Comprehensive Community Care (C3) Criteria

Inclusion Criteria - potential referrals need to meet a majority of the following criteria:

- Age 60 and older – exceptions made on an individual basis.
- Client has a history of increased utilization of the health care system for their complex, chronic medical conditions. This is evident through physician/specialist visits in the community and/or number of recent Emergency Department visits and/or Acute Care admissions (typically 3 or more over the past 18 months).
- Moderate to high risk of not managing to remain in the community as indicated through the Resident Assessment Instrument (RAI)
- MAPLe score of 4 or 5
- Require assistance with managing ADLs (typically at least 2)
- Require assistance with multiple IADLs (typically 3 or more)
- Multiple co-morbidities (typically 3 or more)
- Multiple high risk medications
- Candidates who are functionally frail as evidenced by CHESS score, physically disabled or cognitively impaired are appropriate if alternate, less comprehensive services do not meet candidate's needs.
- Candidate can be safely cared for at home within the resources the C3 program can provide. Services are based on assessed individual need.
- The candidate and their support network are committed to the candidate staying at home and are willing to accept coordinated care services in partnership with the C3 program.
- Will attend the day program on a regular basis and have the ability to access and use the available transportation from the C3 program.
- Caregiver requires the supportive services of the program to continue in their care giving role.
- Lives within the catchment area of the program.
- Potential length of stay in the program is no less than three months.

Exclusion Criteria:

- Mental illness or cognitive impairment with behaviors that place the client, other clients, or staff at risk or negatively impact the programming for other participants.
- Requires the use of a mechanical lift
- Already receiving funded care through residing in a Supportive Living or Long Term Care facility
- Candidate's health issues prevent participation in the program.

Discharge Criteria:

- Medical and functional improvement such that they no longer require the level of support provided through the C3 program.
- Medical and/or functional decline to a point that their needs can no longer be supported through the C3 program model. Client has unscheduled care needs.
- Client requires discharge to palliative care services as they have become homebound.
- Client is not participating in the program fully and not benefitting from the level of support provided.

To have a referral made to the program:

- If you are a home care client please discuss with your home care case manager
- If you are not a home care client – call 403-943-1920 to arrange for a home care assessment.

For general information call the program Client Service Manager at 403-686-8110 (Sarcee site) or 403-520-3356 (Beddington site).