



Valuing Home and Community Care

Key findings and path forward

April 7 2010

THE BOSTON CONSULTING GROUP

Agenda

Executive summary

Key findings

Proposed path forward

Appendix

- Synopsis of interviews
 - Client and informal caregivers
 - CCAC Case Managers
 - "Work-alongs" with PSWs and Meals on Wheels
 - Healthcare Professionals
- Detailed assumptions and calculations

The following vignettes document the perspectives of several stakeholders interviewed

Over 45 stakeholders from wide-ranging backgrounds interviewed

20+ vignettes capturing individual perspectives included in this document

- 8 interviews with clients and informal caregivers
- 6 interviews with CCAC Case Managers
- "Work-along" interviews with Red Cross PSWs and Meals on Wheels program
- 5 interviews with Healthcare Professionals

Considerations regarding client interviews

- HCC clients interviewed were chosen on the basis of their fit with the segment profile, and may not perfectly match "the average client in scope"
 - unique financial situation, family support, health status
 - potential bias towards more independent and cognitively capable individuals

Participant names have been changed to protect anonymity

HCC client: Georgina



Client name	Georgina
Age	84
Region	HNHB
HCC history	~5 years

Client profile	
Medical condition	Generally frail
Catalyst for services	Hospitalization - lung infection
Living arrangement	At home
Primary informal care provider(s)	Son and daughter
Other sources of informal care	None
Key activities requiring assistance	
• Personal support	~14 hours/month
• Cooking/housework	~26 hrs/month; frozen meals
• Transportation	~20 hours/month
Estimated direct cost of HCC usage	
• Est. public cost of services	~\$7,200/year
• Est. private out-of-pocket costs	n/a
Intensity of medical attention	
• Visits to doctor	~6 times per year
• Primary reasons	General check-ups
• Visits to hospital	2 times in last 5 years
• Most recent visit	Bilateral knee replacement

Perspectives

Measurable impact	<p>Believes HCC allows her to remain at home</p> <ul style="list-style-type: none"> • Personal support is the critical service for her • Without HCC, she would probably move to Assisted Living
	<p>Husband refused outside help: "He was far too stubborn about being independent."</p> <ul style="list-style-type: none"> • "He barely let the PSW button his shirt" • Georgina acted as primary caregiver to him

Quality of life	<p>"Only place I call home": "I've lived in my home for 46 years. This is my home."</p> <ul style="list-style-type: none"> • "My husband also felt safer at home, both in terms of emotional and physical security."
	<p>Friendship: Great relationship with PSW that has built over many years of service</p> <ul style="list-style-type: none"> • "I'm a people person and it can get lonely at home"; great circle of friends but hard for them to get together

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Caregivers for Georgina: her son and daughter

Georgina recalls the stress she felt caring for her late husband and speaks on behalf of her kids



Primary informal caregiver	Son and daughter
Relationship	Children



Caregiver profile	
Key support provided by primary informal caregiver	
• Cooking/housework	~20 hours/month
• Transportation	~20 hours/month
Alternate caregivers	
• None	
Intensity of informal care usage	
• Reliance on informal care (% of total)	~66%
• Hours of informal care	~40 hours/month
• Hours of care transferred to HCC	None
• Primary use of additional time	n/a

"My care is pretty good but the CCAC Case Managers can be too 'business-like' – hard to reach and with no bedside manner."

Perspectives

Measurable impact

Family support is limited: "My family can care for me, but they aren't available every day; they are here in emergencies."

- When Georgina was hospitalized and couldn't leave husband alone, son and daughter stepped up their level of care, but it was difficult

In caring for her husband, Georgina **complained of fatigue** as health effect of caring for husband

- "My husband was completely dependant on me"; wouldn't accept help from others
- She was frequently concerned for his safety while watching him be fiercely independent

Quality of life

In caring for her husband, feels she **managed reasonably well as a caregiver**

- Husband became a recluse when he didn't feel well; this limited her ability to be out of the house, which was very hard

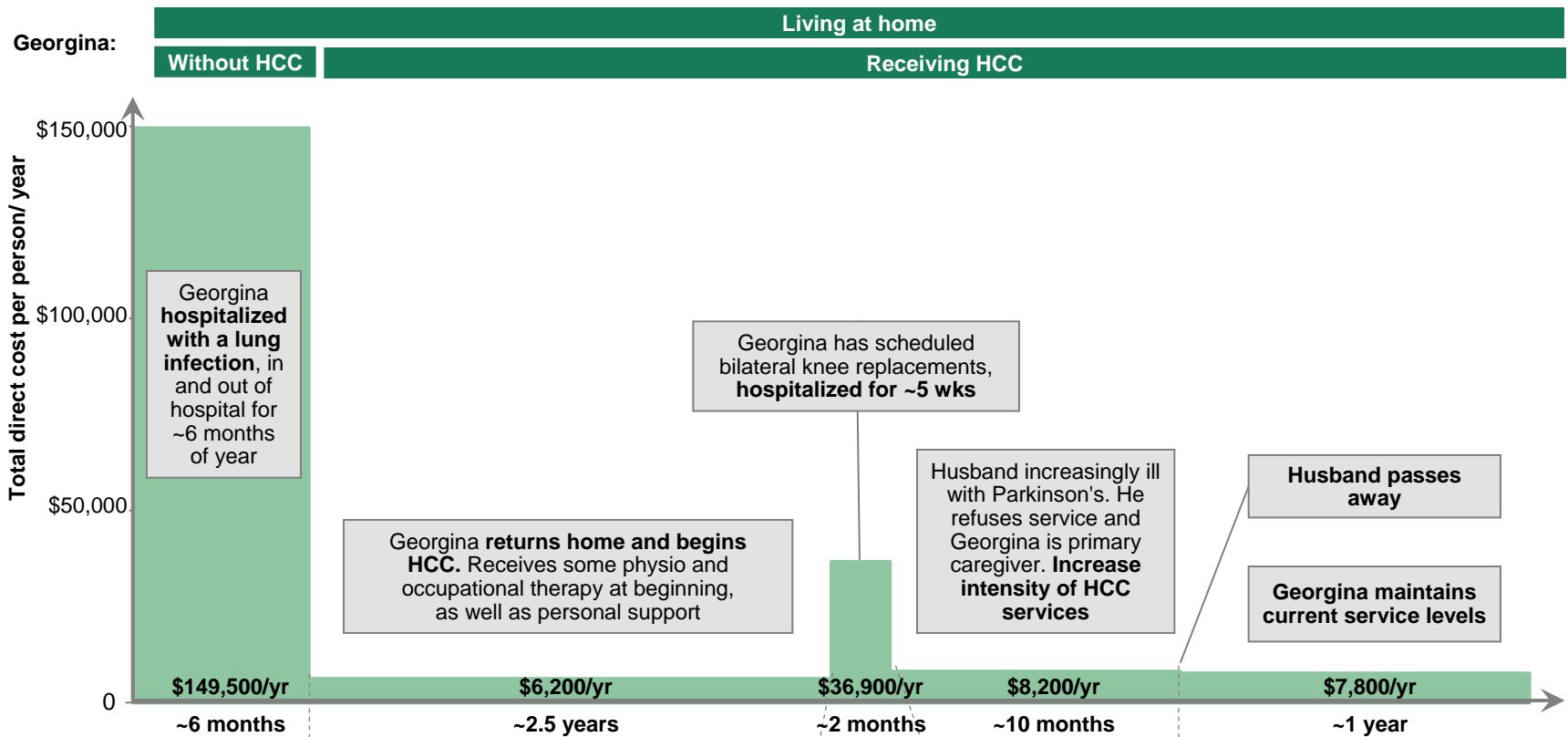
General impressions

Quality of care: Feels that she has received good care and credits the consistency in her PSW

- Believes there is significant variation in the quality of the caregivers, based on the "personal touch" vs. "business-like attitude"

Estimated direct healthcare costs over time

Georgina has lived in her home for 46 years



Services used	Total Direct Cost per Person per Year				
	~6 months	~2.5 years	~2 months	~10 months	~1 year
HCC incl. CSS ¹	\$900	\$5,600	\$800	\$7,600	\$7,200
LTC	-	-	-	-	-
Assisted living	-	-	-	-	-
Acute	\$148,000	-	\$35,500	-	-
Primary	\$600	\$600	\$600	\$600	\$600
Avg. annual cost/person²	\$149,500	\$6,200	\$36,900	\$8,200	\$7,800

1. Home and community care including community support services. 2. HCC direct costs, excluding 100% private purchased paid services.

Source: BCG interviews, BCG analysis, OACCAC data

VHCC-Key findings and path forward-7Apr10-TOR.ppt

HCC client: Annette

Annette passed away earlier this year



Client name	Annette
Age	80
Region	HNHB
HCC history	~7 years

Client profile	
Medical condition	Osteoporosis
Catalyst for services	Mobility issues
Living arrangement	Living alone
Primary informal care provider	Daughter and son-in-law
Other sources of informal care	Other children
Key activities requiring assistance (prior to AL/LTC)	
• Personal support	~10 hours/month
• Meals	~7 hours/month, frozen meals
• Housework	~20 hours/month
• Transportation	~10 hours/month
Estimated direct cost of HCC usage (prior to AL/LTC)	
• Est. public cost of services	\$5,900/year
• Est. private out-of-pocket costs	\$-/year
Intensity of medical attention	
• Visits to doctor	n/a
• Primary reasons	Frailty and eyesight
• Visits to hospital	n/a
• Most recent visit	Stroke

Perspectives	
Measurable impact	<p>Family support is limited during the day: "As children we try to provide as much support as possible, but it is hard for us to be there during the working day."</p> <ul style="list-style-type: none"> • HCC support during the day provided Annette and her family with the care necessary to keep her in her home • HCC support also helped give caregivers peace of mind that someone was checking in during the day
Quality of life	<p>Maintain independence: "Our mom was able to maintain her independence much longer with HCC support – and that was very important to her"</p> <p>No place like home: Annette loved her house</p> <ul style="list-style-type: none"> • Felt she had already compromised in her 70s when she moved to a smaller, two bedroom bungalow • "She hated the thought of not living at home – it meant the world to her"
General impressions	<ul style="list-style-type: none"> • "Our mom felt that there was variation in the quality of care, and sometimes we had to go through a few different people to find someone she was comfortable with."

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Caregivers for Annette: her daughter and son in-law



Primary informal caregiver	Louise & Peter
Relationship	Daughter & son in-law



Caregiver profile	
Key support provided by primary informal caregiver	
• Meals	~7 hours/month
• Housework	~7 hours/month
• Transportation	~5 hours/month
Alternate caregivers	
• Son & daughter in-law	~6 hours/month
• Son & daughter in-law	~6 hours/month
• Daughter & son in-law	~6 hour/month
Intensity of informal care usage	
• Reliance on informal care (% of total)	n/a
• Hours of informal care	~37 hours/month
• Hours of care transferred to HCC	n/a
• Primary use of additional time	Employment

"....there is no doubt my mom would have been in long-term care much earlier without the help she received...."

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.
 VHCC-Key findings and path forward-7Apr10-TOR.ppt

Perspectives

Measurable impact

Proximity impacts ability to provide support

- "I live in the same town as my mom but other family members live in different locations which makes co-ordination of care difficult and most of the work falls to me and my husband"

Quality of life

Maintain independence

- "My mom was so stubborn about living on her own – I was prepared to put in the hours necessary to help her because I knew how much her independence meant to her and could tell that she didn't like asking non-family for assistance."
- "By living at home and having me help out my mom was able to continue doing things she enjoyed like volunteering at the church much longer than she might have if she had been in a nursing home."

As a caregiver herself:

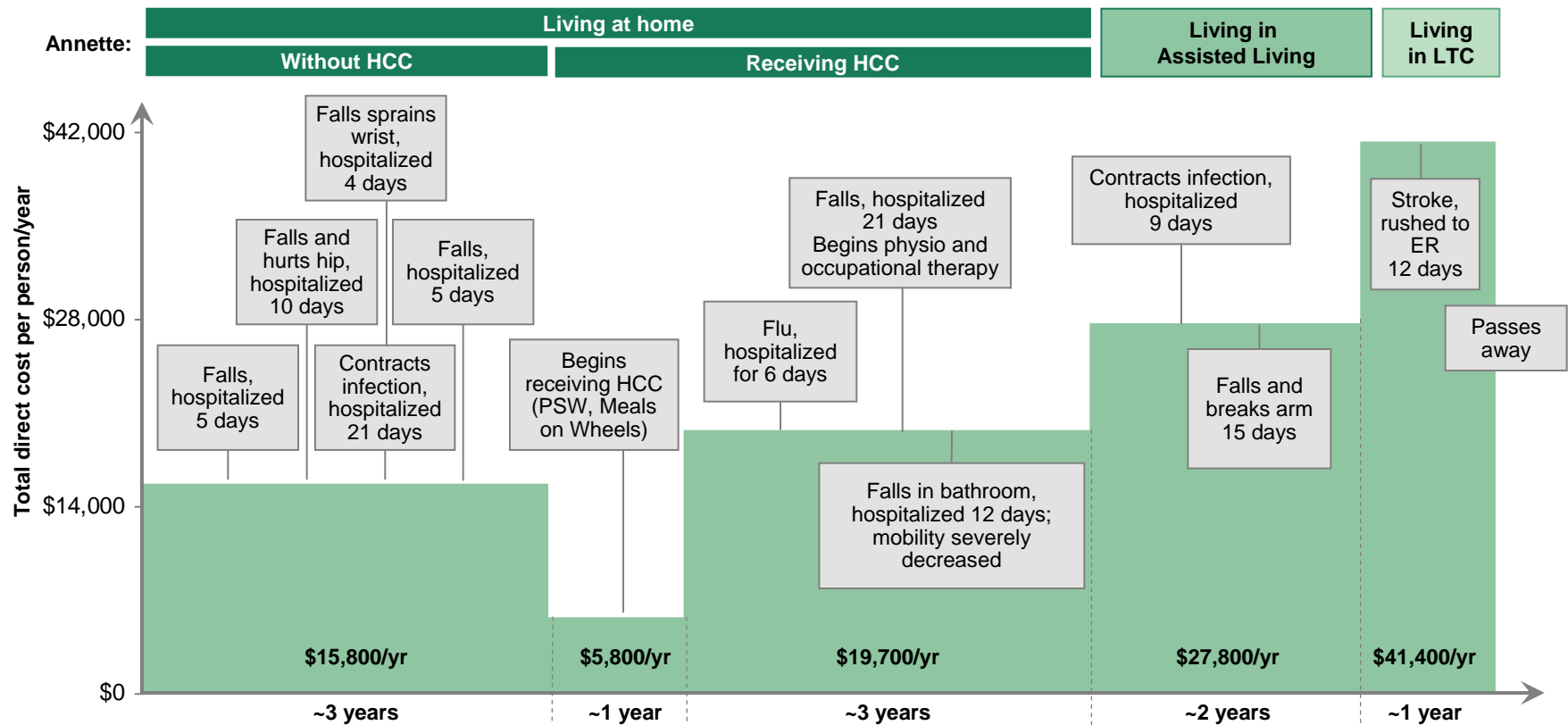
- "In the last few years my mom was living at home it became more difficult – I was always worried about her falling and felt that if I didn't check in every day she wouldn't eat etc – it was pretty stressful."

General impressions

- "It gave me huge comfort knowing that someone else was at least checking in"

Estimated direct healthcare costs over time

Annette has osteoporosis and lived independently until her late 80s



Services used	Living at home		Living in Assisted Living		Living in LTC
	Without HCC	Receiving HCC	Receiving HCC	Receiving HCC	Receiving HCC
HCC incl. CSS ¹	-	\$4,800	\$5,900	-	-
LTC	-	-	-	-	\$28,600
Assisted Living	-	-	-	\$15,000	-
Acute	\$14,800	-	\$12,800	\$11,800	\$11,800
Primary	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Avg. annual cost/person²	\$15,800	\$5,800	\$19,700	\$27,800	\$41,400

1. Home and community care including community support services. 2. HCC direct costs, excluding 100% private purchased paid services. Source: BCG interviews, BCG analysis, OACCAC data

HCC client: Doug



Client name	Doug
Age	84
Region	Champlain
HCC history	~3 years

Client profile	
Medical condition	Parkinson's disease
Catalyst for services	Caregiver exhaustion
Living arrangement	With his wife Jackie in Assisted Living
Primary informal care provider	His wife Jackie
Other sources of informal care	3 children
Key activities requiring assistance	
• Personal support	4 hours/month
• Nursing	1 visit/month
• Cooking/housework	n/a
• Transportation/shopping	n/a
Estimated direct cost of HCC usage	
• Est. public cost of services	\$1,900/year
• Est. private out-of-pocket costs	\$-/year
Intensity of medical attention	
• Visits to doctor	3 times/yr (excl. blood tests)
• Primary reasons	General check-ups
• Visits to hospital	1 time in last 3 years
• Most recent visit	Pneumonia

Perspectives

Measurable impact

Time for LTC: Case manager respectful of wish to stay at home

- Family trusts Case Manager; when she said it was time for LTC, family knew to listen
- Would've gone earlier but hard to find location where could live together; LTC would have separated them

Primary care: "There is a doctor and nurse on site now, but we prefer to make an outing of going to the doctor"

- Go to the doctor 2x monthly for tests

Quality of life

"Being together is most important to us. At home we could be together, like always"

- Eventually found a high-service assisted living establishment that they could both move into

Value independence: Both Doug and Jackie want to live as independently as possible, since Jackie can still care for them

- Gets up on his own schedule and Jackie prepares breakfast and lunch for them

General impressions

Quality of care varies: Were satisfied with services received at home, but extremely dissatisfied with HCC now

- New PSW is very rough, and is pretending to do more than she does

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Caregiver for Doug: his loving wife Jackie

Doug and Jackie have been married for 61 years



Primary informal caregiver	Jackie
Relationship	Wife

Caregiver profile		
Key support provided by primary informal caregiver		
• Personal care		n/a
• Cooking/housework		n/a
Alternate caregivers		
• Transportation	Children	n/a
• Shopping	Children	n/a
Intensity of informal care usage		
• Reliance on informal care (% of total)		n/a
• Hours of informal care		n/a
• Hours of care transferred to HCC		n/a
• Primary use of additional time		n/a

"It was hard caring for him home, but we were together ... for better and for worse."

Perspectives

Measurable impact

"I didn't need help from the CCAC": Jackie denied needing assistance with caring for Doug for years

- Always believed that there must be someone else in need, someone without anyone to care for them

Children close at hand: "Our children are incredible. They are always here when we need them."

Quality of life

Worrying about one another: "One reason it was critical for us to stay together was so that we didn't worry about each other."

- Doug is distressed about Jackie's health
- Jackie is worried about Doug

Driving time: Children used to commute ~ half hour each way to the family home

- New assisted living facility is 5-10 minutes away
- "We didn't want to burden them anymore with the long drive to and from our house. We'd rather them spend that time with their children."

General impressions

Waitlists : Waited years for Doug to be admitted to an Adult day program

- Jackie feels missed window of opportunity
- "If I had had that, maybe that would've been enough of a break for me"

Opportunities

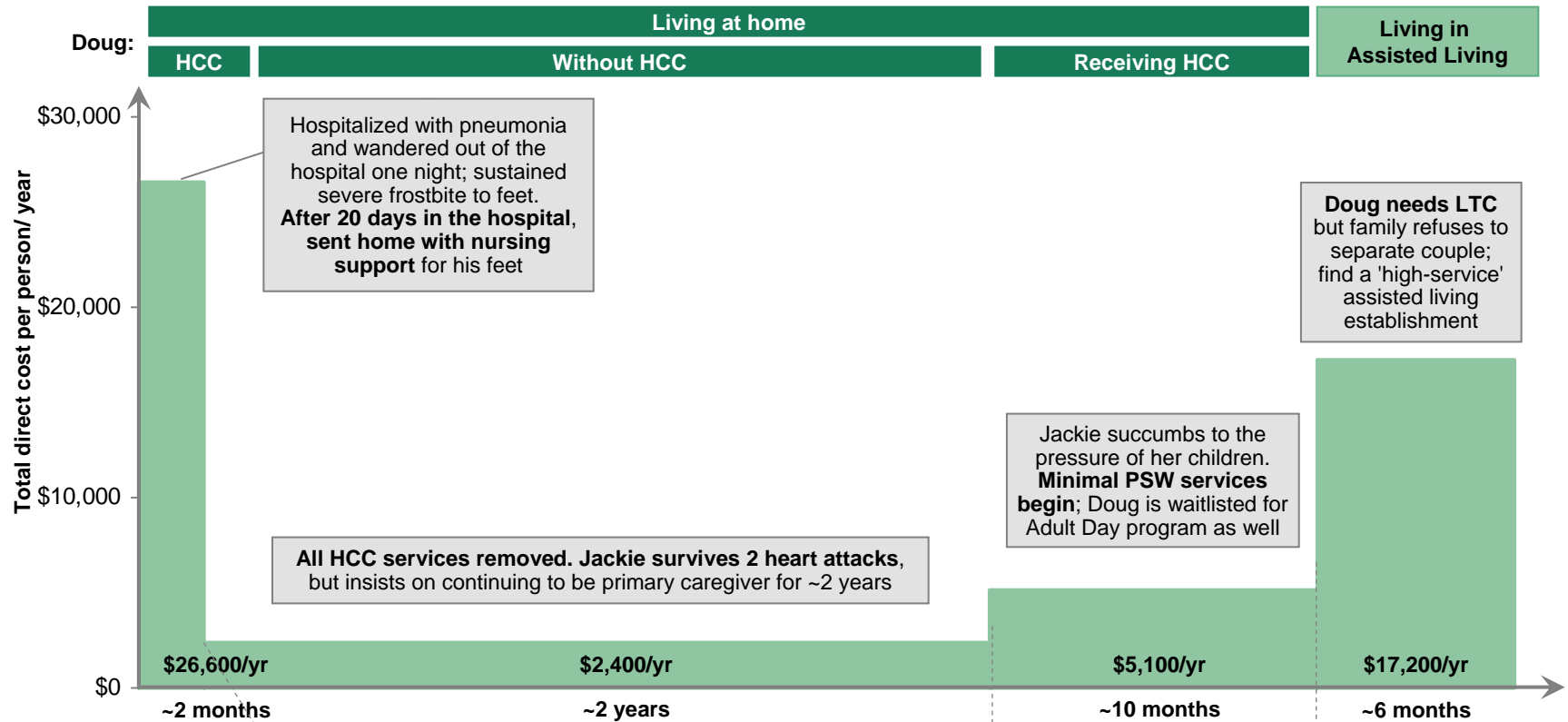
Concerned that if gave up service, would never get it again:

- This argument allowed Jackie to justify allowing some support into the house

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Estimated direct healthcare costs over time

Doug and Jackie recently moved to 'high-touch' assisted living establishment together



Services used	Total Direct Cost per Person/Year			
	Living at home (HCC)	Living at home (Without HCC)	Living at home (Receiving HCC)	Living in Assisted Living
HCC incl. CSS ¹	\$4,500	-	\$2,700	\$1,900
LTC	-	-	-	-
Assisted Living	-	-	-	\$15,000
Acute	\$19,700	-	-	-
Primary	\$2,400	\$2,400	\$2,400	\$300
Avg. annual cost/person²	\$26,600	\$2,400	\$5,100	\$17,200

1. Home and community care including community support services. 2. HCC direct costs, excluding 100% private purchased paid services.

Source: BCG interviews, BCG analysis, OACCAC data

VHCC-Key findings and path forward-7Apr10-TOR.ppt

HCC client: Violet



Client name	Violet
Age	98
Region	HNHB
HCC history	~2 years

Client profile	
Medical condition	Generally healthy, frail, falls
Catalyst for services	Leg surgery
Living arrangement	At home alone
Primary informal care provider	None
Other sources of informal care	None
Key activities requiring assistance	
• Cooking/housework	4 hours/month
Estimated direct cost of HCC usage	
• Est. public cost of services	\$5,400/year
• Est. private out-of-pocket costs	\$-/year
Intensity of medical attention	
• Visits to doctor	4 - 5 times a year
• Primary reasons	General check-ups
• Visits to hospital	One ~2-week stay in her life
• Most recent visit	Leg surgery 4 years ago

Perspectives

Measurable impact	<p>" I would likely move to assisted living without my Personal Support Worker"</p> <ul style="list-style-type: none"> • Help with few specific tasks putting her at risk (eg, laundry, bathing, odd jobs)
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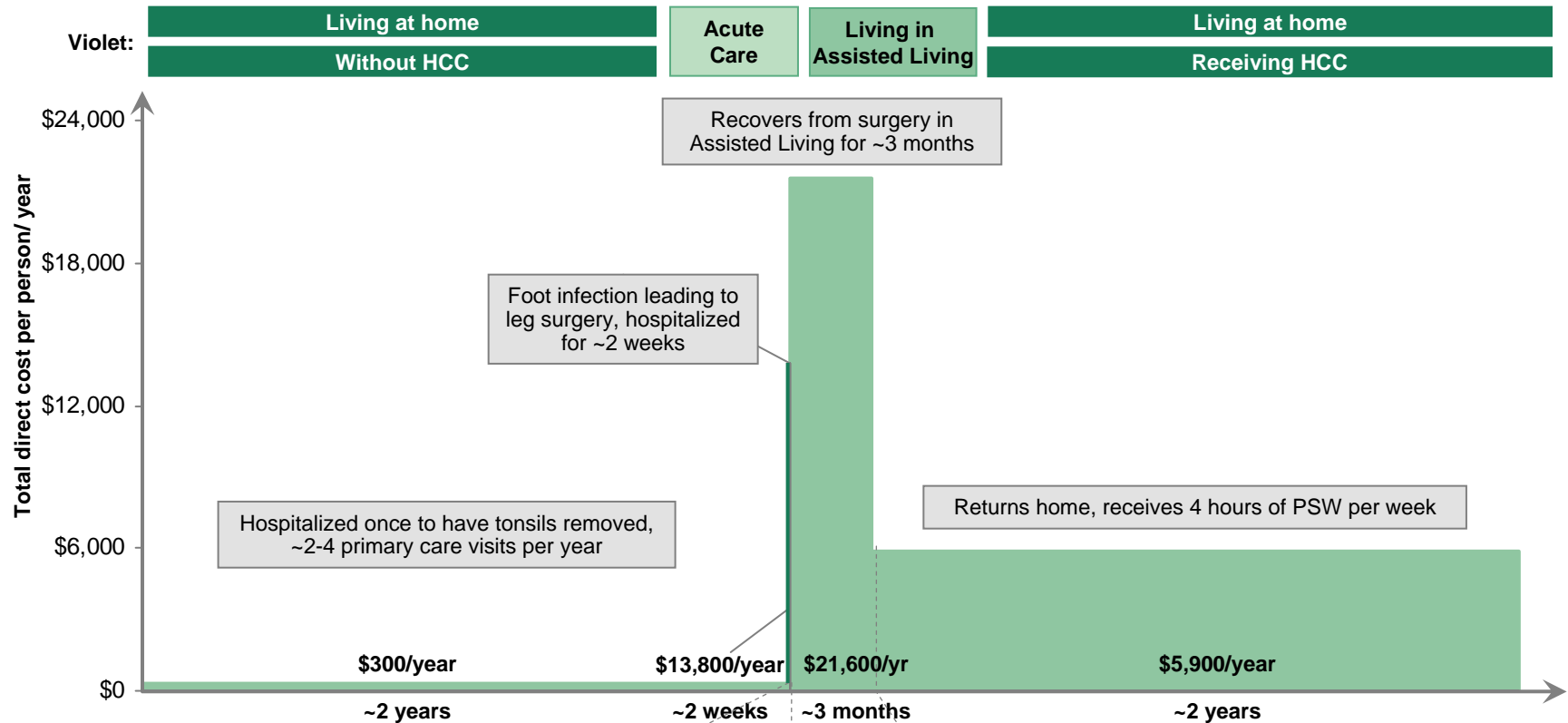
Quality of life	<p>"I appreciate the company of my PSW. I would be much lonelier without her"</p> <ul style="list-style-type: none"> • Has few people to interact with <p>Provides peace of mind to client and relatives</p> <ul style="list-style-type: none"> • "It's comforting to know someone is here in case I fall in the shower" • Relatives find comfort knowing someone visits her on a regular basis
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General impressions	<ul style="list-style-type: none"> • Extremely satisfied with the services she receives • Has had a few different PSWs, all very helpful
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Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Estimated direct healthcare costs over time

Violet is 98 and minimal home making support enables her to live at home independently



Services used	~2 years	~2 weeks	~3 months	~2 years
HCC incl. CSS ¹	–	–	\$6,100	\$5,400
LTC	–	–	–	–
Assisted Living	–	–	\$15,000	–
Acute	–	\$13,800	–	–
Primary	\$300	–	\$500	\$500
Avg. annual cost/person²	\$300	\$13,800	\$21,600	\$5,900

1. Home and community care including community support services. 2. HCC direct costs, excluding 100% private purchased paid services.

Source: BCG interviews, BCG analysis, OACCAC data

VHCC-Key findings and path forward-7Apr10-TOR.ppt

HCC client: John

"I spent my life dreaming about being here in a beautiful home with my wife and my orchard."



Client name	John
Age	80
Region	HNHB
HCC history	~1 year

Client profile	
Medical condition	Gastrointestinal condition
Catalyst for services	Hernia operation
Living arrangement	With daughter
Primary informal care provider	Daughter
Other sources of informal care	None
Key activities requiring assistance	
• Nursing	2 visits/month
• Dietician	1 visit/month
Estimated direct cost of HCC usage	
• Est. public cost of services	\$2,700/year
• Est. private out-of-pocket costs	\$-/month
Intensity of medical attention	
• Visits to doctor	~18 times per year
• Primary reasons	General check-ups
• Visits to hospital	1 time in past year
• Most recent visit	Hernia operation

Perspectives

Measurable impact

Improve health outcomes: Strongly believes that the personalized program and time spent with nurses in his home improves his health

- Would see doctors more frequently otherwise
- "We spend time talking about what will work for you vs. what the standard treatment is. We are not all the same."

"Without community care, I'd likely still be home, but I'd probably be having trouble."

Being active: Strongly believes that his health is dependant on staying active and outdoors

Quality of life

Living his dream: Spent his entire life working towards the life he has made for his retirement

- "I've had two loves in my life – my wife and my farm. Now that my wife has passed, I can't imagine leaving this farm."

Opportunities

"Someone to talk to": Wishes that there was an opportunity through HCC to have "someone to talk to" (companion rather than social worker)

- Extremely embarrassed by his medical condition and believes that should offer more counseling options

Rural services: Believes there aren't enough services for seniors in rural areas

- Will likely need to give up his farm when he loses his driving license

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

HCC client: Emma (John's late wife)

John was primary caregiver for his wife Emma before she passed away this fall



Client name	Emma
Primary caregiver	Husband John

Client profile (Emma)	
Medical condition	Severe arthritis
Catalyst for services	Increasingly limited mobility
Primary informal care provider	Husband John
Key activities requiring assistance	
• Personal support	4 hours/month
• Arthritic therapy	8 hours/month
• Cooking/housework/transportation	n/a
Estimated direct cost of HCC usage	
• Est. public cost of services	\$5,900/month
• Est. private out-of-pocket costs	\$-/month
Intensity of medical attention	
• Visits to doctor	4 times/yr
• Primary reasons	General check-ups
• Visits to hospital	1 time/yr
• Last visit	At the time of fall

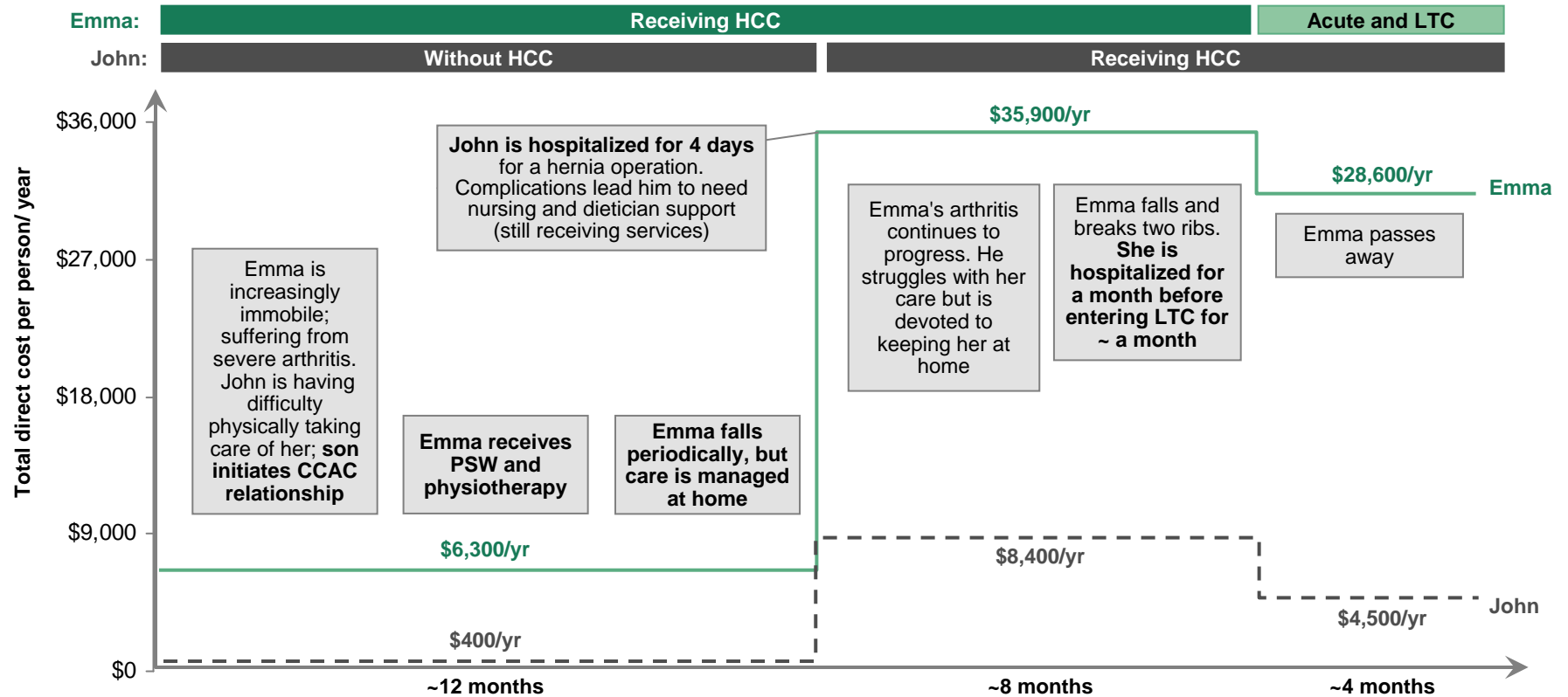
"I have to take my hat off to them. I don't know what I would have done without their help."

Perspectives	
Measurable impact	<p>Enabled her to stay at home a long time: "My wife loved it here – the house, the peace of being surrounded by her family. This was her life."</p> <ul style="list-style-type: none"> • HCC made a meaningful impact • Without HCC, "my wife couldn't have lived at home with the little bit of services we were receiving, certainly less than one year" <p>After final hospital stay, he was concerned for her safety; feared that he would endanger her further by trying to help her</p> <ul style="list-style-type: none"> • Family decided she was too ill to return home from hospital; needed to place her in LTC • John recalls one of the hardest moments of his life was leaving her at the LTC home the first night; she begged him to stay <p>Respite not readily available: While respite services were described, he never received any</p>
Quality of life	<p>Constant supervision: "I wouldn't leave her side I was so worried about her."</p> <ul style="list-style-type: none"> • Feels proud now, knowing he did the best he could grateful to have had those extra moments
General impressions	<p>Strong supporter HCC: "I recommend the CCAC and the services they provide very highly."</p> <ul style="list-style-type: none"> • "Our Case Manager has a heart as big as Ontario."

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Estimated direct healthcare costs over time

First accessing HCC for his wife, John continues with HCC after she passes away



Services used	~12 months		~8 months		~4 months	
	HCC incl. CSS ¹	LTC	HCC incl. CSS ¹	LTC	HCC incl. CSS ¹	LTC
HCC incl. CSS ¹	\$5,900/yr	–	\$5,900/yr	\$2,700/yr	–	\$2,700/yr
LTC	–	–	–	–	\$28,600/yr	–
Assisted Living	–	–	–	–	–	–
Acute	–	–	\$29,600/yr	\$3,900/yr	–	–
Primary	\$400/yr	\$400/yr	\$400/yr	\$1,800/yr	–	\$1,800/yr
Avg. annual cost/person²	\$6,300/yr	\$400/yr	\$35,900/yr	\$8,400/yr	\$28,600/yr	\$4,500/yr

1. Home and community care including community support services. 2. HCC direct costs, excluding 100% private purchased paid services.

Source: BCG interviews, BCG analysis, OACCAC data

VHCC-Key findings and path forward-7Apr10-TOR.ppt

HCC client: Tom

Tom lives with his wife Thelma and her 93 year old mother



Client name	Tom
Age	80
Region	HNHB
HCC history	~4 years

Client profile	
Medical condition	Heart condition; dementia
Catalyst for services	Heart surgery
Living arrangement	With his wife Thelma
Primary informal care provider	Wife Thelma
Other sources of informal care	Daughter
Key activities requiring assistance	
• Personal support	8 hours/month
• Housework	12 hours/month
• Cooking/frozen meal delivery	5 meals / month
• Transportation	n/a
• Adult day program	4 days/month
Estimated direct cost of HCC usage	
• Est. public cost of services	\$3,900/yr
• Est. private out-of-pocket costs	\$1,400/yr
Intensity of medical attention	
• Visits to doctor	6 times/yr
• Primary reasons	General check-ups
• Visits to hospital	~1 time/2 years
• Most recent visit	Blood infection

Perspectives

Measurable impact	<p>Believes in 'professional' care: Strongly believes that in order to keep strong husband and wife relationship, need boundaries around caregiving</p> <p>Resistant to LTC: "I feel sorry for my friend that has to go to a nursing home. It's full of strange people and those who move there don't seem to last long." <ul style="list-style-type: none"> • "He won't like it there; neither would I." • "Thankfully Theresa will never send me there." </p>
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Quality of life	<p>Comforting to be at home:</p> <ul style="list-style-type: none"> • "Its comforting to have Tom here – to talk to, to cry to, to watch a movie with." • "I feel good when I'm at home. I want to stay here as long as possible."
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Effective use of healthcare resources	<p>Dependence on primary care: "I don't go to the doctor much. I feel good when I'm at home – I got better a lot faster." <ul style="list-style-type: none"> • As health stabilizes, goes to the doctor less • Monitoring provided by HCC service providers </p>
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General impressions	<p>Satisfied with services: "Right now we are ok." <ul style="list-style-type: none"> • Have good relationship with Case Manager • Service levels recently increased, managing better </p>
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Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Caregiver: his loving wife Thelma

"I won't let my wife give me a bath. I'm not her child and I need my dignity as her husband."



Primary informal caregiver	Thelma
Relationship	Wife

Client profile	
Key support provided by primary informal caregiver	
• Cooking	
• Transportation	
Alternate caregivers	
• None	
Intensity of informal care usage	
• Reliance on informal care (% of total)	n/a
• Hours of informal care	n/a
• Hours of care transferred to HCC	~50 hours/month
• Primary use of additional time	Relaxation

"I often think – how am I doing all this? And I worry a lot since I'm not really the healthiest person in the world as it is."

Perspectives

Measurable impact	<p>Value of Adult Day program: Thelma insists that Tom go to the program 1 day/wk to give her a break</p> <ul style="list-style-type: none"> • She often spends the entire day in bed; catching up on sleep and relaxing • "It takes my mind off caring for him. I feel happy that I can go somewhere and not think about my responsibilities at home." • Also thinks it helps Tom by allowing him to meet other people that share his current struggles
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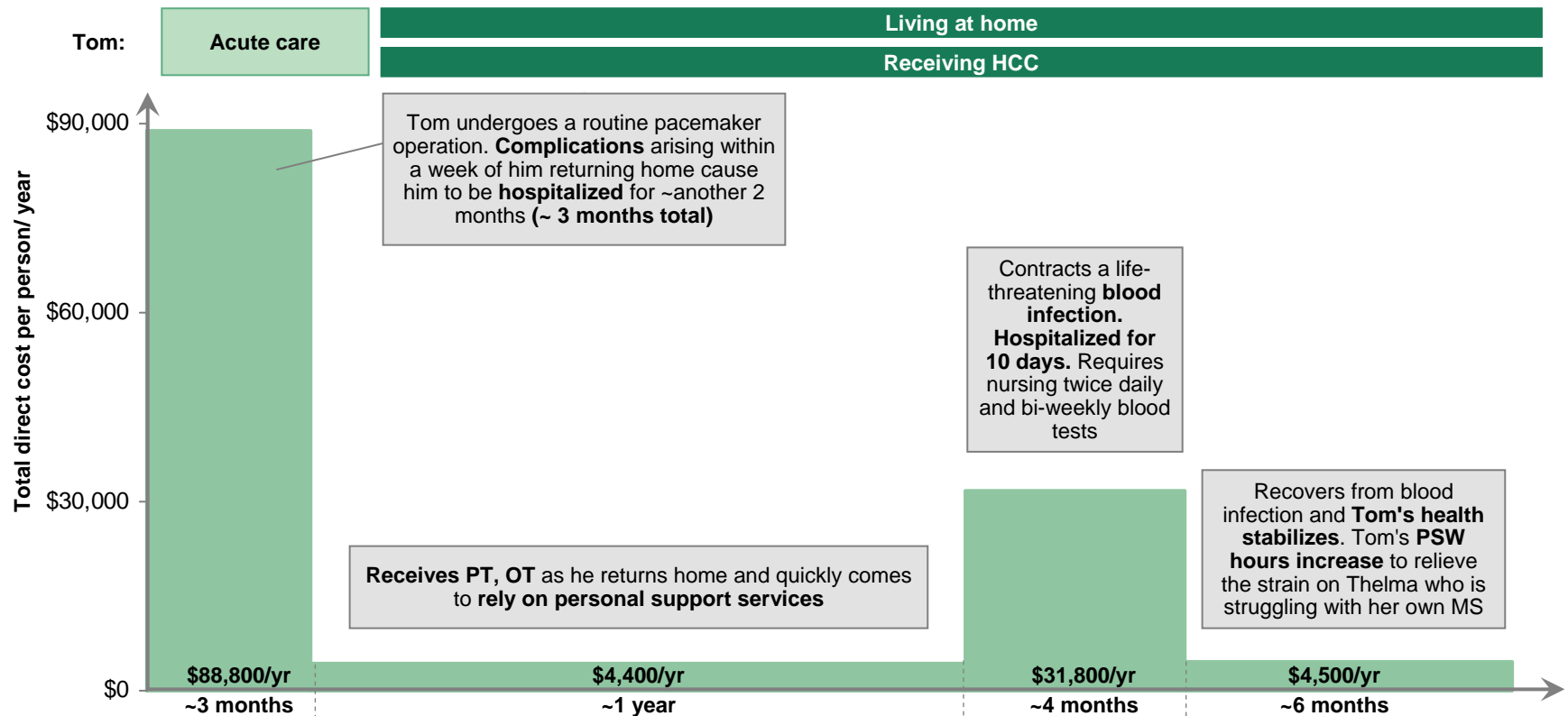
Quality of life	<p>Afraid to leave: Before began HCC, she was "terrified to leave the house"</p> <ul style="list-style-type: none"> • Now feels she has a "support network" to take breaks when she needs them <p>Toughest adjustment: "Tom can't do anything more to help me. He used to help out a lot with the house and caring for my mother."</p> <ul style="list-style-type: none"> • "Now I'm all on my own caring for everyone, and it's a lot to handle."
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General impressions	<p>"Care is better at home": "There is no love in your care when you aren't at home."</p>
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Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Estimated direct healthcare costs over time

Tom and Thelma were glad to see Tom's personal support hours increase recently



Services used	Period			
	~3 months	~1 year	~4 months	~6 months
HCC incl. CSS ¹	–	\$3,200	\$19,500	\$3,900
LTC	–	–	–	–
Assisted Living	–	–	–	–
Acute	\$88,800	–	\$9,900	–
Primary	–	\$1,200	\$2,400	\$600
Avg. annual cost/person²	\$88,800	\$4,400	\$31,800	\$4,500

1. Home and community care including community support services. 2. HCC direct costs, excluding 100% private purchased paid services.

Source: BCG interviews, BCG analysis, OACCAC data

VHCC-Key findings and path forward-7Apr10-TOR.ppt

HCC client: Hailey

"I don't think it is fair to take over my kids' lives, so I take one day at a time on my own."



Client name	Hailey
Age	80s
Region	HNHB
HCC history	~9 years

Client profile	
Medical condition	Longstanding arthritis
Catalyst for services	Knee replacement surgery
Living arrangement	Alone
Primary informal care provider	Son and daughter-in-law
Other sources of informal care	Other children
Key activities requiring assistance	
• Personal support	4 hours/month
• Homemaking	6 hours/month
• Physiotherapy	Few sessions, periodically post-surgery
Estimated direct cost of HCC usage	
• Est. public cost of services	\$1,400/year
• Est. private out-of-pocket costs	\$1,200/year
Intensity of medical attention	
• Visits to doctor	~2 times/yr
• Primary reasons	For specific treatment only
• Visits to hospital	~3–times in last 9 years
• Most recent visit	Knee and hip replacement

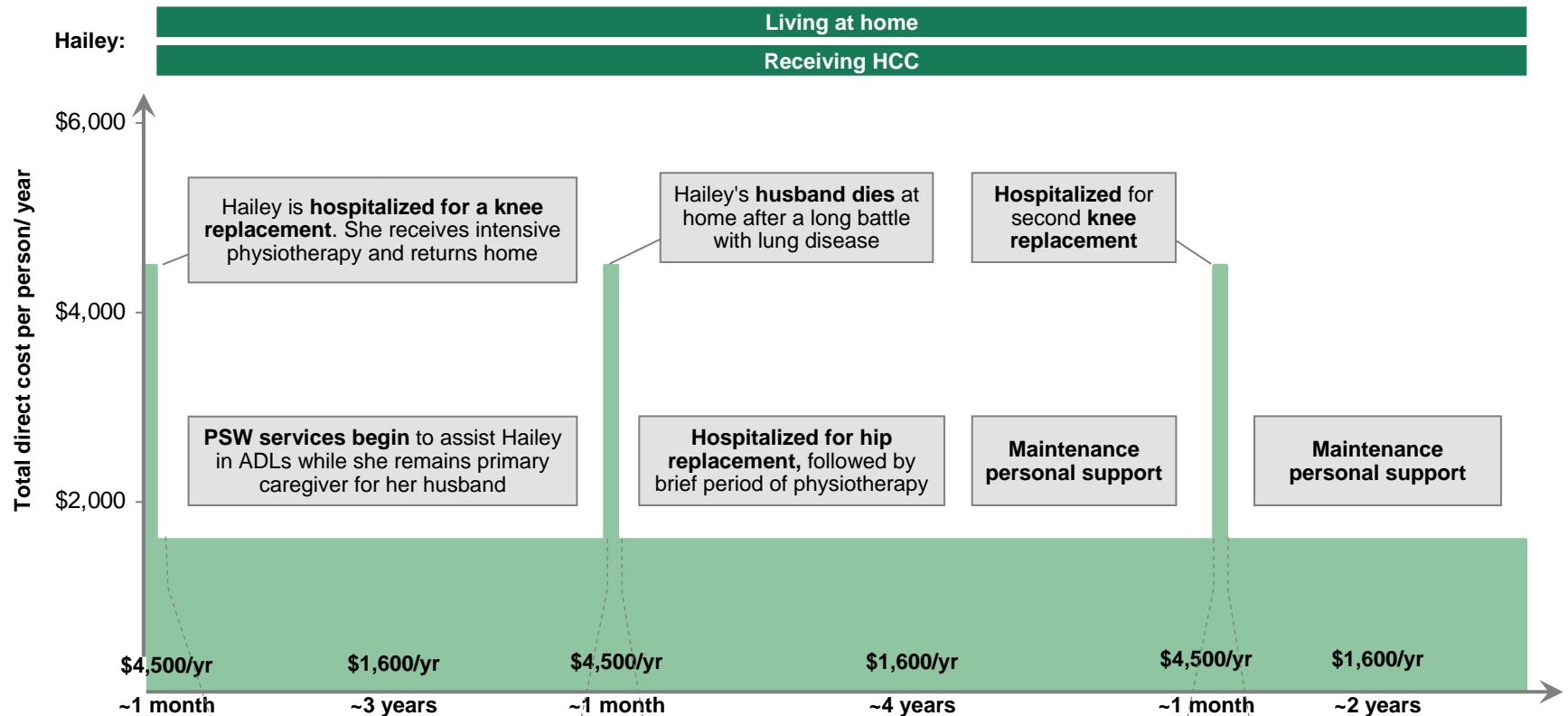
Perspectives

Measurable impact	<p>Without HCC: Believes she could stay at home without HCC and "make do"</p> <ul style="list-style-type: none"> "My bed might not be made, but I could just take it slow." <p>Seldom visits doctor: Only believes should visit the doctor when you absolutely need something</p> <p>Monitoring and prevention: Jokes that PSWs often "think they are doctors...constantly making suggestions, taking notes and telling on [her]" to Case Manager</p>
Quality of life	<p>Grateful for HCC assistance with husband: Husband died at home 9 years ago, but not sure she could have "done it without [HCC]"</p> <ul style="list-style-type: none"> His care was immensely physical "I don't know how I ever would have managed alone; thankfully I never even had to consider it." <p>Conscious of caregiving pressure: Children face enormous pressure with their own lives and families</p> <ul style="list-style-type: none"> "I will always take care of myself."
General impressions	<p>Quality of care issues: Recalls several mixed experiences with PSWs</p> <ul style="list-style-type: none"> Prefers a strictly professional interaction; several PSWs were inappropriately personal <p>"Staying in the system": Feels that others need the services more than her in light of cutbacks</p> <ul style="list-style-type: none"> But worries she needs to stay "in with them" to ensure that services are available in future

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Estimated direct healthcare costs over time

Hailey was widowed 8 years ago and lives alone



Services used	Period 1 (~1 month)		Period 2 (~3 years)		Period 3 (~1 month)		Period 4 (~4 years)		Period 5 (~1 month)		Period 6 (~2 years)	
	Cost	Services	Cost	Services	Cost	Services	Cost	Services	Cost	Services	Cost	Services
HCC incl. CSS ¹	\$600		\$1,400		\$600		\$1,400		\$600		\$1,400	
LTC	-		-		-		-		-		-	
Assisted Living	-		-		-		-		-		-	
Acute	\$3,900		-		\$3,900		-		\$3,900		-	
Primary	-		\$200		-		\$200		-		\$200	
Avg. annual cost/person²	\$4,500		\$1,600		\$4,500		\$1,600		\$4,500		\$1,600	

1. Home and community care including community support services. 2. HCC direct costs, excluding 100% private purchased paid services.
Source: BCG interviews, BCG analysis, OACCAC data

HCC clients: Ennio and Josie

"100% would not be able to live at home without HCC."



Client name	Ennio and Josie
Age	late 80s - early 90s
Region	HNHB
HCC history	~10 years

Client profile (couple)	
Medical condition	Various broken bones, dementia
Catalyst for services	Josie fell and broke her pelvis
Living arrangement	At home
Primary informal care provider	Daughter
Other sources of informal care	Other children
Key activities requiring assistance	
• Personal care/housework	Up to 60 hrs/month
• Cooking/transportation	n/a
• Adult day program	8-10 days/month
• Physio/occupational therapy	Up to 4 visits/month
Intensity of medical attention	
• Primary reasons	General check-ups
• Most recent visit	At the time of Ennio's fall

Perspectives

Measurable impact	<p>Complete dependence: Receive care in one way or another from the moment they get out of bed until the moment they go back to bed</p> <ul style="list-style-type: none"> • Rely on HCC for personal care needs, nursing, rehabilitation, mobility, cognitive stimulation etc. <p>Private spend: Pay for supplemental care out-of-pocket on evenings/weekends</p> <ul style="list-style-type: none"> • "It's not because we are wealthy but rather because this is the rainy day."
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Quality of life	<p>"The comfort of home is the best gift we could give them as children."</p> <ul style="list-style-type: none"> • Parents fear losing privacy, dignity and control over schedule by being institutionalized • Family appreciates the freedom to "come and go" and feels more comfortable visiting
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Opportunities	<p>Coordination and management: "The value of our Case Manager is really in suggesting other new services as opposed to managing the current ones."</p> <ul style="list-style-type: none"> • Support in day-to-day coordination of services is considered greatest area for improvement
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Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Caregivers for Ennio and Josie: Madeline and 3 siblings

"Being a good caregiver for me is about seeing life through their eyes"



Primary informal caregiver	Madeline
Relationship	Daughter

Caregiver profile	
Key support provided by primary informal caregiver	
• Personal care	15 hours/month
• Cooking/housework	15 hours/month
• Transportation	15 hours/month
Alternate caregivers	
• Linda (Daughter)	5-15 hours/month
• Gerry (Son)	5-15 hours/month
• Annette (Daughter)	5-15 hour/month

"We are highly committed and extremely involved as a family. That's the only reason why this works."

Perspectives

Measurable impact

Health impact: Stress of caregiving can have a significant negative impact on caregiver health

Scheduling: "Managing HCC services is a full-time job in itself and there is no help for that"

- "Consistency is the key to success – my parents have a very elaborate schedule of care. If one piece gets disrupted, it is chaos."

Quality of life

Family believes they have made a "monumental sacrifice" to keep their parents at home

- "My parents are extremely grateful for the sacrifices we make on their behalf and this helps us to keep going"
- Proximity makes all the difference - time and distance translate directly to additional burden

General impressions

Requires active advocacy: Willingness and ability of family to advocate care needs is what ensures that staying at home is possible

- Must have the sophistication to take responsibility for finding information and demanding resources required

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

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CCAC Case Manager: Sarah



Case manager	Sarah
Region	HNHB
Experience in HCC	>30 years
Frail elderly as % of cases	~75%

"... about building long-term supportive relationships with families. "

Contribution to client's life

- **"A little bit goes a long way"**: Estimates that over half of her clients live alone and only require minimal HCC support, but she is confident that without this support, they would see more frequent hospitalization, earlier reliance on long-term care, etc.
 - If removed HCC today, estimates that ~50% of clients would progressively deteriorate over a matter of months and end up in some form of long-term care; remainder could get by for awhile longer relying more heavily on their informal caregivers
- **Source of comfort**: HCC provides a significant quality of life benefit by reducing anxiety of clients who know that there is someone they trust that they can call when they have an issue, that someone that will check in on them periodically, etc.

Contribution to caregiver's life

- **Challenging role**: A lot of families are not able to take on the burden of caring for loved ones; HCC can help to "fill the gap"
 - Caregivers have their own lives and other sources of stress
 - Caregiving is not always easy; big difference between "going grocery shopping and helping to bathe" a loved one
- **"Peace of mind"**: Caregivers frequently complain about significant anxiety, depression, etc. about the situation; HCC typically helps relieve the concern of caregivers who know that there is someone checking in on their loved one

Effective use of healthcare resources

- **Basic monitoring**: #1 benefit of HCC in this area is that the daily interactions with personal care workers frequently uncover signs of medical distress not articulated by client because of denial or failure to recognize needs
 - As such, clients are able to get basic treatment in a timely way and prevent further escalation of condition

General impressions

- **Trusted advisor**: CCACs develop long-term relationships with families and become a trusted support to them
 - "We try to move with the clients and their families as they progress and offer them new alternatives."
 - Also provides counseling throughout experience and recommend when next level of care is appropriate
 - While families aren't always ready to listen to recommendations, as time passes difficult decisions are made; Case Managers are there to support them

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

CCAC Case Manager: Jennifer



Case manager	Jennifer
Region	HNHB
Experience in HCC	>35 years
Frail elderly as % of cases	>75%

"Many of the clients we meet are from a generation that has survived tough times – many of them are extremely resourceful and very determined to stay at home."

Contribution to client's life	<ul style="list-style-type: none"> • Biggest challenges for this population: 1) meal preparation, 2) transportation, and 3) housekeeping <ul style="list-style-type: none"> – Yet in rural areas, there are few services for meal preparation and transportation
Contribution to caregiver's life	<ul style="list-style-type: none"> • Need care themselves: Estimates that in up to ~40% of cases, she ends up assigning services to benefit the caregiver in addition to the 'main' client because they are struggling to cope and becoming high-risk themselves <ul style="list-style-type: none"> – Services are typically designed to be preventative in nature (eg, physiotherapy, occupational therapy, etc.) • Strong supports: Believes a great source of HCC value to caregivers is their relationship with the visiting PSWs <ul style="list-style-type: none"> – Caregivers develop strong relationships with PSWs and frequently lean on them in discussing the challenges they face, the questions they have, etc.
Effective use of healthcare resources	<ul style="list-style-type: none"> • Consistency of interactions: The value of HCC in prevention is due to the consistency in monitoring it offers <ul style="list-style-type: none"> – Regular contact with clients allows minor changes in client to be perceived; "you can usually tell when client doesn't seem right." – Different service providers interacting with clients are likely to pick up on different types of indicators of change in status
Evolutionary practice	<ul style="list-style-type: none"> • "Gatekeepers" program: Designed to educate members of the community who interact frequently with the elderly (eg, taxi drivers, bank tellers, etc.) to recognize the signs of a senior in distress and report it anonymously <ul style="list-style-type: none"> – Significant source of new referrals and effective way of introducing seniors to the slate of HCC services available • "Home First" program: Designed to help transition hospital patients back home by allowing for additional services and service levels above 'maximum' HCC hours <ul style="list-style-type: none"> – Effective at enabling some people who would not otherwise make it home to rehabilitate there

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

CCAC Case Manager: Anastasia



Case manager	Anastasia
Region	HNHB
Experience in HCC	>25 years
Frail elderly as % of cases	>70%

"Home and community care is the best kept secret in the world."

Contribution to client's life	<ul style="list-style-type: none"> • Most important service: Believes PSWs provide most valued service to this population as they care for clients' most basic needs • Social element: Very often, clients value the services more than anything for the social interaction it brings them <ul style="list-style-type: none"> – Estimates that up to 50% of her clients suffer from some degree of depression; PSWs provide socialization and lift spirits – As such, services are key to improving mental health and overall well-being of clients
Contribution to caregiver's life	<ul style="list-style-type: none"> • Empathetic listener: Caregivers frequently develop strong relationships with their HCC providers; these providers act as the "reassuring friend" when caregivers hit their "wits end" <ul style="list-style-type: none"> – Caregivers value having someone to call for assistance, suggestions – help – when they need it; someone who understands the situation and what they are going through in particular
Effective use of healthcare resources	<ul style="list-style-type: none"> • Integration with FHTs: Believes that there is huge value in having Case Managers part of FHTs for coordination of care <ul style="list-style-type: none"> – In visiting client homes, Case Managers are able to "see the true story and assess the real change in situations" which would otherwise be easier to deny (eg, whether there is food in the fridge, whether house is kept clean, etc.) – Doctors are able to proactively respond; draw medical conclusions where appropriate, propose appropriate treatment plans
General impressions	<ul style="list-style-type: none"> • "Long-term care should be last resort": Adamantly believes that, while long-term care has an important role in the healthcare system, should be a method of last resort <ul style="list-style-type: none"> – Main reason to refer someone to a nursing home is when they become high-risk and lose "capacity to consent"; otherwise, if a person does not want to go to long-term care, she will fight to keep them at home
Opportunities for improvement	<ul style="list-style-type: none"> • Improve access to information: People are not always referred at appropriate point of contact <ul style="list-style-type: none"> – In addition to widespread knowledge lacking in the community, people at risk in hospitals don't even always meet with a Case Manager – "In an ideal world, we would get the chance to meet with everyone at risk."

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

CCAC Case Manager: Christine



Case manager	Christine
Region	HNHB
Experience in HCC	>20 years
Frail elderly as % of cases	>75%

"I have one client who would be devastated if she had to leave home – she'd lose her cat, her paintings on her walls, the food she likes – it's where she belongs."

Contribution to client's life	<ul style="list-style-type: none"> Two main sources of value of HCC: <ul style="list-style-type: none"> Comfort of home: The comfort brought by being surrounded by your things, your friends, your life when you aren't well Independence: Regimented nature of long-term care is challenging; particularly for clients who are cognitively healthy
Contribution to caregiver's life	<ul style="list-style-type: none"> Shortfalls create high-risk situations: In the absence of enough HCC, stress on caregivers can become extreme; in addition to breakdowns and health problems, in cases of severe stress, begins to see emotional and physical abuse <ul style="list-style-type: none"> Abuse continually underreported since clients are vulnerable and afraid of losing caregiver support
Effective use of healthcare resources	<ul style="list-style-type: none"> Trusting relationships: As a result of frequent interactions and dependence placed upon personal support workers, client tend to be more open about real issues with PSWs than with their doctors; allows conditions to be uncovered earlier "Team" structure: Partnering of Case Managers with FHTs is working really well, in particular in the areas of integrating services based on knowledge sharing, but also in educating one another on methods (what to look for, what to ask, etc.)
General impressions	<ul style="list-style-type: none"> "No one wants to be a caregiver": She commonly hears "I never dreamed I'd be where I am today, doing what I'm doing" or "I never wanted to be a nurse" from caregivers <ul style="list-style-type: none"> All too frequently, illness challenges the plans individuals make for their retirement Caregivers step up to a challenge of caring for their loved one, all the while coping with the loss of these dreams Clients often feel loss when they aren't able to "live these plans", in addition to the guilt they feel for requiring care
Opportunities for improvement	<ul style="list-style-type: none"> Broaden respite programs: Day and short-stay overnight programs "make a world of difference to caregivers"; "sometimes on good night's sleep makes a world of difference in their ability to cope." <ul style="list-style-type: none"> Also instrumental in allowing caregivers to plan time off However, spots are not readily available

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

CCAC Case Manager: Katherine



Case manager	Katherine
Region	HNHB
Experience in HCC	17 years
Frail elderly as % of cases	70-75%

"HCC is particularly effective because it's a 1-on-1 personalized care plan."

Contribution to client's life

- **Most important service:** "I think if you asked clients what service makes the most meaningful impact for them, they would say the personal support services they receive"
 - PSWs build a rapport as family members rather than medical professionals
- **Hard to ask for help:** Believes that it is philosophically difficult for many individuals to ask for help from outsiders when it goes against their personal or community's values
 - While this is commonly seen in certain cultural/religious groups, also often seen in rural communities

Contribution to caregiver's life

- **"Sandwich generation":** The group that arguably has the toughest spot as caregivers are those who are stuck between caring for their parents and their children; "the people who aren't ever getting a break"
- **Suffer quietly:** Caregivers are also guilty of minimizing and not acknowledging the burden they face
 - Many caregivers under-utilize support/respite services; many of them are slow recognize and admit that they too need help

Effective use of healthcare resources

- **Personalized care:** Believes health outcomes improve with HCC since HCC offers personalized care plans, specific to each client's and family's needs
 - Services can be easily added and discontinued as deemed appropriate

Opportunities for improvement

- **Rural areas underserved:** Transportation is a key influencing factor in rural areas where there are little to no public services
 - Significantly increases people's dependence on others and leads to further isolation
 - Reduces clients' ability to volunteer and actively engage in the community
 - Prevents people from being able to access respite/socialization programs such as Adult Day programs, etc. and to use all relief time productively (eg, caregivers can't get to grocery store and back in an hour)
- Availability of meal assistance programs is also challenging

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

CCAC Case Manager: Elaine



Case manager	Elaine
Region	Southeast
Experience in HCC	13 years
Frail elderly as % of cases	~100%

"Unfortunately, no matter what services we provide, it is never enough."

Contribution to client's life	<ul style="list-style-type: none"> • Fear limits usage of HCC: People want to remain at home in part because scared of LTC <ul style="list-style-type: none"> – This generation sees going to a nursing home as "going to die" – Afraid that families won't visit them if not to help care for them – Also fearful of poor treatment; stories of abuse/mismanagement not uncommon to hear (regardless of truth) • #1 QoL benefit of HCC is social interaction <ul style="list-style-type: none"> – Limited mobility, not feeling well, etc. causes people to remain in their homes, isolated – Each visit allows a HCC worker to "bring the outside world into them"
Contribution to caregiver's life	<ul style="list-style-type: none"> • Impact of HCC: Believes spouses are really the ones who benefit from 'time relief', children benefit more in terms of comfort • Key restrictions on ability to care: <ul style="list-style-type: none"> – Financial situation (income) – Stress in their own lives, with their own families – Living situations (layout of house, space, proximity, etc.) – Own medical problems (caregivers in their 50-70s)
Effective use of healthcare resources	<ul style="list-style-type: none"> • Medication management: Misusing medication is extremely common but completely preventable, and yet causes a huge number of complications requiring medical attention/hospitalization every year • Difficult diagnosis: When left untreated, many people develop more complex conditions, which are then harder to diagnose and often get mistreated (eg, simple bladder infection leading to delirium)
Overall impression	<ul style="list-style-type: none"> • Believes most people in need end up accessing HCC, but long after they should have <ul style="list-style-type: none"> – Partly an access issue – clients and caregivers don't know what information is available – Partly an understanding issue - clients assume they have to pay for services; don't want to or can't afford it – Partly a denial issue - clients are fearful of admitting how badly they need assistance

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

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"A day in the life": Personal support workers



Procured service	Personal Support
Provider organization	Red Cross
Region	HNHB

"It takes a very special person to be a personal support worker."

Contribution to client's life

- **Consistency is key:** Changing a PSW frequently is not fair for the client
 - "This is a human being you are caring for – you can't have just anybody coming in to help them with very personal tasks. That won't make them feel comfortable."
- **Member of the family:** Frequently see PSW as a member of the family so much so that PSWs often asked to do tasks and chores well beyond the scope of their role

Effective use of healthcare resources

- **Least expensive form of healthcare:** Pays to invest in PSWs in terms of resource allocation and prevention programs
 - More specialized skills can be delivered at a fraction of the cost when PSWs are trained and supervised for various treatments/therapies (eg, physiotherapist trains PSW to perform exercises with client)
 - Tube feeding, catheterization, etc. are other examples of previously hospital-based, nurse-delivered services
- **Do manage to prevent incidents:** PSWs regularly report incidents and changes in health status to Case Managers, and these leads are followed up on in practice
 - Feel that more frequently aware of what is going on than family perhaps, since they stop and really pay attention to the client

Opportunities

- **Biggest challenge for PSWs:** Unstructured work (ie, no set hours, no salary, high proportion of travel time, etc.) for a generally underprivileged group (PSWs are very often single mothers)
 - Work with this segment is extremely volatile (eg, clients frequently hospitalized, etc.)
 - Retention initiatives focused on training and safety and new geographic areas, but lack of consistency in pay is #1 problem
- **Not enough service:** Maximum service levels are not always appropriate and lead to odd results for some clients (eg, services cut short in months with 31 days; can increase hours for palliative clients, but then same client left without services at end of month)

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Testimonials of the value of Personal Support Workers

Excerpts from select private notes to personal support workers

" [She] was thoughtful, kind and supportive. Helpful at every turn, great attitude and was deeply appreciated. Job well done. A credit to your organization."

– Client's spouse

" ... want to extend thanks and appreciation, not only for what she did but also for the living and nonjudgmental way in which she did it."

– Client

" ... want to express appreciation for the competence and efficiency of the caregiver who attended to my husband ... [She] was loyal and very uplifting with her very pleasant nature."

– Client's wife

"Leaving Mom was less difficult knowing you were there to help her."

– Client's son

" To my mind the best thing these caregivers give is patience and understanding of older people and this makes us feel that we have a friend doing whatever she can to make us feel comfortable. A patient, kindly manner makes a great difference to someone who has to depend on other people to do things that they used to be able to do themselves."

– Client

" I really think they are some of the best Health Care Professionals that I have had the privilege of knowing."

– Client's daughter

Note: All testimonials reviewed had been sanitized of client names. May reflect opinions of clients outside of project scope.
Source: Red Cross

"A day in the life": Meals on Wheels volunteers



Community support service	Meals on Wheels
Provider organization	VON
Region	HNHB

*"It's about seniors helping seniors ...
I give 100% and I get 150% back."*

Contribution to client's life

- **Choice is important:** Service places high value on client's preference (some choice in meal options; consideration and alternate choices provided for those with dietary restrictions, allergies, tastes)
 - "While we can't please everybody, most people are very satisfied with a good wholesome meal."
- **Consistency:** Try to keep people on volunteers routes, so that they interact regularly with the same clients
 - Build relationships with some of the clients; "when they eventually pass away, it does feel like losing a friend."

Effective use of healthcare resources

- **Checking in:** Most clients receive meals multiple times per week, which gives both them and their caregivers great comfort in knowing someone is "checking in" those days
 - During the few minutes they spend in the house, server volunteers try to observe client and will often notice if anything is wrong
 - Servers will frequently follow-up with the VON if there is an issue with the health of the client. VON in turn contacts the family, appropriate medical professional, etc.
 - The more consistent the route, the more minor the change the volunteer can detect

Overall impressions

- **Volunteers are proud of service:** All volunteers interviewed think the program is impressive, well-run and makes a meaningful difference to clients' lives
- **Why volunteer?** Most volunteers would echo the same refrains - to keep active, to be social, to give back to the community, to help the less fortunate, etc.
 - "I believe that what you give always comes back to you. Some day it will be someone else's turns to help me stay at home."

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

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Neurologist and Hospital Administrator: David



Professional	David
Medical background	Acute and primary care provider - Hospital administrator, Neurologist
Years of experience	24 years
Frail elderly as % of cases	15%

"The most important factor in determining hospital discharge is the ability of the caregiver at home."

Measurable impact	<ul style="list-style-type: none"> • Prevention difficult: Doesn't believe that HCC can truly prevent wrongful use of system for this particular population <ul style="list-style-type: none"> – Hard to know how much of common aging conditions could be avoided – Can always say that if someone had more care, they would have prevented some amount of formal treatment • Social admissions¹: But acknowledges that social admissions are a huge problem <ul style="list-style-type: none"> – Once in hospital, independent functioning often deteriorates, clients are susceptible to infectious diseases, etc.
Quality of life	<ul style="list-style-type: none"> • Client's quality of life: "I have no doubt whatsoever that being at home is what people always prefer." <ul style="list-style-type: none"> – HCC adds value as long as facilitates this, but ultimate ability to stay at home depends on caregiver – However, frequently believes his patients feel and function better once they are moved to a assisted living/LTC home – Greater availability of hands-on assistance and stimulation (eg, social interaction, intellectual engagement) • Additional support for caregivers: Believes that HCC is really about supplementing care that caregivers can't otherwise provide <ul style="list-style-type: none"> – Respite is not available or accessible enough to make a major impact for caregivers • Significant source of stress: Caregivers don't acknowledge burden; frequently have to force a conversation with families about their 'breaking point'
Opportunities for improvement	<ul style="list-style-type: none"> • Low awareness: Continual problem with access and awareness within the system despite initiatives <ul style="list-style-type: none"> – Patients, acute and primary care physicians are not provided with enough information to make fully educated decisions • Poor feedback: Loop from Case Managers and HCC providers back to primary care physicians is also problematic <ul style="list-style-type: none"> – Very often doctors are not told what services clients receive, how these services evolve over time
Overall impressions	<ul style="list-style-type: none"> • Strong resistance: Very high proportion of patients and caregivers will not accept any (or very limited) help which constrains ability of HCC to add value to patient/caregiver's experience <ul style="list-style-type: none"> – Clients only trust their informal caregivers, who, in turn, don't want clients to be more uncomfortable than they are already

1. Social admissions indicates a person who is admitted to the hospital because he/she is not functioning at home, but does not require the medical expertise and level of care of a hospital specifically; person could be assisted through other sectors of care

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Hospital Administrator: Gabrielle



Professional	Gabrielle
Medical background	Nursing background
Years of experience	>20 years
Frail elderly as % of cases	n/a

"Hospitals have a great relationship with CCAC, but there are definitely still gaps."

Measurable impact

- **ALC and risk in hospitals:** 23% of all acute beds in her hospital are occupied by ALC patients; elderly patients in particular are at risk when they remaining in the hospital unnecessarily
 - Increased risk of hospital acquired infections
 - Lack of therapeutic programs (no programs to promote the ADL skills training needed)
 - Difficult for patients to maintain cognitive status due to boredom and lack of stimulation
- **" Home to Stay" program:** While program relies heavily on caregivers and may be more expensive than remaining in hospital, believes that it is more effective at keeping people at home over the long-term and promotes better health outcomes

Quality of life

- **Choice of LTC creates backlog:** Currently HNHB clients are given the choice of specific long-term care placement they want
 - Best locations have waiting lists that are months or years long
 - Ability to choose is highly valued by clients, though in practice can drastically inflate costs by forcing them into ALC
 - Concern that once an elderly person gets settled, it is much more difficult to make him/her move – therefore hesitant to go somewhere for a short-term

Overall impressions

- **Funding is driven by greatest need at the moment:** Ultimately believes that which organizations or sectors of care get better funding is really cyclical and is always about just stemming short-term needs by shifting the pressure in the system
 - The root cause of capacity constraints are never addressed

Opportunities for improvement

- **Integration:** Believes that integrating CCAC Case Managers into hospital teams is a critical improvement to the system
 - While there are currently Case Managers in the hospital, they rotate and don't become embedded in the hospital team
 - For best results, believes Case Managers need to be close to the hospital patients and acute care teams, doing rounds

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Dementia Care Program Administrator: Janet



Professional	Janet
Medical background	Social worker; seniors community services coordinator
Years of experience	>25 years
Frail elderly as % of cases	~100%

"There is so much that can still be done to help those at risk."

Measurable impact

- **Intensity of healthcare usage:**
 - Acute care usage is dependant on whether receiving appropriate care or being left at risk
 - Expects that in the absence of HCC, clients would be hospitalized more frequently due to preventable issues
 - Primary care decreases in the absence of HCC since clients still living at home will be more likely to go straight to emergency and clients in assisted living or LTC will have additional medical direction on site
- **Redistribution in absence of HCC:** Nearly all Mild MAPLe clients and 50-80% of Moderate MAPLe clients will remain at home in absence of HCC
 - Without system capacity constraints, most people would move into Assisted Living, not Long-Term Care, if had to leave home
- **Caregiver time:** Believes that caregivers still give lots of time to loved ones in Assisted Living or LTC because they care; family perceives a need there that just simply doesn't exist

Quality of life

- **Clients' quality of life:** Ensures better/more complete physical care, provides more social engagement reduces the anxiety and stress that they see in caregivers, therefore increasing self-esteem and self-worth
- **Caregivers' quality of life:** Reduces stress, anxiety, depression and fatigue on family/spouse which improves general health and well-being, allows caregiver time to pursue more meaningful social interaction and "spontaneous joy" through hobbies, and enhances their relationship with the client

Opportunities for improvement

- **Believes strongly in several new programs** in HNHB, eg, Gatekeepers Program and Falls Prevention Clinics
 - Advocate for additional funding for Partnership with March of Dimes (extremely valued by high risk and underserved seniors) and supportive housing arrangements (program too small to make a meaningful difference itself)

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

ER Doctor: John



Professional	John
Medical background	ER Doctor, Director of Residency Program
Years of experience	15 years
Frail elderly as % of cases	25% elderly living at home, 5% elderly living in LTC

"It seems like home and community care providers act like a substitute family in cases where there is a gap."

Measurable impact

- **Redistribution in absence of HCC:** Doesn't believe majority of HCC services are specialized enough to enable people to stay at home; more about checking up on clients that don't have enough informal caregiver support
 - Only a few clients would move to Assisted Living or LTC, in cases where there was no one to care for them at all or where the intensity of the services would be too much for the caregiver
- **Dependence on ER:** Believes that HCC doesn't change dependence on ER for the average person living alone, but that in Assisted Living and LTC, patients are more likely to access the ER because:
 - Impractical to treat the patient in a doctor's office (given lack of transportation, mobility concerns, etc.)
 - Speed of treatment (tests and complicated assessments get done faster in ER, therefore limiting liability concern)
 - Incentives in compensation (doctors are not incented through compensation structure to see these patients)

Quality of life

- **Most patients prefer home:** Some people have 100% understanding of what their limitations are, but remain "fiercely independent"; other people are more realistic about their needs and feel needs are often better served in Assisted Living/LTC
 - "It all comes down to intensity of service needs – if patients are non-ambulatory or have cognitive problems that make them unreliable, then they simply can't stay at home"
- **Caregiver burnout:** Can frequently perceive caregiver burnout when caregiver begins to bring loved one to ER multiple times for trivial reasons
 - "You get the idea they've given up"; it becomes malpractice for the doctor to then allow the patient to repeatedly return home
 - Unfortunately, respite beds don't seem to be as readily available as could be helpful

Opportunities for improvement

- **ER bumps priority in wait list:** ER patients get priority access over admitted acute patients to LTC beds
 - Since admitted patients are hard to transfer to LTC, in many cases, hospital will resist admitting patients and leave them in ER

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Nurse Practitioner: Debbie



Professional	Debbie
Medical background	Nurse practitioner with a Family Health Team
Years of experience	n/a
Frail elderly as % of cases	~45% of cases

"People just do better at home. "

Measurable impact	<ul style="list-style-type: none"> • Believes CCAC Case Managers do a great job of getting the "real" sense of how the patient is doing: <ul style="list-style-type: none"> – Whether them and their family are managing and how well they are coping with strain – With this information, the FHT can then determine what type of additional care, assessments, etc. need to be implemented • Caregiver health is a value driver in itself: If HCC can reduce stress, fatigue and physical difficulty of caring for another person, would see much less in the way of caregiver healthcare costs
Quality of life	<ul style="list-style-type: none"> • Caregivers tend to be extremely devoted: Often joke that "caregivers will draw their last breath caring for loved one, because they want them to be happy and comfortable."
Overall impressions	<ul style="list-style-type: none"> • Believes that the primary care provider is ultimately responsible for the patient and needs to be at the center of care team: <ul style="list-style-type: none"> – While currently have a good relationship with Case Managers, they need to stay closely connected to make sure FHT can look at "full picture" – Questions whether HCC providers or even CCAC can really provide a complete assessment; thinks that people may be prematurely recommended for LTC
Opportunities for improvement	<ul style="list-style-type: none"> • Value isn't yet in proactive care: Approach to care should be more proactive in focus <ul style="list-style-type: none"> – "HCC could drive way more value if they instituted regular nursing assessments at home"; continuous assessments by relevant professional – "Every incident or issue that isn't caught at home has a cascading effect."

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Physiotherapist: Carla



Professional	Carla
Medical background	Physiotherapist, ex-CCAC Case Manager, ex-nurse, ex-OT
Years of experience	10+ years
Frail elderly as % of cases	75-80%

"New technology is nice, but it's removing the "human factor", the live discussions between Case Managers and service providers"

Measurable impact	<ul style="list-style-type: none"> Therapists can teach clients safe habits for completing activities of daily life in their own environment <ul style="list-style-type: none"> cooking with microwave, strategies to remember to turn oven off etc Support from equipment (raised toilet seat, lifts) enables client to stay at home with decreased informal caregiver assistance OT can alleviate safety concerns leading hospitals to be apprehensive about discharging a client otherwise ready to return home Recovery is accelerated in a familiar setting
Quality of life	<ul style="list-style-type: none"> Occupational therapy is one of the most appreciated services by both clients and caregivers, it helps people stay at home safely and comfortably. Provides comfort for caregivers that loved on is able to function in a safe environment
Overall impressions	<ul style="list-style-type: none"> Not enough communication and coordination within HCC sector (between CCACs and service providers) and across sectors <ul style="list-style-type: none"> Noted improvement to coordination in the continuum of care over the last few years, but still more opportunities to coordinate In HNHB, the "hospital-to-home" transition is fairly smooth because there are Case Managers in hospitals New technology is nice, but it's removing the "human factor", the live discussions between Case Managers and service providers <ul style="list-style-type: none"> "Information only flows one way in CHRIS, from CCACs to service providers. If I want to provide feedback, I need to call the CM"
Opportunities for improvement	<ul style="list-style-type: none"> Enable Case Managers to make "OT/PT" referrals, where therapist can assess client and recommend which one is best suited Enable therapists to provide feedback on client progress to CCAC directly in CHRIS Increase client information available in CHRIS to help therapists make more educated decisions about "accepting or declining" a service request (accurate diagnosis, reason for intervention, complete address, age, description of current situation)

Note: Names have been changed to protect anonymity. Opinions and quotations may be paraphrased.

Agenda

Executive summary

Key findings

Proposed path forward

Appendix

- Synopsis of interviews
 - Client and informal caregivers
 - CCAC Case Managers
 - "Work-alongs" with PSWs and Meals on Wheels
 - Healthcare Professionals
- Definitions and glossary

Maintenance and LSS service codes in scope for initial study

Code	MIS code for requested product category	Description
91	Acute (in-home)	To address the client's need for short-term education, care or support as a result of illness, disability or injuries. These are individuals with a clearly identifiable and predictable outcome or recovery, length of service is limited to approximately 60 days and involves primarily nursing and often only require single service
92	Rehabilitation (in-home)	To optimize the client's functional status within limits of their disability and to facilitate social integration and independence. These are individuals with decreasing short-term activity limitations and participative restrictions. They are primarily therapy services and rarely require only single service
93	Maintenance (in-home)	To maintain the client's independence by preventing/ minimizing the premature decline in health and/or functional status. It is expected that the functional status will remain stable and that the medical condition of these clients is stable, with less than 4 hospital admissions per year. There will be a stable need for assistance with ADLs (activities of daily living) or with some IADLs (independent activities of daily living). The client is able to cope normally and may not require institutionalization if no caregiver is available
94	Long-term supportive (in-home)	To delay institutionalization by providing supportive care and relief of symptoms to preserve the client's level of function and autonomy. These are clients with noticeable progressive decline in function lasting greater than three months. Their length of service is extended and has no set time limit. The expectation is that the client's functional status medical condition will decline and that there will be more than 4 hospital admissions per year. There will be an increased need for assistance with ADLs and IADLs. There will also be a decreasing ability to cope and the client would require institutionalization if no caregiver support were available. Respite is a key factor here
95	End of life (in-home)	To alleviate symptoms, reduce pain and provide support for clients in the last stages of their illness with high need for medical support. These are individuals whose health condition is not responsive to curative treatment and who are dying. Time is limited usually to less than 6 months. CCACs may wish to capture yet another level of detail within a service recipient category. For example: if a long-term supportive (LTS) patient has an acute episode requiring additional service levels for a short period of time. The client would remain in the long-term supportive in-home SR category but internally may be designated as LTS-acute for the period of the acute episode to capture the change in service intensity

Source: OACCAC

VHCC-Key findings and path forward-7Apr10-TOR.ppt

Glossary

AL:	Assisted Living
BCG:	The Boston Consulting Group of Canada
CCAC:	Community Care Access Centre
CPAC:	Community Provider Associations Committee
CSS:	Community Support Services
ER:	Emergency Room
FHT:	Family Health Team
HCC:	Home and Community Care, includes CCAC and community support services and does not include services provided/received in Assisted Living
HNHB:	Hamilton Niagara Haldimand Brant
LTC:	Long Term Care
LSS:	Long Stay Supportive
MAPLe:	Method for Assigning Priority Levels
OACCAC:	Ontario Association of Community Care Access Centres
OT:	Occupational Therapy
PSW:	Personal Support Worker
PT:	Physiotherapy
RFP:	Request for Proposal
VHCC:	Valuing Home and Community Care