
*Homecare or Long-term Care Placement?
Setting the Balance of Care in Urban and
Rural Areas of Northwestern Ontario*

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Background to Problem

- The Canadian healthcare system faces challenges related to both demand and supply

Demand

- Aging population
- People have care needs
- Generally prefer to age at home

Background to Problem

Supply

- The health care system consists of many different sectors, each with different legislation, rules, affecting eligibility for service, volume of service, etc.
- Difficult for individuals to navigate multiple systems of care.
- Difficult for care managers to mobilize the best mix of resources.
- As a result, people may end up in the wrong parts of the health care system.

Theoretical Framework

Balance of Care Framework

The ability to “shift the BoC” is affected by geography (Critical Human Ecology) and the “rules of the system” (Neoinstitutionalism)

Critical Human Ecology
focuses on the interface
between personal and
environmental resources.

Neoinstitutionalism
emphasizes the formal and
informal rules of “institutions”
and the impact that this has
on policy decisions.

Research Questions

“What are the characteristics of individuals waiting for long-term care placement in urban and rural areas of Northwestern Ontario?”

“What proportion of older persons eligible for long-term care placement in urban and rural Northwestern Ontario can safely and cost-effectively remain at home if given access to a community-based package of care?”

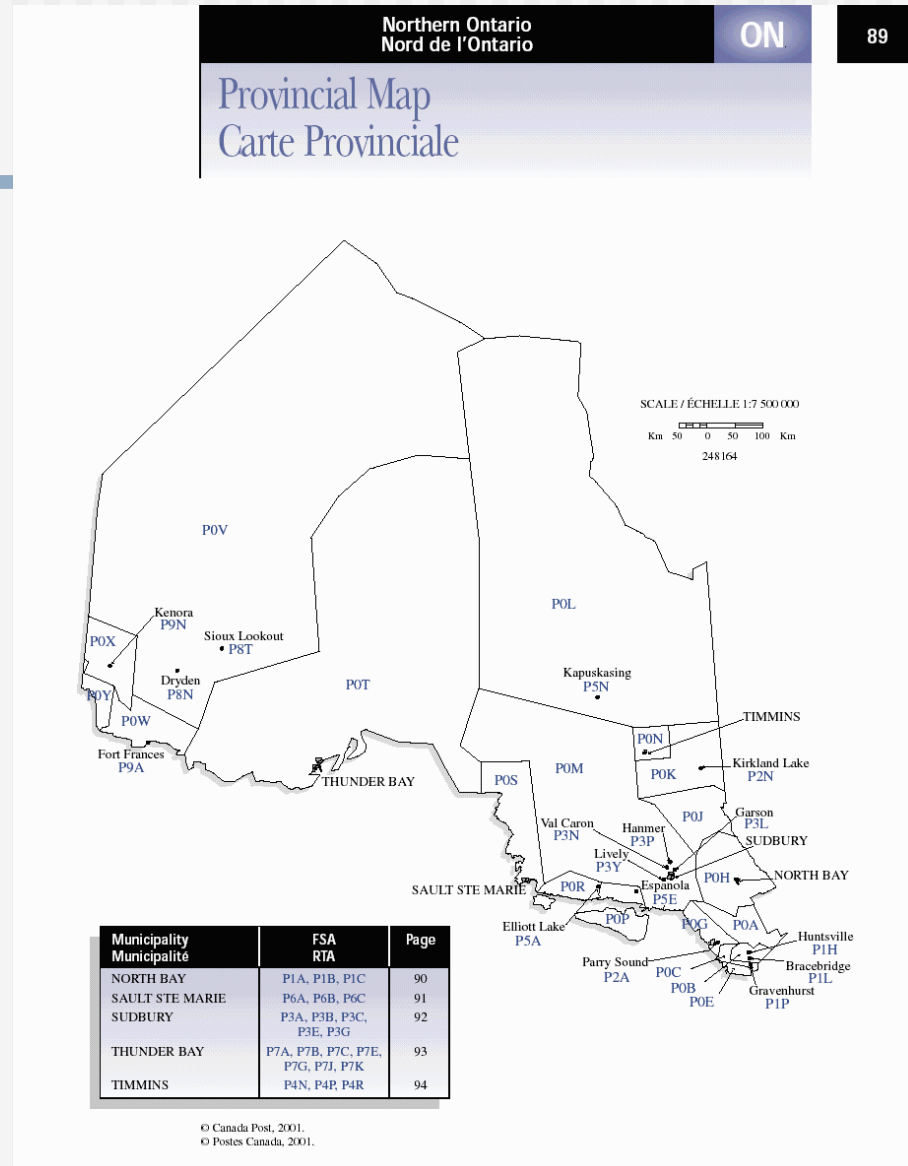
Sample

$n = 864$
(2.7% of people 65+ in NWO)

Thunder Bay
(urban NWO) = 475

Surrounding region
(rural NWO) = 382

No postal code = 7



Methodology

Step 1: Obtain Resident Assessment Instrument for Home Care (RAI-HC) dataset from Northwest CCAC

Methodology

Step 2: Analyze RAI-HC Data provided by North West CCAC (divide groups in urban and rural to compare)

- 1) ADL impairment-** toileting, personal hygiene, locomotion and eating (no, some, great)
- 2) IADL impairment-** medications management, housekeeping, meal preparation and phone use (no, some, great)
- 3) Cognition** (intact, not intact)
- 4) Presence of a family caregiver in the home?** (yes, no)

Methodology

Step 3: Stratify individuals based on 4 key variables from the RAI-HC (36 possible configurations/groups)

Step 4: Select most populated groups for further analysis

Step 5: Take each populated category and write a case study to present to expert panel

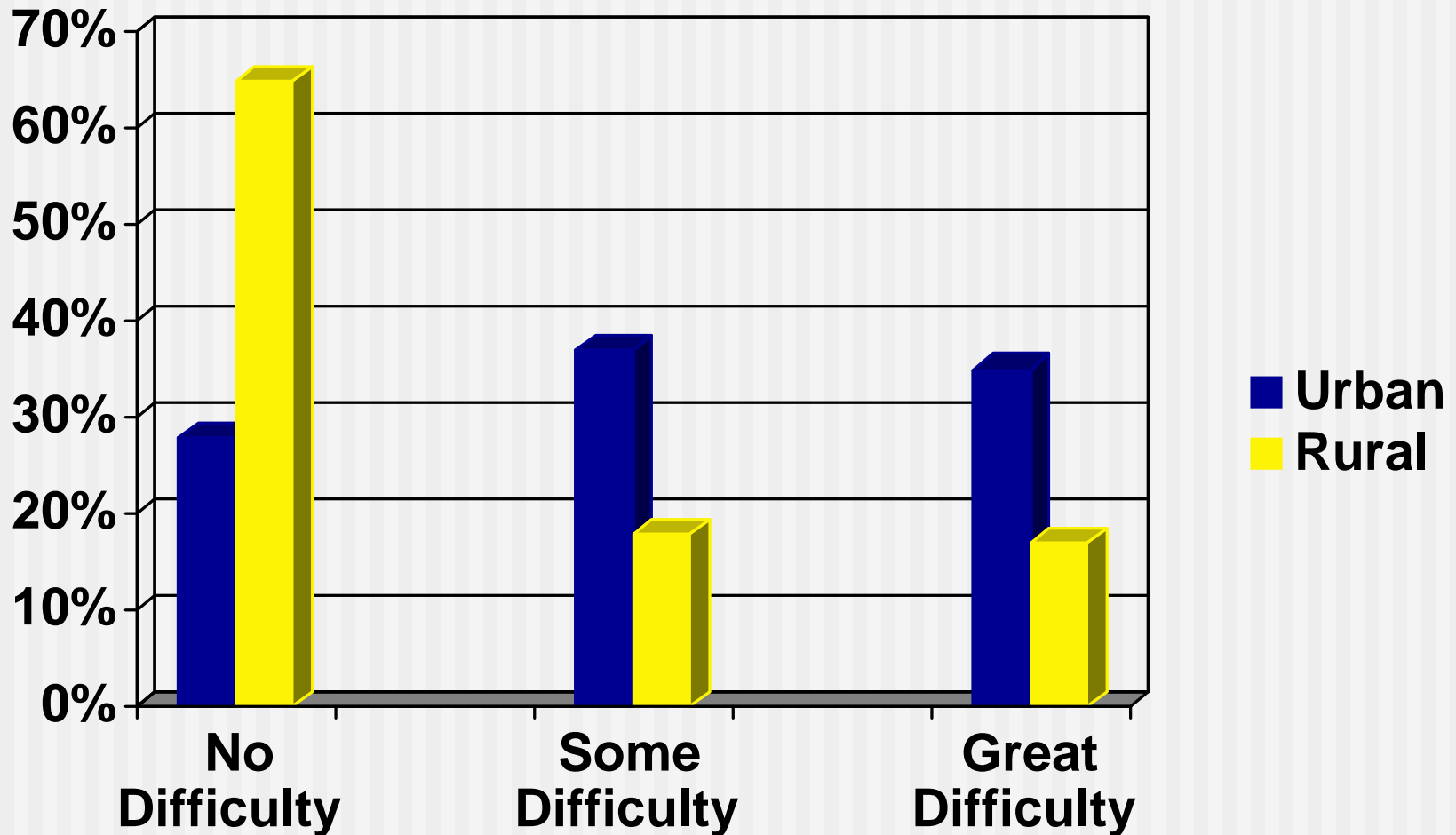
Methodology

Step 6: Panel designs a care package (if it is a safe alternative to placement). One package is put together for the urban sample; another for the rural sample.

Step 7: Using 07/08 government cost figures, care package costs are calculated and compared to the cost of a long-term care bed. From here it is determined how many people can safely and cost-effectively remain at home.

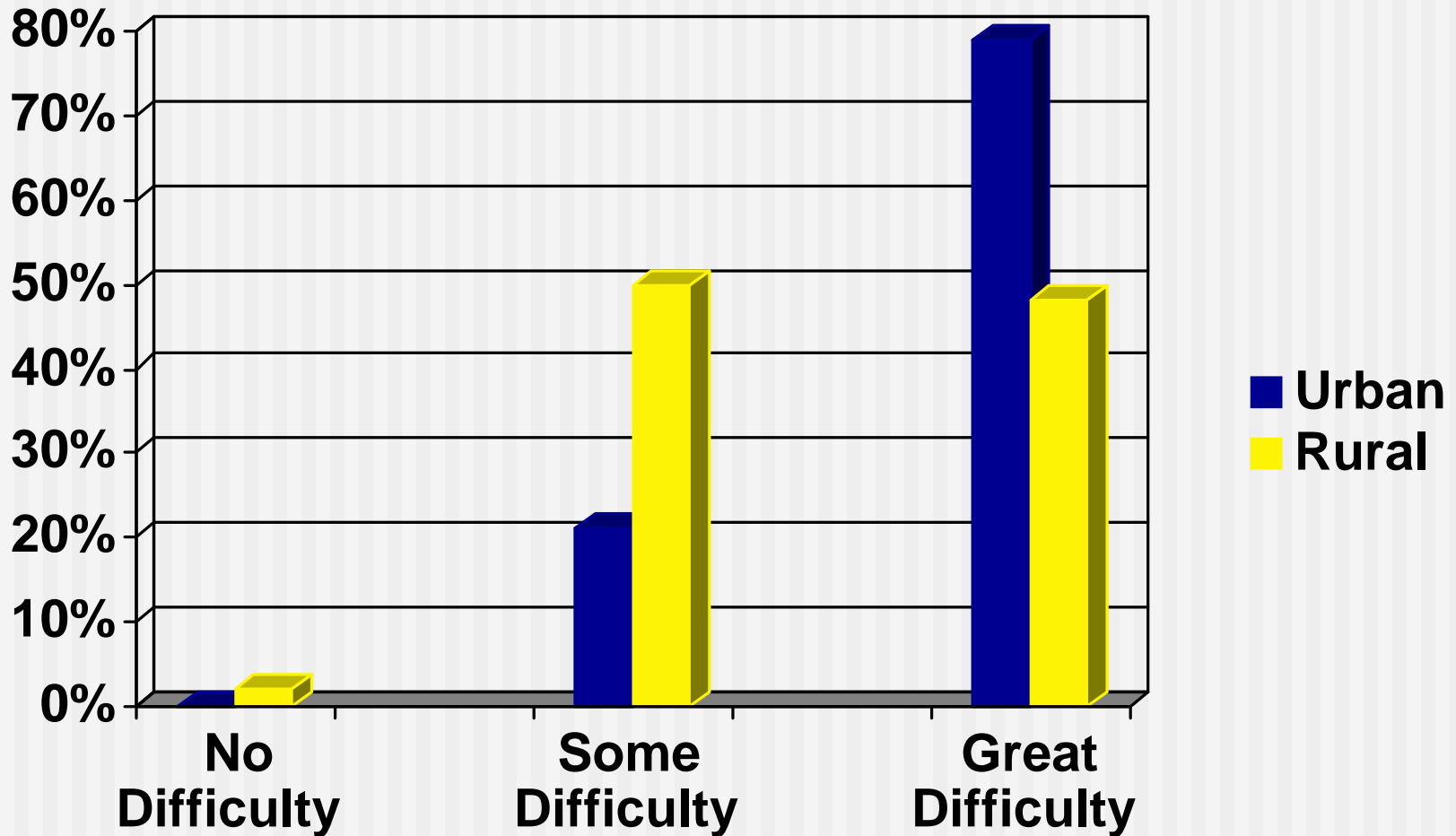
Variable 1: ADL Difficulty

eating self-performance; personal hygiene; locomotion in the home; and toilet use



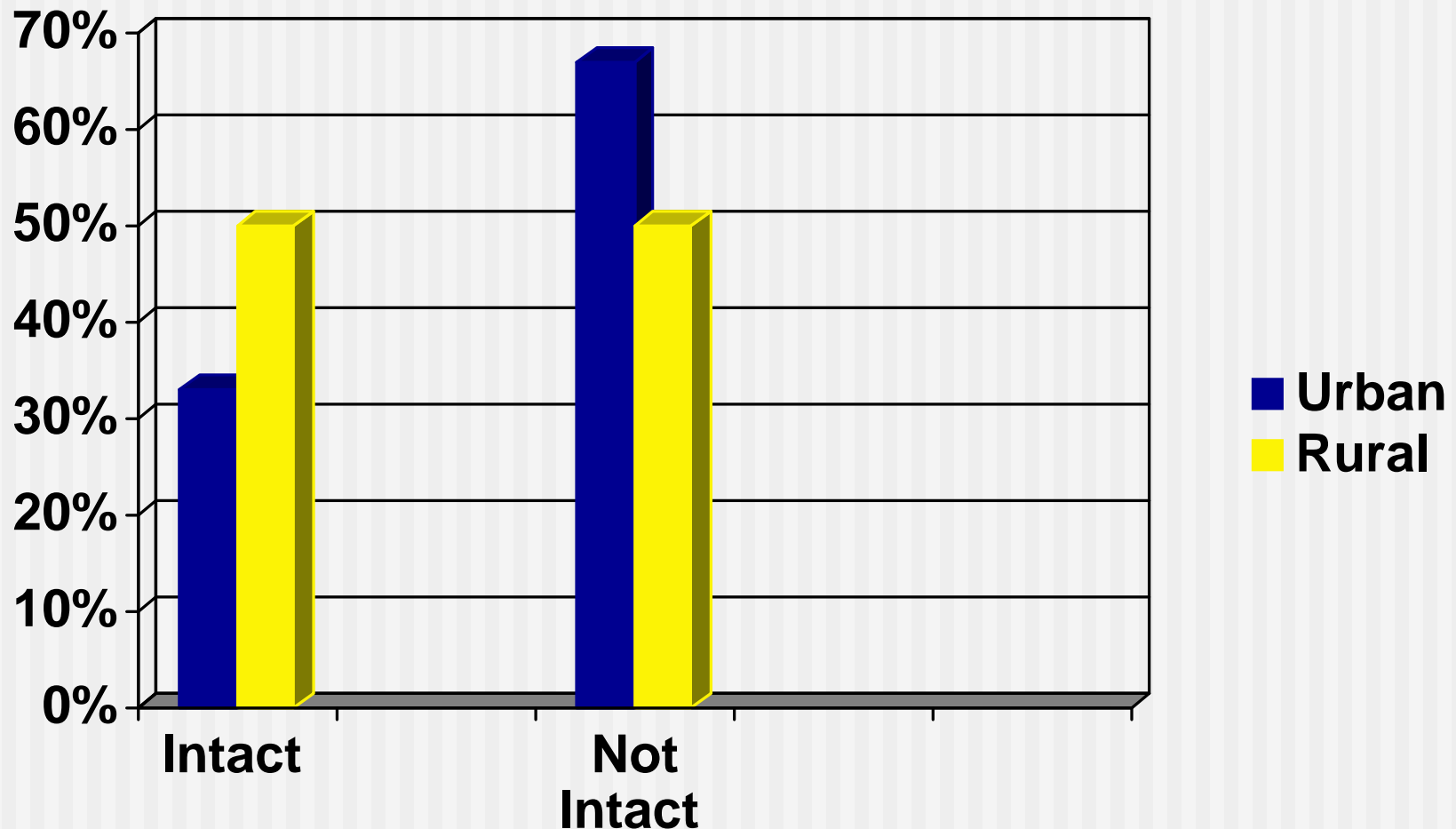
Variable 2: IADL Difficulty

meal preparation; housework; phone use; and medication management

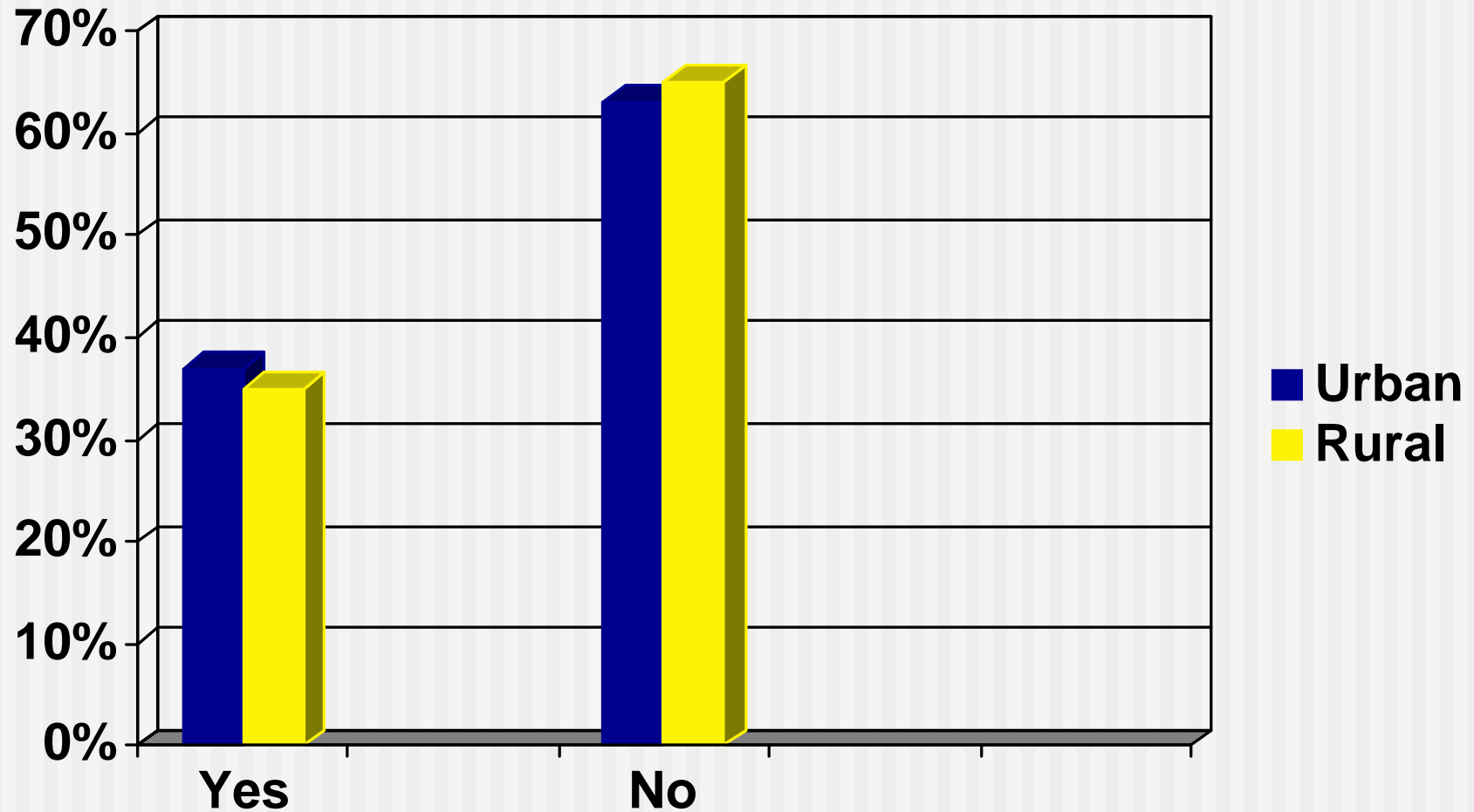


Variable 3: Cognition

short term memory; cognitive skills for decision-making; ability to make self understood; and eating self-performance



Variable 4: Presence of a Caregiver in the home



Here are two examples from the 36 possible stratifications...

Low Needs Group

Cognitively Intact
No ADL Difficulty
Some IADL Difficulty
Live-in Caregiver

Urban = 1%
Rural = 6%

High Needs Group

Not Cognitively Intact
Great ADL Difficulty
Great IADL Difficulty
No Caregiver in the Home

Urban = 12%
Rural = 6%

Summary of Care Package Components

Similar (Core) Services

- Meals on Wheels
- Transportation
- Day Program
 - OT
- Personal Support
 - LTC Respite
 - Emergency Response Installation

Differences

Urban- CCAC Social Work; Professional In-Home Respite Care; Caregiver Support Education
Rural- Volunteer respite; community support counseling

Results

Just over one quarter (27%) of the waiting list in NWO can safely and cost-effectively age at home if given access to enhanced community based packages of care.

BUT....there are significant geographical differences

Results

	Safe and cost effective	Safe but not cost effective	Not safe
Urban <i>n</i> = 438	8%	79%	13%
Rural <i>n</i> = 355	49%	30%	21%

What accounts for the difference?

Differences relate to both demand and supply

Demand

- Individuals waiting for long-term care placement in rural N.W.O have lower levels of need (they populate groups that tend to have lower cost care packages)

Supply

- The cost of community support services is lower in rural N.W.O.
- More units of service (overall) in urban packages

Conclusions

- Individuals waiting for placement in **urban NWO** have **significantly greater needs** than those waiting for placement in **rural NWO**
- People go onto waiting lists for long-term care as a result of demand and/or supply characteristics
- Regardless of geographical setting, most individuals have difficulty with IADLs

Policy Implications- Human Ecology Framework

- Geographical differences in the use of waiting lists for LTC homes (lower threshold for waiting list placement in rural areas).
- Limited scope of services in rural areas; in urban areas services are there but in limited capacity.
- Limited access to informal support (from family, friends, and volunteers)- out-migration due to lack of employment.

Policy Implications- Neoinstitutionalism

- The presence of a waiting list may send the wrong message to policymakers- waiting list for a service may be equated with a need for that particular service.
- Flexibility is key- in allowing care managers to create client-centered packages with the right mix of resources.
- Inclusion of services that support individuals with IADLs is crucial- however; these types of services are least likely to be publicly funded.
- Allowing more individuals to age at home will inevitably have an impact on family caregivers.

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North West LHIN

North West CCAC

North West Balance of Care Steering Committee and Expert Panel

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Questions?

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