily living to live as independently as possible in the community. CSS users include individuals who require minimal assistance with activities of daily living as well as those with such high needs that they are “at risk” of losing independence and requiring care in an institution. Most are seniors, but other needs groups, including persons with disabilities and a growing number of medically-fragile children and their families, also utilize CSS.

CSS may include:

- Assistance with personal activities of daily living (PADL or ADL) such as eating, bathing, grooming, walking, dressing, toileting and personal hygiene [Link: ADL](#)
- Assistance with instrumental activities of daily living (IADL) such as preparing meals, vacuuming, laundry, changing bed linens, bathroom and kitchen cleaning, managing finances, using the telephone and shopping, as well as transportation (e.g., to medical appointments) [Link: IADL](#)
- Respite care/caregiver services that provide relief for family caregivers and stimulation and support for care recipients
- Assessment and care coordination/management services which identify needs, monitor vulnerable clients, facilitate the client’s entry into other parts of the health and social care system (hospitals, long-term care facilities and home care), and coordinate services on behalf of the client and family

CSS may also include professional home care services such as nursing, physical and occupational therapy, and social work.

CSS are provided by a mix of individuals and organizations including:

- family, friends, and neighbors
- publicly-funded home care agencies (e.g., Ontario’s Community Care Access Centres (CCACs))
- not-for-profit community support service agencies (CSSAs) which may receive some public and charitable funding but rely heavily on fund-raising and volunteers to stretch their resources
- commercial, for-profit providers

Because Canadian Medicare requires coverage only for “medically necessary” hospital and doctor services, CSS are not public entitlements. As a result, eligibility, access and costs vary widely. For example, in Ontario, professional home health care services (e.g., nursing) are provided free-of-charge through publicly-funded CCACs to eligible individuals when budgets permit and services are available. Not-for-profit CSSAs provide mostly non-medical social support services, but because of limited budgets, they may charge user fees on a sliding scale geared to income and subsidize services for individuals with low incomes. Individuals who can afford it can purchase services from commercial for-profit providers at cost.

What does the evidence tell us?

A growing body of international research suggests that when appropriately targeted, managed and integrated into the broader continuum of care, CSS can play an important role in maintaining the

health, well-being and autonomy of individuals and families, while reducing demand for more costly emergency, hospital and residential care (e.g., nursing homes).

Britain. Perhaps the most consistent and compelling evidence comes from the UK. The PSSRU (Personal Social Services Research Unit), University of Manchester, has pioneered a “balance of care” (BoC) methodology which aims to determine the most appropriate mix of institutional and community resources required to meet the needs of an aging population. PSSRU studies over more than a decade have shown that targeted, managed and integrated community care for older persons at risk of institutionalization can:

- Reduce admissions to residential facilities by 15% to 28%
- Reduce care costs
- Enhance social activity, morale, and satisfaction with life development for older persons, while reducing depression, and stabilizing care needs
- Reduce stress and the burden of care for informal carers
- Increase satisfaction for service providers including family physicians

PSSRU studies are now being used to inform national policy objectives in the UK including a reduction in unnecessary hospitalizations and long-term care admissions, support of informal caregivers, and the planning, commissioning and monitoring of an adequate supply of cost-effective, safe care in the community. [Link: PSSRU](#)

United States. Initiated in the early 1970s in San Francisco, California, the On-Lok/PACE program (Program of All Inclusive Care for the Elderly) remains a groundbreaking model for integrated community-based care. In 2000, there were 36 PACE projects in the U.S. [Link: On Lok](#). On-Lok clients are all nursing home eligible and very frail. One-third are over 85 years of age; they average 7.9 medical conditions (e.g., diabetes, dementia, coronary heart disease, and cerebrovascular diseases); 60% have cognitive problems (e.g., Alzheimer’s disease); most live alone; and 40% are poor enough to qualify for a public income

supplement. PACE services are organized around adult day care where individual needs are assessed and managed on an ongoing basis by a multi-disciplinary team. Government funding for PACE clients averages 95% of the costs of institutional care. Most resources are channeled into CSS including transportation and home care; just over a fifth (22%) of spending goes toward health care (e.g., hospitals, long-term care, x-rays, lab tests, medications and medical specialists). [Link: Rachlis \(2004\)](#). Research shows that PACE clients

- average fewer days in hospital than comparable groups of seniors
- have better health status and quality of life, lower mortality rates, increased choice in how time is spent, and greater confidence in dealing with life’s problems [Link: PACE \(2001\)](#).

Canada. In his influential study in British Columbia, Hollander compared service utilization and costs to government for four cohorts of home care and residential care clients (1987/88, 1990/91, 1993/94, 1996/97) over time [Link: Hollander \(2002\)](#).

Key findings include:

- overall health care costs to government for all clients receiving home care were between 50-75% of facility care
- costs for stable home care clients were approximately 20-50% of facility care\
- public costs for people with moderate needs were \$9,624 for home care but \$25,742 for facilities (a 62% savings); costs for people at the highest level of care were \$34,859 and \$44,233 respectively (a 21% savings)
- home support services (rather than professional health care services) were key to maintaining people at home and achieving overall lower costs

[Link: Hollander Analytical](#).

Positive outcomes have also been reported for two integrated models -- SIPA (Système de services intégrés pour personnes âgées en perte d'autonomie) and CHOICE (Comprehensive Home Option of Integrated Care for the Elderly).

Initiated in Montreal in 1995, SIPA was organized around two CLSCs (Centres Locaux de Services Communautaires). It used community-based multi-disciplinary teams and case managers to integrate institutional, social and community services for seniors with complex health problems. SIPA took on clinical and financial responsibility for primary and secondary care.

Outcomes include (Johri et al., 2003):

- Lower emergency department and long-term care costs (albeit offset by higher primary health care and home and community care costs)
- Enhanced quality of life for seniors

CHOICE, described as the first replication of the PACE model of fully integrated managed care in Canada, was introduced in Edmonton in 1996, with three demonstration sites. CHOICE was publicly funded to provide a continuum of care (including a day health centre, health clinic, sub-acute care, home support, transportation and emergency response but not acute care and LTC facility care) to older people with multiple, complex needs (including chronic mental health problems, multiple medical conditions, and cognitive impairment). Outcomes include (Pinnell Beaulne, 1998):

- Reduced utilization of ambulatory care (25%), inpatient services (30%), ambulance services (11%), and pharmaceuticals (86%).
- An overall cost savings of \$14/day/client, for an estimated annual cost savings of between \$1.3 and \$1.5 million for 270 to 300 clients
- High levels of satisfaction among participants and informal carers

Additional positive evidence comes from a recent Toronto study which compared the use and outcomes of CSS for at risk seniors in supportive housing (where CSS are integrated and managed around client needs by case managers) and social housing (where CSS may be available but not usually on an integrated and managed basis) [Link: Lum \(2005\)](#). In contrast to PACE models where seniors are transported to care, seniors in supportive housing receive care in their own apartments. Findings suggest that:

- Frail seniors (over 80 years, with multiple health conditions and functional deficits) can be supported in the community with minimal,

low cost CSS such as laundry, vacuuming, cleaning and changing bed linens

- Seniors in supportive housing are less likely to use 911 and hospital emergency departments -- 64% in social housing, but only 34% in supportive housing will call 911 at night (they are more likely to use a panic button which calls on-site staff)
- Managed access to CSS does not replace, but complements family caring -- 54% of seniors in social housing and 69% in supportive housing see visitors 3-4 times a week; 95% and 84% respectively get help from family for grocery shopping, banking, seeing the doctor, and paying bills
- Particularly in supportive housing, confidence about getting help when needed promotes mental well-being and moderates use of services – 86% in supportive housing report “peace of mind” about getting help when needed.

On the horizon: PRISMA (Programme de recherche sur l'Intégration des Services de Maintien de l'Autonomie)

An major experiment in care integration is currently underway in Quebec. Established in 1999, PRISMA aims to develop mechanisms and tools for integrated service delivery. [Link: PRISMA \(2005\)](#). While some models (e.g., PACE) aim for integration through a single provider, PRISMA operates at the coordination level where provider organizations keep their own structure but agree to participate in a “blanket” system. PRISMA conducted a demonstration project (1999 to 2001) which gathered data on 1,230 participants, 65 years of age or older, with functional disabilities, incontinence, physical mobility problems, communication problems, or cognitive problems. Each participant lived in a private household. Findings suggest that service integration led to a reduction in costs while maintaining care quality and without shifting a greater burden to families. PRISMA is based on 4 mechanisms:

- Coordination between decision-makers and managers at regional/ local levels
- Utilization of a single-entry point
- Case management

- Individualized service plans

What conclusions can we draw?

There continues to be debate in Canada over the costs and outcomes of CSS. Some secondary analyses of previous studies have suggested that the evidence in support of CSS is “elusive” and inconsistent Link: HSURC (2002) and Link: CHEPA (2003). However, studies have often focused on different or heterogeneous populations (including individuals with very different characteristics and levels of need), and one-off services whose impact is hard to judge. Short time frames may also be problematic, since Hollander’s findings suggest that the outcomes of service cuts are most apparent after 2 to 3 years.

Nevertheless there is growing evidence that CSS can produce positive outcomes at individual and system levels particularly when:

- Resources are targeted at those at highest risk of institutionalization (thus also establishing the cost of an institutional bed as a comparative base)
- There is early and ongoing assessment of health and social needs
- There is a designated case manager who combines planning and coordination with a therapeutic supportive role
- Service providers take on clinical and financial responsibility for a full range of health and social services
- Service budgets are based on needs and allow innovative approaches to care

Additional Links

A very useful point of entry into the international literature is Social Care Online (United Kingdom) <http://www.scie-socialcareonline.org.uk>

Prepared by

Fern Teplitsky, Health Planner/Consultant; Paul Williams, University of Toronto; Raisa Deber, University of Toronto; Janet Lum, Ryerson University; and David Salib, Ryerson University.

Last Edited

March 10, 2006

References (cited in text but not linked)

Johri M, Beland F, Bergman H. International experiments in integrated care for the elderly: A synthesis of the evidence. *International journal of geriatric psychiatry*, 2003, 18:222-235.

Pinnell Beaulne Associates Ltd (1998). CHOICE Evaluation project. Evaluation summary. Final report; November 26, 1998.