

Supporting Seniors in the Community: A Balance of Care Model

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The Balance of Care (BoC) Model

- Lengthy long-term care waiting lists, a high number of alternate level care (ALC) patients occupying costly acute care beds and a growing senior population who prefer to age in the community calls for a model that determines the appropriate balance between institutional and community-care resources for frail seniors.
- The BoC was developed in the UK by Dr. David Challis and his colleagues at the Personal Social Services Research Unit (PSSRU). The BoC aims to determine the most appropriate balance of community and institutional care for frail seniors. In other words, it aims to determine the most appropriate care setting for seniors “at risk” of losing independence and requiring facility care to see if their needs can be met in the community with the appropriate mix of resources.
- In UK experiments, it was determined that up to 28% of seniors in a long-term care (LTC) facility could remain in the community with the appropriate health and social care package at a similar or lower cost with better outcomes for themselves and their caregivers. (Challis & Hughes, 2002). This model demonstrates that properly managing resources can take strain off acute and institutional care sectors.
- The BoC holds considerable potential as a planning and resource allocation tool to improve efficiency across the care continuum.
- A research team based at the University of Toronto will be applying this model in two Ontario communities- Waterloo and Thunder Bay. A cross sector expert panel will design and cost out community care packages for seniors on LTC waiting lists to determine how many seniors can be diverted from the waiting list to the community.
- When care packages are put together, health and social care needs will be considered for both the senior and their caregiver with the goal of maximizing their quality of life.

A BoC In Focus Fact Sheet written by Kuluski et al (2006), is available at CRNCC.ca

Research Questions

“What is the appropriate balance of institutional and community care resources for frail seniors?”

“What proportion of seniors can be diverted from the long-term care facility waiting list to the community if given access to the appropriate mix of health and social care resources?”



Institutional Care
(long-term care)



Community-Based Care
(homecare, supportive housing, etc).

Sample

Seniors aged 65+ on long-term care waiting lists in Waterloo, Ontario and Thunder Bay, Ontario. Upon completion of these two case studies, this project will be extended to other parts of the province.

Methodology

1. Identify sample (seniors on the long-term care waiting list).
2. Classify seniors into relatively homogenous groups based on common characteristics retrieved from the Resident Assessment Instrument for Home Care (RAI-HC) database.
3. Determine how many seniors fall into each group.
4. Select groups with at least 5% of seniors and create a vignette for each group (e.g. Mrs. S was referred from the hospital, has mild cognitive impairment, has experienced a decline in social functioning, has no family caregiver, requires some help with ADL (bathing) and IADL (meal preparation).
5. Have an expert panel (care managers from different health care sectors) review case vignettes and construct integrated care packages for each vignette.
6. Estimate the costs of these packages and compare to LTC facility cost in order to recommend the most appropriate care setting.

Anticipated Timeline

Results available Spring 2007 (Waterloo) and Spring 2009 (Thunder Bay)

Acknowledgements

Funding provided by CIHR Team in Community Care and Health Human Resources and CIHR institute of Aging. Support provided by the Canadian Research Network for Care in the Community (CRNCC), Paul Williams (doctoral research supervisor and Balance of Care Team Grant Lead)) and the Balance of Care Project Steering Committee in Waterloo, Ontario.

Implementing the BoC is contingent on cross-sector collaboration and planning. This project has bridged the gap between various health care sectors as evidenced in the list below:

Balance of Care Steering Committee Members (to date):

- Gloria Cardoso, Project Manager, Waterloo Wellington Community Support Services Network (WWCSSN)
- Rosemary DalBello, Langs Farm- Community Health Centre
- Raisa Deber, Professor, University of Toronto
- Audrey Devitt-Wilson, Manager, Community Services Outreach, St. Joseph Health Centre
- Marg Donald, Director, Wellington/Dufferin CCAC
- Donnamarie Dunk, Senior Director, Waterloo Wellington LHIN
- Deb Gemmell, Executive Director, RAISE Home Support
- Laura Holtom, Assistant Administrator, Wellington Terrace Long Term Care
- Kerry Kuluski, University of Toronto, PhD Student
- Janet Lum, Associate Professor, Ryerson University
- Beatrice Mudge, Cambridge Memorial Hospital
- Janice Paul, Chair WWCSSN, ED KW Friendship Group
- Barbara Pidcock, Consultant, Ministry of Health and Long-Term Care
- David Salib, Nursing Student, Ryerson University
- Marianne Walker, President/CEO St Joseph Health Centre
- Paul Williams, Professor, University of Toronto