

# Cross sector complex care model

## Evaluation report executive summary

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for the Cross Sector Partners

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# Executive summary: Evaluation of the cross sector complex care model

The cross sector model was developed in response to rising concern among families, caregivers, and members of health and social services communities that the current approach for supporting young adults under 40 years of age with medical complexities and developmental disabilities is insufficient. These individuals face challenges accessing traditional supports and services that are designed either for individuals with developmental disabilities or for individuals with medical complexities, but not for individuals with both.

The cross sector complex care model offers a highly individualized approach to care that integrates services from health and developmental service providers into a single, coordinated person-centred package. The model enhances social determinants of health for the individuals supported by investing in access to health and social services, social networks, food and housing.

The model has been implemented in York Region at the Reena Community Residence and The Richmond Hill Hub, and now houses 9 individuals. At the Reena Residence and the Hub, the package of services includes:

- Accessible housing that is safe for individuals with disabilities.
- Person-centred transition before, during and after the move.
- Person-centred services to support activities of daily living and community participation.
- Access to appropriate and timely health and medical services, accompanied by a care provider.
- Community integration through structured day programming/individualized programming.
- Care coordination/case management.
- Equipment and supplies necessary to manage declining health conditions and changing physical needs.
- A system of supports available as needs change.

This evaluation set out to 1) understand the benefits and drawbacks of the model; 2) examine the value of the model in relation to alternatives; and 3) learn about key success factors, challenges and lessons learned. The findings are intended to guide similar initiatives, inform funding decisions and stimulate conversations, collaborations and actions for joint-funded work between LHINs and MCSS.

The evaluation was carried out in February and March, 2017. It was informed by administrative records as well as interviews with almost all of the individuals supported, family members, staff/supervisors and cross sector partners. The program is still quite new, so there isn't yet enough data to support firm conclusions about longer-term impacts on health, safety and quality of life. However, by looking closely at costs, benefits and implementation, the evaluation provides a better understanding of the model's potential to fill a gap in the system, while also meeting the unique needs of individuals.



Reena Community Residence



Richmond Hill Hub

*The artwork displayed in this report was created by individuals in the cross sector program.*

## Findings: Benefits and drawbacks of the cross sector complex care model

The cross sector model of care is a promising approach to service for adults with medical complexities and developmental disabilities whose needs are not being met in traditional models of care (i.e., home or traditional group home settings).

One of the most promising contributions of the model is that individuals develop friendships and lasting relationships with peers in a natural social environment – with people who are not family and not staff. And they do this while living independently in their own residence, actively connected to the wider community.

In the supported environment, individuals show potential to increase participation in directing their own care, express choice, and feel socially included. They are as independent as they can be.

From a health perspective, the model enables *access* to *appropriate* health care and developmental services that would be limited in the family home. It increases the capacity to secure appropriate care which has the potential to decrease worsening of symptoms and unnecessary complications in a vulnerable population that may be cognitively challenged to communicate the decline of their own health.

For families, the model provides assurance that their son/daughter can live in an environment where they are understood and cared for. Parents report that they experience less stress, their health is restored, and they have the opportunity to fulfill their roles as parents (rather than as caregivers) for the first time in their lives.

For the health system, the model provides a safe and medically appropriate alternative that could alleviate strain on LTC homes and reduce the number of individuals occupying beds in hospitals that are deemed ALC. Although it is too early to know with certainty, based on the information so far, the model shows promise that having the right supports in place may decrease length of stay in hospital, and reduce risk of transfer to LTC. As each of the sites train their staff with the right mix of skills to support individuals with both medical and developmental complexities, the model exemplifies the blended workforce needed to support these individuals.

The drawback, which reflects broader system issues rather than this model specifically, is that, as of today, the wider system is simply not designed to fund, scaffold or facilitate replication of the cross sector model in other locations or regions. The pioneering nature of this model meant that strong leadership from both sectors and considerable time and energy were invested to successfully launch the program. By sharing the approach and lessons learned, the model is a demonstration of an innovative cross sector collaboration within the wider system.

Partnership approach enables:

- Effective cross-ministry dialogue, laying the foundation for future collaboration.
- Cost, liability and risk for health and safety to be shared across sectors dedicated to improving health from a social determinants of health perspective.
- Inclusion of CCAC in the partnership builds confidence and trust that medical needs are being met through an integrated suite of services customized for each individual.

***“I have freedom compared to living at home.”  
(individual supported)***

## Findings: How the cross sector model compares to alternatives

The cross sector model has the potential to fill gaps in the system.

For this population, the cross sector model allows for greater integration of care than a traditional group home setting, at a comparable cost, shared between two ministries (assuming additional supports could be provided within a group home to meet individuals' medical needs). Integration of care is important for safety, increased independence and full community participation.






Compared to the family home (a less costly alternative), this model appears to be safer, provides more appropriate care (in most instances), and is more sustainable in the long run, because it does not rely on aging family members to be lifelong caregivers. It also has the potential to provide more equitable care (as quality of care, safety, and individual experience are highly variable across families).

Given the poor match between this population's needs and the typical staffing model in a group home, individuals with medical and developmental complexities would likely end up in LTC (inexpensive) or acute care (very expensive), which are not suitable living environments for this population and do not provide appropriate types or levels of care.



*“I don’t feel like a caregiver nurse...[we] play chess....[go for] walks and ice cream. For the first time in many years we are treating them and acting like sons and mom and dad.” (parent)*

### Annualized per person cost estimates to support individuals with medical and developmental complexities in alternative models of care

 Cross-sector model	 Family home	 Group home (with additional supports)	 Long-term care	 Acute care
<b>Moderate:</b> \$249k total, including: <ul style="list-style-type: none"> <li>▪ \$116k LHIN</li> <li>▪ \$132k MCSS</li> </ul>	<b>Low:</b> \$147k total, including: <ul style="list-style-type: none"> <li>▪ \$74k LHIN</li> <li>▪ \$21k MCSS</li> <li>▪ \$52k family</li> </ul>	<b>Moderate:</b> \$262k total, including: <ul style="list-style-type: none"> <li>▪ \$42k LHIN</li> <li>▪ \$220k MCSS</li> </ul>	<b>Low:</b> \$89k total, including: <ul style="list-style-type: none"> <li>▪ \$70k LHIN</li> <li>▪ \$19k MCSS</li> </ul>	<b>High:</b> \$470k total, including: <ul style="list-style-type: none"> <li>▪ \$450k LHIN</li> <li>▪ \$19k MCSS</li> </ul>

## Findings: Implementation process and lessons learned

### Implementation process

There were 7 foundational steps to implementing the cross sector model in York Region:

<b>1. Establish a strong cross sector leadership team</b>	Implementation was guided by a cross sector leadership team of funders and service providers whose members are extremely committed to the project, are well-connected within the community, are influential within their own organizations, and work well together. This provided a strong foundation for success.
<b>2. Secure cross sector funding</b>	Both the LHIN and MCSS committed funding to the program. By working collaboratively, the core team members were able to use that funding to implement a streamlined, unified initiative, despite the funds flowing through separate organizations and having different budgetary and reporting requirements.
<b>3. Secure appropriate housing stock</b>	Finding accessible, subsidized housing was a big challenge. Reena was able to commit to five spaces within its community residence structure. The core team members were eventually able, by leveraging their connections within the community, to find a second building that was suitable for the program.
<b>4. Identify candidates for the program</b>	Individuals who were high priority within both the health and developmental services sectors had to be identified manually, as there was no common database, no wait list, and no unique identifier that was common across the two systems.
<b>5. Hire and cross-train staff</b>	Each individual has a dedicated support team. Staff are hired by different organizations and have different skillsets, but need to function as a unified team. Common management, common training, and cross-training are used to cultivate a “we are one team providing seamless support” mentality.
<b>6. Plan for smooth transitions</b>	Transitions are planned carefully to help the individual and their family prepare for the move to the program. The transition period can take a few weeks, or as long as 3-4 months. It includes daily visits from the support team, and helping the individual imagine their future life in the program.
<b>7. Arrange opportunities for community participation</b>	Linkages were established with formal programming, with programming available on-site at the Reena Residence, and outside programming arranged at the Hub. In addition, individualized programming/activities were arranged on an ongoing basis according to individual interests.

### Lessons learned

Many lessons were learned over the course of implementing the model. Highlights include:

- Implementation needs to be led by a strong cross-sector leadership team including both funders and service providers.
- Partners need to be willing to invest heavily in relationships. This will take a lot of time and energy, and is critical to success.
- To provide truly person-centred supports, there needs to be blurring of roles and functions across typical ministry funding lines (overlap in roles).
- A “we are one team providing seamless support” mentality should be promoted among staff from the outset, and supported with training and cross-training.
- Housing for this population requires thoughtful, long-term planning; affordability, accessibility and proximity to services are key considerations.
- It was difficult to identify eligible clients before families went into crisis. A better system is needed (e.g., referrals, wait list, common identifier across systems).
- Discharge criteria and processes should be determined before they are needed.
- Transitions require careful planning, and must be tailored to the individual and family. They take time (up to 4 months in some cases).
- Parents may need support adjusting to their new role in their son/daughter’s life.

## Conclusions



### The cross sector model is a promising solution

The cross sector model implemented in York Region is a **creative cross sector housing solution** for young adults with medical and developmental complexities.

By providing an integrated package of health care and developmental supports, the model enables individuals to **live independently in their own residence, participate actively in their community, form friendships, and have more voice in directing their own care.**

It is still too early to draw firm conclusions about the longer-term benefits of the model, but the early findings are extremely positive, and suggest that the model shows promise for meeting needs of this population in all domains that were examined: quality of life, access to integrated services, and safety. Comparator settings did not consistently share this promise, which suggests that the unique needs of this population are not adequately met in these alternate settings.

The model has the potential to fill gaps in the system. Compared to the family home, this model appears to be **safer**, provides **more appropriate care** (in most instances), and is more **sustainable** in the long run, because it does not rely on aging family members to be lifelong caregivers. For this population, it allows for **greater integration of care** than a traditional group home setting, at a **comparable cost, which is shared across two ministries**. A worthwhile pilot project would test the replicability of the model elsewhere, to ensure these gains are not specific to this context.

While the findings are very preliminary, the evaluation showed that the model may also contribute to reductions in downstream healthcare costs (e.g., by preventing hospitalizations, reducing length of stay in hospital and delaying admission to LTC homes). This is an area worth monitoring as these individuals age.

### A great example of cross-ministry collaboration

One of the unique features of the cross sector model is its mobilization through joint funding and delivery of supports between the MCSS central region and the Central LHIN. As a regional model, it embodies what can be achieved when funders, partners, leaders, and staff from different sectors work together to deliver integrated, individual-focused service.

Nonetheless, the implementation process was not simple, and highlighted some of the real challenges in implementing collaborative cross sector initiatives at the regional level.

The three biggest systemic barriers to collaboration were:

1. **There are few cross sector communication channels** at the regional and provincial levels. As a result, there is little dialogue, and limited understanding of how the other sector works.
2. **Funding mechanisms don't align** across the two systems. There are different funding timelines, geographical boundaries, and reporting requirements.
3. There is **no easy way to identify individuals who need both developmental and health supports**, since each system maintains its own records, with no common identifier.

Opening up lines of communication at the regional and provincial level would provide a foundation for future collaboration by (a) building mutual understanding of how healthcare and social support needs of individuals and families are defined, tracked, and prioritized; and (b) supporting joint sector strategies to prevent and mitigate crises in high-risk families and individuals.

## Summary of recommendations

*“Society creates more disabilities than there really are. Let’s give them the support and watch those abilities come out.” (supervisor)*

### For MCSS and LHINs:

**Recommendation 1:** Building on lessons learned and the experiences of cross sector partners in York Region, test the replicability of the cross sector model in other regions of Ontario.

**Recommendation 2:** Examine policy and legislative barriers to integrated cross sector programming with an eye to eventually mitigating or removing the barriers. (e.g., pilot a joint funding project, harmonize reporting requirements, or commission a project to look into options for a common identifier).

**Recommendation 3:** Create incentives for regional collaborative efforts to meet the needs of individuals with medical and developmental complexities. This could take the form of joint funding pots used to incentivize leaders in local organizations to replicate, innovate or evaluate current initiatives.



### For cross sector work in other regions:

**Recommendation 4:** The team responsible for a cross sector initiative should include funders and service providers from both sectors, as well as housing.

**Recommendation 5:** CCACs and DSOs should establish and maintain relationships with one another at multiple levels.

**Recommendation 6:** When implementing the cross sector model elsewhere...

- a) Plan to have an integrated budget, even if funding streams remain separate.
- b) Secure accessible, affordable housing stock early in the planning stage.
- c) Plan to include day programming that is age appropriate.
- d) Develop practical systems for identifying, following and prioritizing individuals and families.
- e) Invest in a blended workforce with a mix of healthcare and developmental support worker skills.
- f) Build a “one team” mentality from the start, providing seamless support.
- g) Plan for deliberate, thoughtful transitions; start planning earlier to avoid crises.

### For the York Region team:

**Recommendation 7:** Document and review health utilization and critical incident data periodically to determine if any ED visits or critical incidents are potentially avoidable through prevention strategies. Establish formal processes for staff to learn signs and symptoms of changes in health status, and the protocols for management of specific diseases. Involve families in these processes during the transition period.

**Recommendation 8:** Continue to identify/develop assessment tools that are appropriate for this population, i.e., young individuals who are challenged cognitively, with complex/chronic conditions, and physically disabled. Administer these tools on a regular basis (e.g., annually, or more frequently, if appropriate) and include them in performance reports and evaluations.

**Recommendation 9:** Maintain open communication about program boundaries with individuals, staff and families. Develop criteria for transition and processes for transition to an alternative environment. If applicable, also begin to develop structures and processes to support palliative care.

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