CCAC CARE COORDINATION COST ANALYSIS: CCAC & CARE COORDINATOR INTERVIEW FINDINGS

(APPLIED HEALTH RESEARCH QUESTION)

HSPRN
health system performance research network

ELLEN G. SCHRAA, WALTER P. WODCHIS

CONTEXT

Community Care Access Centres (CCAC) were established by the Ministry of Health and Long-Term Care in 1996 to help the public access government-funded home and community services, and long-term care homes. Currently CCACs capture client utilization data and costs of direct home-care services received by each client, but not the amount of care coordination (CC) activity provided to each client. In the absence of measuring care coordination resource use by client, CCAC care coordination costs must be allocated to home care clients using a methodology which approximates the actual client use of care coordination resources.

OBJECTIVES

This project reviewed care coordination services and makes recommendations on possible methodologies for the allocation of CCAC care coordination costs to home care clients for the analysis of costs of publicly funded home care in Ontario.

METHODS

Six costing methodologies were proposed and several key informant interviews were held for face-validity testing. We conducted structured interviews with 8 care coordinators and 5 directors drawn from 3 CCACs across the province: Erie St. Clair, Hamilton Niagara Haldimand Brant, Toronto Central CCACs.

FINDINGS

The care coordinators confirmed three main care coordinating activities: intake, ongoing care coordination and infrequent or episodic care coordination. Directors confirmed that all three CCACs have implemented or are implementing a client care model that organizes care coordination according to the client population (e.g. children, maintenance, complex etc). Clients are categorized into these population groups based on a number of individual factors, i.e. health conditions, support network, RAI score, etc. In addition to CC staff, all three CCACs make use of team assistants or service assistants who also assist with client services and might be appropriate for inclusion as part of direct service allocation. The interviews confirmed inconsistent reporting of direct workload measures on the part of CC and team/service assistants. We review 6 approaches to allocating care coordination resources:

1. *Average Cost Approach* allocates total CC costs equally among all home care clients.
2. *Direct Service Approach* allocates CC costs to clients in proportion to the direct home care services received.
3. *Service Recipient Approach* would first divide total CC resources into separate pools for different Service Recipient Clients/SRC groups (eg. short stay, end-of-life, etc) and then apply one of the first 2 methods.
4. *Case-Mix Adjustment Approach would allocate* CC costs according to client functional status.
5. *Activity-Based Costing Approach* begins with defining the activities involved in providing care coordination services and assigning activity-based-costs to clients based on their utilization of care coordination activities.
6. *Risk-based Approach* allocates care coordination costs for service recipients based on the risk for long-term care placement using functional assessment tools.

CONCLUSIONS

There are two main recommendations arising from this report. The first is to empirically test the proposed allocation methods and recommendations for future data capture. The interview results suggest that optimally cost pools would be created for different SRC groups. The researchers recommend that an effective workload tracking system be put in place to record time spent in client care coordination activity.

FOR A COPY OF THE FULL REPORT CLICK HERE OR VISIT OUR WEBSITE http://hsprn.ca