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POSTER ABSTRACT

Cluster Care: An Integrated, Community-Based Model Addressing Social Determinants to Improve Population Health and Reduce Hospital Utilization

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Efforts to improve population health often fall short by failing to address the social determinants of health including housing insecurity, social isolation, income inequality, and access to culturally appropriate care. Seniors with cognitive impairment and responsive behaviours are particularly vulnerable, frequently experiencing long hospital stays and limited access to secure Long-Term Care (LTC) placements. These systemic gaps highlight the urgent need for radical, system-wide transformation that shifts care out of institutions and into the community, built on the needs and strengths of people and local partners.

In response, WoodGreen Community Services, in collaboration with Michael Garron Hospital, developed and implemented a Community Memory Care Cluster an evidence informed, integrated care model providing 24/7 onsite Personal Support Worker (PSW) support in shared, home-like environments for seniors who can no longer live independently. This model fills a critical gap between assisted living and LTC, particularly for individuals with complex medical and behavioural needs.

Method: ology & Rationale: Cluster Care was designed using a needs based, population health framework, grounded in:
•Regional health utilization data identifying high numbers of Alternate Level of Care (ALC) patients awaiting LTC placement
•MAPLe (Method for Assigning Priority Levels) assessments to identify seniors with moderate to very high needs (scores 3–5)
•A co-design approach with community members, caregivers, and frontline staff to ensure cultural and contextual relevance
•Integration with WoodGreen's wraparound services, including case management, mental health supports, housing stability programs, adult day programming, and system navigation

Key Results from Six Toronto Cluster Care Sites:
•83% of clients permanently diverted from LTC, reducing demand and systemic cost
•86% of residents had MAPLe scores of 3–5, demonstrating capacity to manage high-needs individuals in community settings

•25% per bed cost compared to acute hospital settings
•17,420 resident days delivered annually across 52 units
•Improved social connection, mental well-being, and continuity of care through integrated day programming and holistic supports

In March 2024, a focused pilot with 10 patients from Michael Garron Hospital experiencing extended hospital stays due to a lack of suitable LTC options demonstrated successful transitions into Cluster Care. Clients experienced improved behavioural outcomes and quality of life, while also creating hospital capacity.
Cluster Care's success offers valuable, transferable insights for urban and rural settings seeking scalable, cost-effective alternatives to hospital ALC and LTC. Key components include:
•A modular, replicable model adaptable to various housing (Freehold, buildings) and community partnerships
•Integrated health and social care delivery, led by trusted community agencies
•A focus on equity and cultural safety, supporting diverse and underserved populations
•Strong cross-sector collaboration between hospitals, primary care, and community organizations

Conclusion: Cluster Care exemplifies how addressing social determinants through integrated, community-based care can:
•Improve population health outcomes
•Reduce health inequities
•Support timely hospital discharge and LTC diversion
•Promote aging in place with dignity
As health systems globally seek to shift resources toward upstream, preventative care, Cluster Care provides a proven, adaptable framework for integrated care and community-based aging support.