



The Balance of Care

Background to the Problem

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

The Balance of Care (BoC) Model

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

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

Targeting “At-Risk” Seniors

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

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

Care/Case Management

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

The Balance of Care Method

The BoC method has the following steps:

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

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

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

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

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

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

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

Selected Balance of Care Findings

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

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

In Conclusion

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

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

Putting Evidence into Action

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

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

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