CBI HEALTH GROUP

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LEADING CHANGE, IMPACTING COMMUNITIES.

40 years

Transitional and Residential Care Services Overview
2017

CANADA'S BEST MANAGED COMPANIES Platinum member

CANADA'S 10 MOST ADMIRED CORPORATE CULTURES™ 2015 Presented by Waterstone

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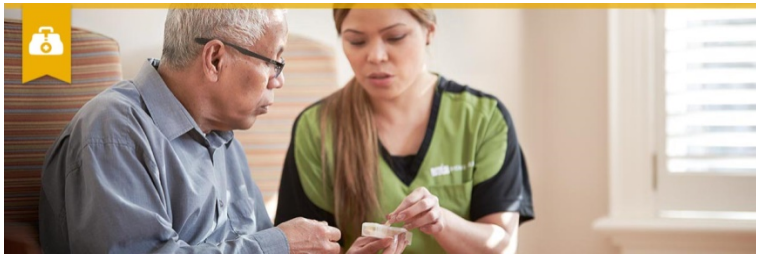
About CBI

CBI HEALTH GROUP

CBI Health Group is the largest network of integrated community health services in Canada

Founded as a research and education based organization, CBI opened its first site in 1975 and grew through the years – currently helping more than 300,000 people within 800 communities across Canada - Through more than 250 + locations & 12,000 employees, providing services to:



- Health Authorities
- Ministry's of Health/Social Development
- Workers Compensation Boards
- Hospitals
- Insurance Providers
- Federal Government agencies
- Employers and various other funders

90% of CBI's partnerships are with Government Authorities and Third Party Funders

Operating Segments

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OUR NETWORK

REHABILITATION

Community-based rehabilitation including physiotherapy, sports medicine, osteopathic and chiropractic care for timely and effective patient recovery.

HOME HEALTH

In-home or in-facility nursing, personal care, rehabilitation and support services for improved patient security, recovery and independence.

NEURODEVELOPMENTAL

Best-practice-based treatment services for individuals with behaviour, communication, learning and motor skills challenges.

TRANSITIONAL & COMMUNITY CARE RESIDENCES

Transitional and Residential Care homes providing multi-disciplinary and specialized care to support patients with a variety of needs.

WORPLACE SOLUTIONS

Health and safety services designed to reduce risk and injury and improve workplace productivity.

ASSESSMENT SERVICES

Independent medical evaluations, disability management and dispute resolution for timely and cost-effective outcomes.

National Footprint

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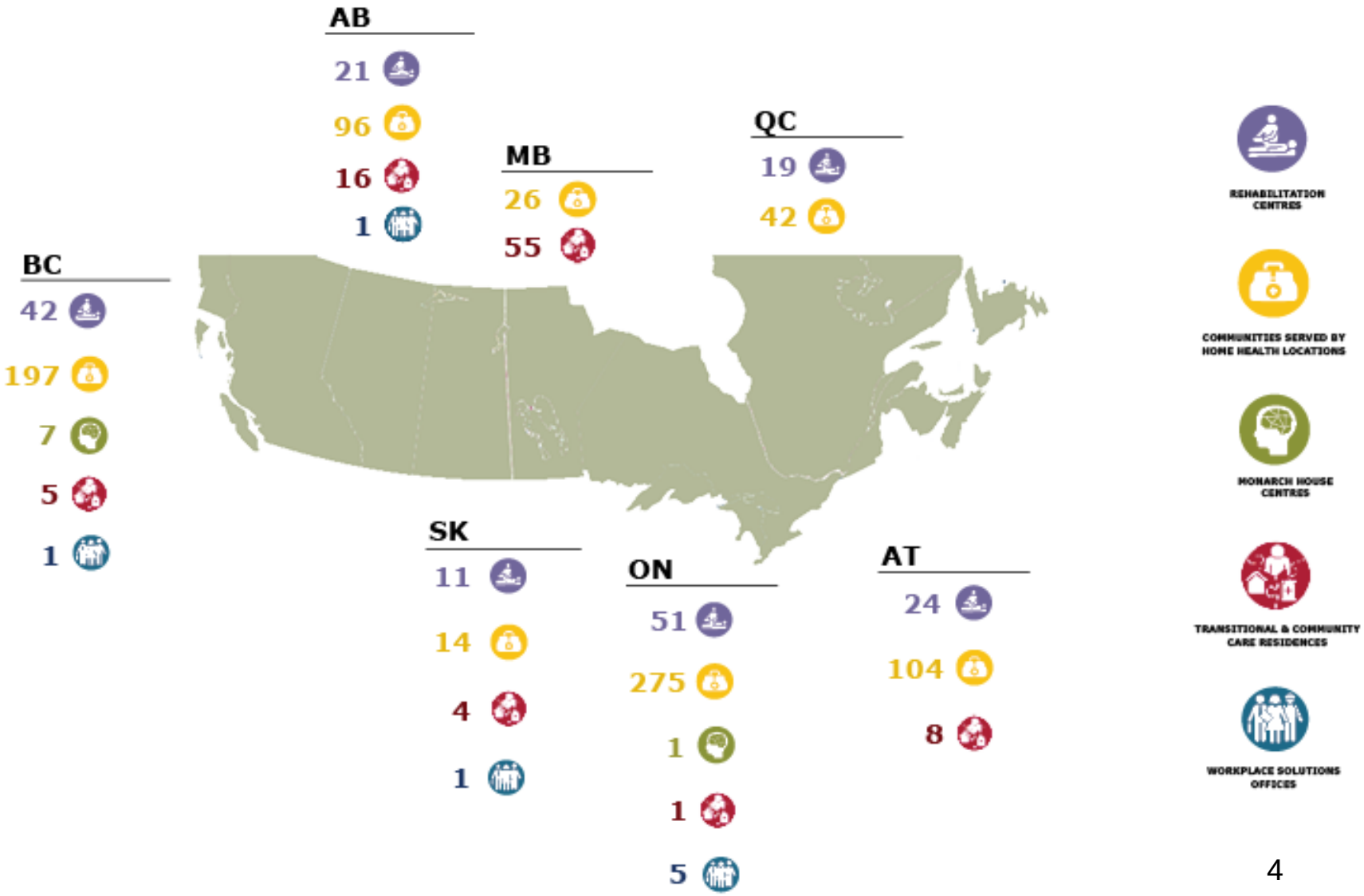

Connecting the Dots
End-to-End Care

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- CBI helps make a complicated system much easier to navigate by connecting the dots for better care.

- CBI assembles interdisciplinary teams to meet community and patient needs. Combining Behaviour Therapists from our neurodevelopmental team, Occupational Therapists and Physiotherapists from our rehabilitation team and Nurses and Caregivers from our home health team, we efficiently manage transitions and care costs.

- Our national network coordinates access to care and connects the appropriate professionals and services to our patients.

- We develop customized and integrated care models utilizing evidence based practice and connecting the values and preferences of our patients with their care plan.

Connecting the Dots
End-to-End Care

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- We connect key performance and value with service delivery metrics, to achieve better health outcomes.

- Our models of care provide new community care options that improve access to care, decrease ALC rates, shorten waitlists and decrease hospital readmissions.

- We can provide a combination of our community care models which could include but are not limited to: discharge planning, comprehensive case management, transitional/residential care, home care, outpatient therapy, remote patient monitoring under a more bundled funding structure that provides a more seamless transition from hospital to community and is a more financially sustainable alternative to the current system

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Transitional and Residential Care Services

Executive Summary – Purpose Built Solutions

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Ministry of Health Problem:

- Each day in Canada, 9,100 beds are occupied by individuals who no longer need to occupy a hospital bed.
- Lack of transitional options and or long term placement alternatives.
- Hospitals have back logs, cancelled surgeries and longer ER wait times due to the shortage of available beds.
- The annual government spend on Alternative Level of Care Beds is approximately **$3.3 Billion**

Ministry of Social Services Problem:

- 51,000 Individuals with a developmental disability in Canada require long term residence and provincial wait lists continue to grow due to inadequate living facilities/residents., some of which remain in hospital beds
- The annual government spend (excluding Newfoundland, and PEI) is estimated **$2.5 Billion.**

Solution:

- CBI has devised a Transitional (short to medium term stay for ALC) and a Residential care model(long term/permanent stay for persons with development disability and complex behaviours). These models provide an integrated level of care that is patient –centered with evidence based outcomes and community re-integration objectives.
- CBI's investment partner Omers allows us to finance the capital needs which helps offset the financial strain to our funders and therefore allows costs to be utilized for direct services only.

Existing Purpose Built Solutions

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In working with our partners, CBI Health Group provides over 80 Residential and Transitional care residences for individuals with developmental and physical disabilities, musculoskeletal injuries, acquired brain injury, mental health challenges, and Alternate Level of Care Patients:

- **Alberta:**
  - ✓ 16 community care homes for adults and children with developmental disabilities and mental health needs
  - ✓ One 16 Bed Transitional Care Facility coming Fall 2017
- **Manitoba:**
  - ✓ 55 community care homes for adults with intellectual disabilities, ABI and Mental Health
- **New Brunswick:**
  - ✓ 8 community care homes for adults/children with autism and mental health needs
- **Saskatchewan:**
  - ✓ 1 community care home currently servicing high needs complex care children
  - ✓ 1 home currently servicing high needs complex care adults with developmental disabilities
  - ✓ One 14 bed long term Transitional Care Home and one 14 bed emergency placement home for children
- **Ontario**
  - ✓ 1 community care home currently servicing high needs complex care young adult through MCSS/MCYS
  - ✓ 1 community care home for high need complex youth through MCYS coming Fall 2017
- **British Columbia**
  - ✓ 4 Transitional care homes for adults with physical injuries and acquired brain injury
  - ✓ One 11 bed independent suites transitional care facility for adults with physical injuries, acquired brain injury, mental health and developmental disabilities
  - ✓ All Services funded by WSBC

Objectives

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In working with our partners, our aligned objectives are:

- Capital Investment partner to build service models that meet the needs of our partners
- To provide patients with high quality healthcare, equivalent to hospital based care, either in a transitional care facility or within their own home or in our residential care facilities
- To decrease hospital length of stay, number of admissions and re-admissions
- To decrease percentage of patients requiring discharge destination to LTC
- To increase satisfaction, quality of life and confidence of patients and their families in their ability to manage and cope with the care in place
- To improve patient experience at transitional points of care
- To provide a more cost beneficial alternative to hospitalization with 30-60% savings
- To ensure we are a collaborative community partner
- To provide more appropriate housing options with specialized services that are patient-centred

Patient Population

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Individuals who could benefit from our Transitional and Residential Care Services:

- Individuals with developmental disabilities and/or dual diagnoses
- Individuals with mental health diagnoses and/or addictions
- Individuals no longer requiring hospital level of care
- Individuals requiring restorative, rehabilitative or convalescent care to regain independence after accident, trauma or acute phase of illness or surgery
- Individuals who are frail and elderly
- Individuals waiting for home modifications, community support/housing, caregiver support or long term care placement
- Individuals with cognitive or behavioural issues
- Individuals who are not accepted to long term care or unable to live at home
- Individuals requiring support to manage chronic or complex conditions
- Individuals with neurological conditions (i.e. ABI, Stroke)

Solution Key Elements

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Integrated model allows for continuum of care into the community with better outcomes

Home-like environments within residential communities

Strong medical knowledge at the management and supervision level with nursing expertise (RN, LPNs, Psych RN)

Dedicated care team assigned to meet individual care planning and goals

Guidance for families and caregivers in how to support patients

Shared living accommodations with the following attributes:

- Private bedrooms
- Fully accessible homes
- 24 x7 personal support care supervised by RNs
- Complex nursing care
- Rehab services
- Meals supervised by registered dieticians
- Behaviour support
- Laundry and Housekeeping
- Per diem rates saving funders an average of 30% – 60% from hospital stays

Integrated Team Health Professionals

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The care plan may involve an **interdisciplinary model** of professional healthcare resources such as:

- Registered Nurse or Psychiatric Nurse (specialized services)
- Licensed Practical Nurse (Delegation tasks)
- Personal Support Worker (Delegation tasks)
- Professional Therapies (PT, OT, SLP, Behavioural Therapists, etc.)
- Physiotherapy Assistants and Occupational Therapy Assistants
- Case Management Coordination (Coordination of services – pre and post discharge)
- Dieticians and Nutritionists
- Physicians, Specialists and Pharmacy

Restorative Care Transitional

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<u>Led by a Registered Nurse with support from an array of speciality services to oversee:</u>

- Medical and therapeutic support
- A specialized care plan to help patients regain their strength, function and independence

The objective is to provide a period of restorative care after the acute phase of an illness with the expectation that they will be able to return home within an established period of transition.

The goals of our Transitional care model include:

- Increased functional independence
- Reduced need for ongoing home supports
- Reduced need for LTC placement
- Reduced re-admission rates
- Improve self-rated health, confidence and well-being

Our transitional care facility can also serve as a more cost effective alternative option if patients are not ready to return home or are waiting for placement to a Long Term Care facility.

High Medical Needs/Complex Behaviours Residential

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The objective is to provide a more appropriate long-term residential care option for those individuals who do not meet admission criteria for LTC or who are unable to live at home. These patients typically have high medical needs requiring 24/7 nursing, high personal support and/or present with behaviour, aggression or dementia related symptoms.

Individuals who would benefit from the program could include those who have the following:

- Wandering that poses a risk to self or others
- Ongoing behaviour management issues
- Demonstrates responsive/aggressive behaviours
- Requires more than 2 hours of skilled nursing a day
- Requires 2 person assist
- Complex skin and wound care issues
- Ventilator Management
- Tracheostomy Care

Complex Individuals Residential

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The objective is to provide an alternative placement for individuals with dual diagnosis, developmental disabilities, mental health or complex behavioral issues who have been living in hospital with no option to discharge to community. CBI provides appropriate housing infrastructure and specialized supports for these individuals to live safely in the community. This model can be jointly funded by both Ministry of Health and Ministry of Community and Social Services.

Outcomes

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The scale of CBI Health has been achieved through a focus on building depth through best practices, performance management, peer to peer benchmarking and administrative and operational outcomes.

- CBI Health is a results oriented organization
- Intensely focused on delivering high quality, consistent care and generating superior patient outcomes
- Takes an evidence-based approach and embraces full accountability
- Highly measured environment that allows our organization to provide consistent and predictable patients outcomes across our national network

Outcomes for our transitional care and high medical needs/complex behaviours residential care homes include:

- ✓ Patient/Caregiver Satisfaction
- ✓ Decrease in number of ALC patients
- ✓ Decrease in ALC rate/total ALC days
- ✓ Decrease average LOS in ED
- ✓ Decrease in number of re-admissions post discharge from transitional care services
- ✓ Lower Cost/patient
- ✓ Decrease percentage of patients requiring LTC admission

Outcomes

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Outcomes for our Complex Individuals residential care homes include:

- ✓ Individual Satisfaction
- ✓ Decrease cost of care with increased independence
- ✓ Number of individuals participating in regular inclusive community activities, including volunteering
- ✓ Percentage of individuals with developmental disabilities who report a level of self-determination which is similar to that of all citizens
- ✓ 100% of staff working with complex needs individuals have the required level of training
- ✓ Accredited Agency with 100% compliance to Ministry/legislative Safety Standards

Current Builds

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ACCESSIBILITY AND AMENITIES

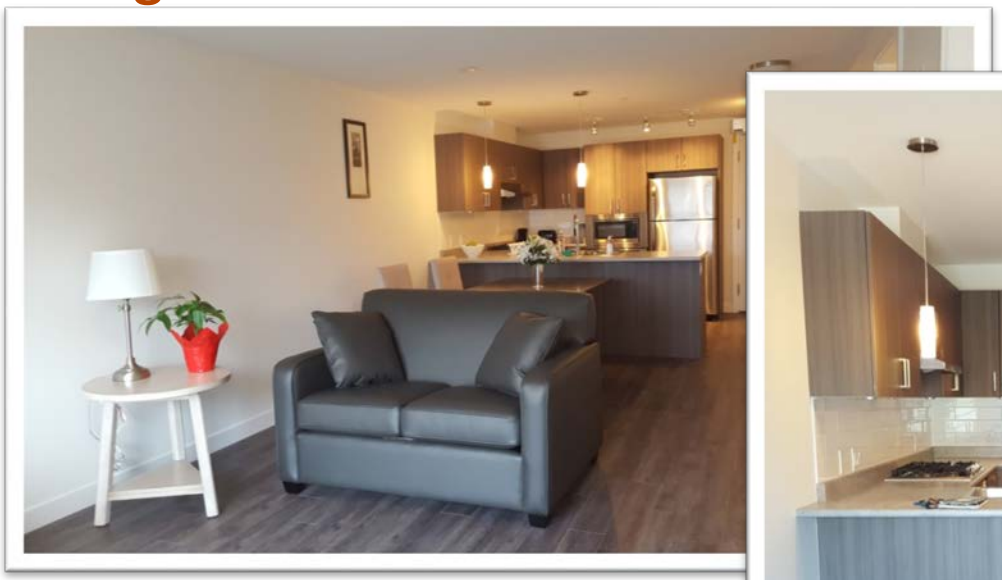
Residential living with Private Rooms and Shared Family Rooms.

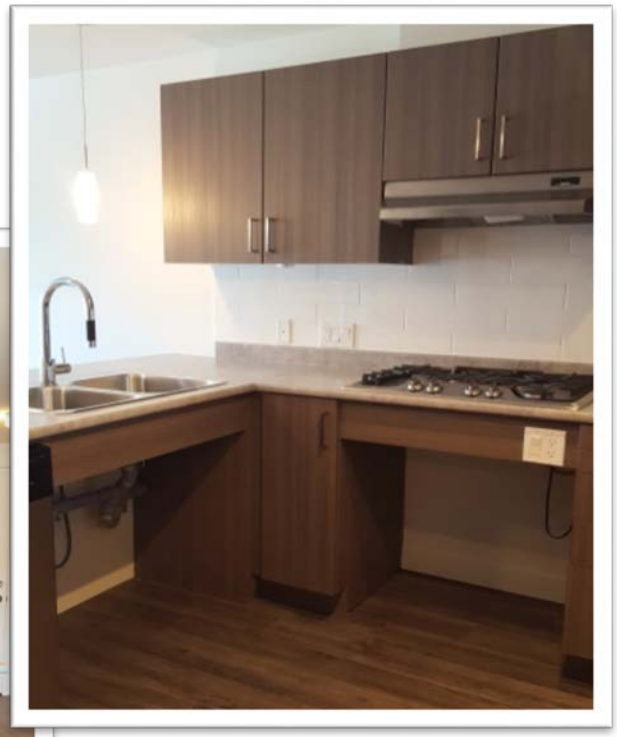
Spacious entrances, easy access and retrofitted for safety and licensing requirements

Spacious and shared eating areas, with fresh-ly cooked daily meals adhering to all dietary restrictions

Independent Suites

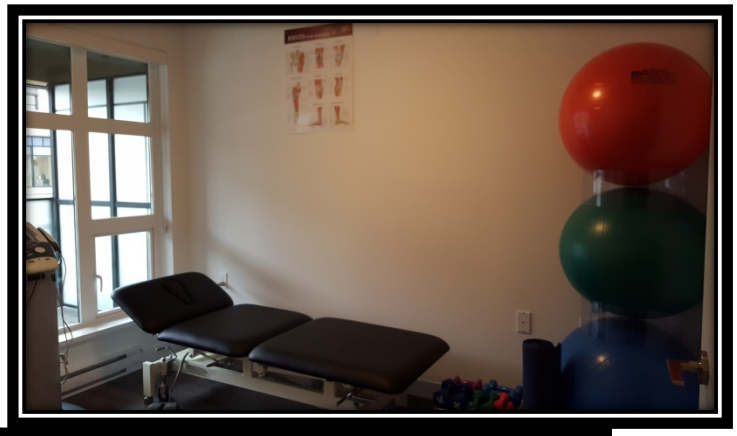
Living Room and Accessible Kitchen





Independent Suites

Fully Equipped Exercise and Treatment Area

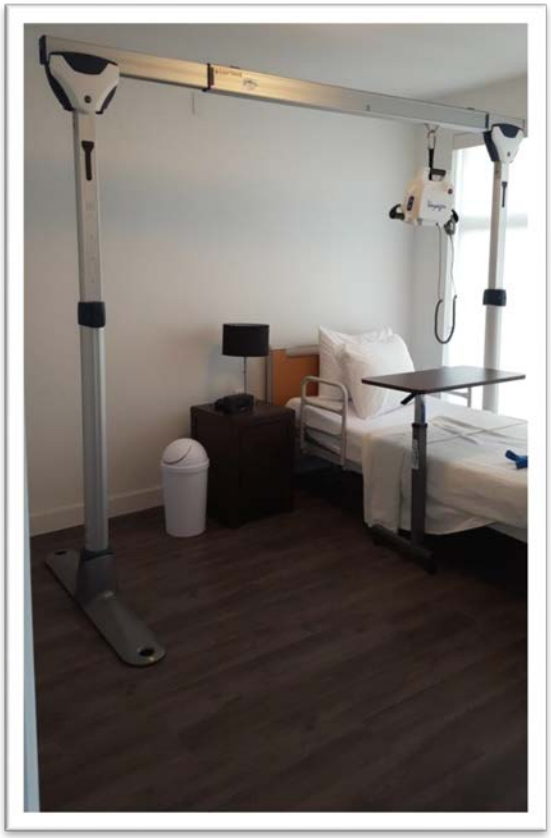


Independent Suites

Accessible Wheel in Shower

Independent Suites

Patient Lift



Thank You