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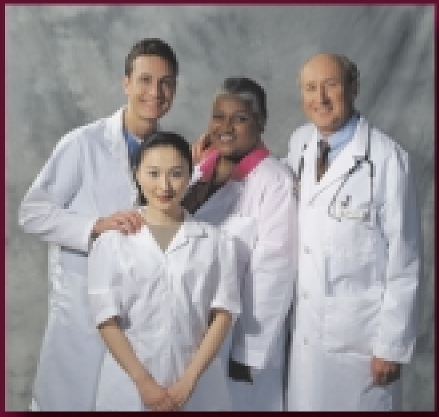

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SYNTHESIS SERIES

Home Care

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This report is one in a series of 10 syntheses of HTF project results covering the following topics: home care, pharmaceutical issues, primary health care, integrated service delivery, Aboriginal health, seniors' health, rural health/telehealth, mental health, and children's health. The tenth document is an overall analysis. All are available electronically on the HTF website (**www.hc-sc.gc.ca/htf-fass**), which also contains information on individual HTF projects.

Executive Summary

The Health Transition Fund (HTF), a joint effort between federal, provincial, and territorial governments, was created out of the 1997 federal budget to encourage and support evidence-based decision making in health care reform. Between 1997 and 2001, the HTF funded approximately 140 different pilot projects and/or evaluation studies across Canada. In order to communicate research evidence from the projects to decision-makers, experts were employed to synthesize the key process and outcome learnings in each of nine theme or focus areas: home care, pharmacare, primary care/primary health care, integrated service delivery, children's health, Aboriginal health, seniors' health, rural health/telehealth, and mental health. This document summarizes the key learnings from 45 projects in the home care theme area. It has been prepared by Evelyn Shapiro, Professor/Senior Scholar, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

Home Care in Canada

Public expenditures for home care services have more than doubled over the last decade. As many as one million Canadians use home care each year, and those numbers are expected to rise in the next two decades. This growth in both numbers and costs has raised concerns about whether it is occurring by default or by design, and whether access to and use of home care should depend on where Canadians live rather than on what they need. It is in this context that the lack of universality in home care services across Canada is increasingly leading to a call for a national home care approach with a single-entry access system.

At the same time, the trend of downsizing the hospital system is increasing the burden on home care programs and is pressuring the home care sector to transform itself from a continuum of care program to one that is subservient to the priorities of the acute care sector. This trend raises the question as to whether the cost of this shift makes sense.

The 45 Health Transition Fund (HTF) studies that fall under the home care rubric demonstrate the home care program's interest in improving services and addressing the pressure points on the system. The projects may be clustered into several major themes:

- making home care services more consistent across Canada;
- providing evidence as to whether home care is a substitute for long-term and acute care services or is in fact an add-on cost;
- exploring how home care might move beyond the traditional model of care targeting the elderly and disabled populations to include currently unserved or underserved subpopulations;
- examining how provincial policies and systemic issues might be impeding the best and most appropriate use of home care; and
- providing services outside the hospital setting.

One key to addressing research questions regarding some of these issues lies in improving the adequacy as well as the reliability of home care information systems. Many of the HTF projects relied on quantitative data but could not start without first gathering baseline data, thus impeding their ability to meet their projected deadlines. The development of a national database is progressing, but its eventual success will depend on the recognition that good provincial data are essential and that provincial policy differences will continue to create problems for the database's capacity to interpret the data.

Significant findings of the projects include a key national study involving 15 interrelated substudies, which found that in British Columbia, where data was available, home care for the elderly is a cost-effective alternative to various levels of care in long-term care facilities. The implications of the projects' findings for organization, management, legislation, service delivery, and resource allocation in regard to home care are fundamental.

Home care projects seeking means to reach underserved populations met with a degree of success in determining how First Nations and Inuit communities could implement their own home care programs, in addressing the unmet needs of the mentally ill, and in improving services to those with dementia, half of whom live at home.

A key finding resulting from studies that attempted to reduce the use of hospital emergency rooms and in-patient beds is that comparatively few studies achieved that goal. Indeed, there are serious implications for home care services that seek to substitute hospital services, and these approaches must continue to be thoroughly pilot-tested. As well, the increasing preoccupation with hospital substitution, as demonstrated by several HTF studies examining how to provide in-home neonatal services, diabetic education, and telehealth services, should raise serious concerns that home care is being led into acting as a substitute for public health services.

Scant attention has been paid to how home support services are organized and delivered. A recurrent theme in the HTF home care reports is dissatisfaction among both case managers and clients with home care policies in jurisdictions that purchase these services from external non-profit or for-profit agencies. And as home care service delivery faces new challenges in meeting the needs of a wider variety of clients, issues of human resource training, management, and wages are becoming of crucial importance.

Together, the HTF projects helped encourage innovations in the home care sector. The HTF's major contribution was in insisting on an evaluation of their effectiveness. The following recommendations arise directly from the project reports or address gaps and priorities that arise from an overview of all the projects.

To Senior Federal and/or Provincial Policy-Makers

- It is time for both levels of government to implement a national home care program that treats all Canadians equally and equitably. The absence of a federal– provincial agreement on a national home care program means that where Canadians live, rather than what they need, determines access to services, residency requirements, the payment of user fees, and the continuity of service providers. Furthermore, since user fees for support services create perverse incentives to use a more costly alternative, serious consideration must be given to basing access to a universal national home care program solely on a professionally assessed need for both health and support services.
- The current separation between case managers and service providers must be addressed. In situations where the public case management function of home care services is coupled with the private service delivery function, the efficiency, cost-effectiveness, and quality of care are hampered.
- Home care programs should not be pressed to assume the responsibility of filling gaps in public health services. Provincial policy-makers should review legislation to clarify both their own role and that of their regions as to which level is responsible for ensuring that gaps in resources are addressed by the most appropriate health care sector.
- If policy-makers decide to reorganize primary care, they would be well advised to start by thoroughly evaluating the results of this change before considering any change in the status or mandate of home care. Home care is a front-line but not a primary health service, and it is a unique blend of health and non-medical support services.
- The need for a Canada-wide data system must be addressed in order for provinces to compare their resources to those of other provinces and to research the relationship of home care use with the use of other health care services.

- Senior policy-makers must address the issue of home care standards and of who should be responsible for monitoring them. They must also address current and future human resource issues affecting the organization and delivery of home care programs.

To Regional and Home Care Managers

- Ways must be found to eliminate or reduce barriers that impede home care's vital links with hospitals and long-term care facilities.
- Regional managers must assume a leadership role in collaborating with hospital and home care managers to address the structural and systemic issues impeding the best use of resources.
- Both regional and home care managers must be careful to identify the potential "losers" if a decision is made to incorporate an innovation into their regular programs within their current budgets.

The HTF projects synthesized in this document have added to our understanding of the issues facing home care in Canada. They make the case that home care's role in the health care system must be acknowledged and strengthened.

Preface

In recent years, Canada's health care system has been closely scrutinized with a view to quality improvement and cost-effectiveness. Fiscal pressures and changing demographics are resulting in initiatives to explore how the efficiency of the health care system can be increased while ensuring that high-quality services are affordable and accessible. Within this context, there has been a need for more research-based evidence about which approaches and models of health care have been working and which have not. New models of care need to be piloted and evaluated before being applied to the health care system. In response to this requirement for evidence, and on the recommendation of the National Forum on Health, the Health Transition Fund (HTF) was created out of the 1997 federal budget to encourage and support evidence-based decision making in health care reform.

A joint effort between federal, provincial and territorial governments, the HTF funded 141 pilot projects and/or evaluation studies across Canada between 1997 and 2001, for a total cost of $150 million. Of that, $120 million supported provincial and territorial projects and the remaining $30 million funded national-level initiatives. The HTF targeted initiatives in four priority areas: home care, pharmaceutical issues, primary health care, and integrated service delivery. Various other focus areas emerged under the umbrella of the original four themes, including Aboriginal health, rural health/telehealth, seniors' health, mental health, and children's health.

The HTF projects were completed by the spring of 2001. In order to communicate the evidence generated by the projects to decision-makers, experts were employed to synthesize the key process and outcome learnings in each theme area. This document summarizes the key learnings in the home care theme area. It has been prepared by Evelyn Shapiro, Professor/Senior Scholar, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

Unique Nature of the HTF Projects

The HTF was quite different from other organizations that fund health-related research in this country, such as the Canadian Institutes for Health Research and its predecessor the Medical Research Council.

- It was a time-limited fund, which meant that projects had to be conceived, funded, implemented, and evaluated all in four years – a very short time in the context of system reform.
- It was policy-driven; policy-makers were involved in the project selection process, and wanted to focus on some of the outstanding issues in the four theme areas in the hope that results would provide evidence or guidance about future policy and program directions.

In order to encourage projects to address issues and produce results that would be relevant to decision-makers, the HTF developed an evaluation framework consisting of six elements (access, quality, integration, health outcomes, cost-effectiveness, and transferability). Each project was required to have an evaluation plan addressing as many of these elements as were relevant. In addition, all HTF projects were required to include a dissemination plan (for which funding was provided) in order to ensure that results were effectively communicated to those best able to make use of them. In addition to these individual dissemination plans, the HTF Secretariat is implementing a national dissemination strategy, of which these synthesis documents are one element. This emphasis on evaluation (systematic learning from the experience of the pilot initiatives) and dissemination (active sharing of results) was unique on this scale.

Most national projects were selected by an intergovernmental committee following an open call for proposals, while provincial/territorial initiatives were brought forward by each individual jurisdiction for bilateral approval with the federal government. At both levels, applications came not just from academics in universities, or researchers in hospital settings, but also from non-traditional groups such as Aboriginal organizations, community groups, and isolated health regions. Groups that had rarely, if ever, thought in terms of research, evidence, evaluation, and dissemination began doing so, and these developments bode well for improved understanding and collaboration among governments, provider organizations, and researchers. The role of federal, provincial, and territorial governments in the selection process ensured that the projects delved into the issues that were of high concern in each jurisdiction. By the same token, there was considerable scope in the range of project topics, and the body of projects was not (and was never intended to be) a definitive examination of each theme.

This unique focus and selection process imparts specific features to the HTF body of projects. The projects that were funded represent good ideas that were put forward; they do not represent a comprehensive picture of all the issues and potential solutions in each of the theme areas. The relatively short time frame meant that many researchers struggled to complete their work on time and the results are preliminary or incomplete; some pilot projects might take a number of years to truly show whether they made a difference. This must be left to others to carry forward and further investigate. Perhaps the greatest value in the large body of HTF projects comes from the lessons we can learn about change management from the researchers' struggles and challenges as they undertook to implement and evaluate new approaches to longstanding health care issues.

Acknowledgements

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Appendix A: List of HTF Projects Relevant to Home Care

1. Introduction

The Health Transition Fund (HTF) was launched by Health Canada to test and evaluate new, better, and more cost-effective ways of delivering health care services to Canadians. Its support encouraged researchers and health care managers to implement innovations in the organization, integration, management, and delivery of health care and to evaluate their outcomes. It is a measure of how far home care has entered the mainstream as an established health care sector in Canada that the response both from researchers and from home care program managers and staff was enthusiastic. The resulting studies covered a wide range of innovations, from initiatives that tested ways of expanding home care's reach to previously unserved or underserved subpopulations to those that assessed the effects of a change in the organization or delivery of existing home care services that was designed to improve their efficiency, efficacy, or cost-effectiveness.

Section 2 of this synthesis provides the context for the studies. Section 3 provides an overview of the HTF studies and groups them by topic area. Section 4 identifies the major trends and recurrent themes in all the studies and discusses their implications. Section 5 addresses the public/private split in the management and delivery of home care services, an issue that has major implications for the continuity of care provision, for client satisfaction, and for decisions to choose home care over a long-term care facility. Section 6 highlights issues that merit special attention from top decision-makers and managers.

All but a few of the HTF studies are considered in this synthesis. These few were excluded either because they were mainly of local interest or because their analyses were too incomplete to be useful to decision-makers. Appendix A lists all the home care studies that were reviewed for the preparation of this synthesis.

2. Context

Home care is a growing sector in Canadian society. Its growth is driven by population aging, attempts to reduce health care costs, and increased public input into where and how health care is delivered. As many as a million Canadians use home care services each year, and those numbers are expected to rise in the next two decades. As health care costs escalate, home care is increasingly being viewed as the low-cost alternative to traditional models of institutional care. However, formal home care expenditures have more than doubled in the last decade and now constitute four per cent of total public health care costs. The observation has been made that home care growth in Canada is taking place "by default and not by design" (Anderson & Parent, 2001).

2.1 What Is Home Care?

There is no precise or universally accepted definition of home care. Generally, home care policies serve people with physical or mental impairment who return home from hospital or who reside in the community and who have been professionally assessed as requiring formal resources to meet their health and social support requirements. Increasingly, home care is called upon to meet the needs of the acutely ill who require intensive and sophisticated services and equipment and to address needs specifically associated with a medical diagnosis or impending death or to compensate for functional deficits in the activities of daily living. There are generally no age limits on home care use, although use tends to increase with age.

Home care has three main functions: to substitute for other more costly services such as hospitals; to substitute for care in long-term facilities; and to provide a maintenance and preventive function that allows clients to remain in the home environment rather than moving to a new and often more costly venue. There are two main streams of home care: professional services, including nursing, social workers, and therapists; and home support services. A wide range of additional programs and services may also be provided, including adult day programs (i.e., geriatric day hospitals), meal programs, home maintenance, respite, medical equipment and supplies, and counselling.

Referrals to home care can come from any source – hospitals, physicians, other community agencies, family members, or potential recipients. Home care is centred on assessing the client, the family, and the home environment. It coordinates the delivery of the health and social support services required by clients living in the community and ensures the provision of a continuum of care to vulnerable clients in accordance with their changing needs. Because of its intimate connections with other health care sectors and its continuum of care perspective, home care is, by definition and by function, an important health care service in its own right, with its own mandate, its own organizational structure, its own workforce, and its own established links with the other health care sectors.

Home care is considered an aspect of "continuing care," which is not a type of service such as hospital care or physician services but a complex system of service delivery. This system evolved as a hybrid of health and social services, with in-built tensions regarding resource allocation between well-organized institutional services and more fragmented community care services. Continuing care, although an evolving concept, remains somewhat vague in meaning; it now generally describes a system of service delivery that includes all of the services provided by long-term care, home support, and home care.

The manner in which health care is funded has influenced the way in which home care has come to be structured across the country. The Canada Health Act sets out two major categories of service: Insured Health Services (IHS), which includes hospital care and physician care; and Extended Health Care Services, including nursing homes, long-term residential care, and home care. Extended Health Care Services are not insured services. As well, the five principles governing the Canadian health care system as outlined under the Canada Health Act (universality, accessibility, comprehensiveness, portability, and public administration) and the restrictions on user fees and extra-billing apply only to IHS. Other continuing care services such as homemakers and adult day care are not covered by the Canada Health Act. They were cost-shared through the Canada Assistance Plan (CAP) and now come under the Canada Health and Social Transfer (CHST). At a social policy level, the non-insured nature of continuing care means there are ongoing discussions and shifts in policy about matters such as user fees and the portability of services. Under these conditions, Canada's provinces and territories have developed different models of how to provide continuing care services.

2.2 Current Issues Facing Home Care

2.2.1 Provincial Policies

Although most home care programs in Canada have similar mandates and common organizational features, differences in home care policies among the provinces are substantial enough to make where Canadians live, rather than what they need, the basis for determining whether they are served, what kind of services they receive, and the conditions under which these services are provided. The following brief examination of each of these policies highlights how far Canadians are from having fair and equitable access to home care services:

- All provinces require professional assessments of individuals and their family circumstances to determine whether, what type of, and how much formal service is required. However, some provinces restrict eligibility to those who have lived in their jurisdiction for a specific length of time, denying access for a designated time to needy Canadians who move from one province to another.

- All provinces delegate the responsibility for assessing clients' needs to public sector case managers. However, there is considerable variation in provincial policies regarding who delivers home care services. In some provinces, all direct service providers work for the home care program alongside case managers. In other provinces, home support services are purchased from private, non-profit, or for-profit sources, whereas in still other cases, all direct services may be purchased exclusively from the private sector. These variations have important implications for home care program's control over worker performance, continuity of care, and informal communication between case managers and service providers.
- Major anomalies exist across Canada with regard to user fees. All the provinces provide medical services without charge, but charges for support services may be subject to a sliding scale of user charges based on financial needs criteria. Most but not all charges have caps on the total cost to users. These differences can affect whether or how individuals use a program's support services and can produce perverse disincentives to use the most appropriate services or the most appropriate locus of care. More importantly, they result in making what Canadians are prepared to pay, rather than what they need, the basis on which they receive home care services.
- Most provinces impose limits on the services that can be provided to any one individual, but they use different approaches. Some limit the number of hours permitted per service; others impose per person cost limits; still others limit the cost per individual to the cost of providing the needed care in an alternative setting. The problem is that, while the rationale for the two latter-mentioned limits is obvious, it is less so for the first type of limit, although this certainly affects service to consumers and the capacity of home care to fulfill its mandate.
- All provinces provide the drugs required for treatment in hospital free of charge. However, most do not provide similar access to drugs for post-hospital care at home, even though a number of provinces have increased the elders' co-payment for drug coverage, placing a greater burden on those requiring medications.
- Although all provinces regularly gather information on home care, their data systems vary both in the data they choose to gather and in their level of sophistication. Several of the provincial information systems are being revised to include more information on the health and social circumstances of caregivers and to make it possible to link the assessment data with service level use and with expenditures for more effective planning. However, provincial policy differences impose serious barriers to implementing a national data system and to carrying out national studies on home care. They also make it impossible to do credible inter-provincial comparisons. Furthermore, policy differences make it difficult if not impossible for researchers whose studies are based on data from one jurisdiction to produce findings that are transferable to other jurisdictions.

These points illustrate the lack of universality of home care in Canada regarding cost, accessibility, eligibility, and quality – all issues that are increasingly leading to a call for a national approach to home care and a single entry system that is the same across Canada. At the same time, key concerns about a national approach have also been raised, including the concern that the acute care model would be emphasized at the expense of maintenance and long-term care at home.

2.2.2 Regionalization

Responsibility for policy-making and resource allocation has shifted from being exclusively that of provincial governments to one in which some of these responsibilities have been delegated to regional authorities. Differences and the lack of clarity in the provinces' legislation setting up regional authorities have left some important gaps in defining jurisdictional responsibilities. (See the recent *Caring for Medicare* report to the Government of Saskatchewan by Fyke, 2001 for one example of this problem.) Regionalization has resulted in different policy and resource allocations decisions even within the same province, exacerbating issues such as equity of access, service use and the transfer of potentially useful results of local experiments to other jurisdictions.

2.2.3 Health Reform

Another change that has had a major impact on home care has been the downsizing of the hospital sector. According to research in three provinces, hospitals have responded to this downsizing by admitting the same proportion of the population they admitted earlier (Brownell et al., 2001; Lepnurm & Lepnurm, 2001; Sheps et al., 2001) but imposing reduced lengths of stay. This change has increased the pressure on home care to discharge patients who need care at home more quickly, to provide more of them with more intensive services at home if necessary, and to speed up transfers from hospital to long-term care facilities. Although the resources available to home care have increased during this time, they have been insufficient to deal with the effects of these changes, and case managers have become increasingly concerned with the speed with which they are often expected to decide whether a patient requires long-term facility placement.

2.2.4 Resource Allocation

While home care has been trying to cope with this increase in post–acute care clients at a time of budget constraints, it has also been attempting to accommodate the increasing number of clients requiring long-term care at home. This increase is a result of the growth in the number of older elders, their increased survival time, and the reduction in the ratio of long-term care beds to the number of persons aged 75 years and older. The result is that home care programs in some jurisdictions have instituted waiting lists for the functionally disabled or have discharged clients who need minimal maintenance services, or both, despite the negative impact of the latter action for future health care costs (Hollander, 2001). In addition, some jurisdictions have had to choose between adding more case managers to handle the increasing number of home care referrals or providing more service delivery resources when, in fact, both are essential.

Perhaps the most serious result of this increase in post-acute care is the pressure for home care to transform itself from a program that is primarily intent on providing a continuum of care to vulnerable clients while maintaining or enhancing their functional independence at home to one that is subservient to the priorities of the acute care sector. If home care is to achieve both goals in line with its mandate, the allocation of resources cannot be maintained at its current level.

2.2.5 Public Health and Housing

The state of public health programs and seniors' housing, which can reduce the need for home care, has important implications for home care programs. However, public health, with severely constrained or reduced resources, has set priorities that limit or virtually eliminate its involvement with elders, the main consumers of home care. Public policies and resource allocation decisions need to favour the involvement of public health in the prevention and management of conditions (e.g., preventing falls among the elderly) that produce functional disabilities.

The now-defunct National Housing Act encouraged federal, provincial, and municipal partnerships and non-profit sponsors to build housing for elderly and low-income persons, allowing the inclusion of space for congregate meals and social interaction. The result of its demise is that new housing of this kind has all but disappeared. Although private investors have built apartments with space and amenities, these units are generally too costly for those who need it most. Serious consideration needs to be given to resolving the current problem in order to support independent living arrangements as well as the delivery of cost-effective home care services when necessary.

2.2.6 Conclusion

Home care is a complex, active, and growing health care sector that serves vulnerable, functionally disabled persons, the majority of whom are elderly, and that also serves the needs of other health care sectors such as hospitals. There is clearly a paradigm shift as public support for community-based services and increased formal home care grows. But major issues must be addressed. Can home care services be made more equitable and accessible across the country? Is home care a cost-effective alternative to institutional care, and if so, under what conditions? Does the trend toward more home care merely shift costs to informal caregivers (i.e., family members)? Do people do as well at home as they do in other care settings? Can some services be provided at home over and above those now offered? How is pressure from the acute care sector affecting home care? Can home care be expanded beyond serving the elderly to accommodate the needs of non-traditional groups such as the mentally ill, Aboriginal communities, and difficult-to-reach populations? These are some of the questions that the projects developed under the Health Transition Fund have begun to address.

3. Overview of the Health Transition Fund Studies

The project reports submitted to the Health Transition Fund demonstrate the home care program’s interest in improving its assessment tools, collaborating with other health care sectors, expanding services to previously underserved populations, and promoting and evaluating innovations that hold promise for achieving both more targeted and more cost-effective services, as well as better health outcomes. Accordingly, these categories will be examined in this section.

In total, 45 studies fell under the home care rubric. They covered a wide range of issues, from the “hospital-at-home” idea tested in *Home Chemotherapy for Children with Cancer* (NA132) to an idea for reorganizing services to take advantage of the clustering of elderly adults in housing complexes (BC122). There were no fewer than 12 national studies, including one major research project (NA101), comprised of 15 substudies, which examined the cost-effectiveness of home care – a ground-breaking move in the Canadian context, where little research has been done to date to address such key questions.

The home care projects are clustered into several major topic areas, to be examined in the “Discussions of the Findings and Lessons Learned” section, which follows. “Improving Assessment Tools and Data Systems” addresses the underlying theme of how to make home care services more consistent across Canada and more consistent in delivery to clients. “Examining the Cost-Effectiveness of Home Care” looks at how a series of studies sought to provide evidence of whether home care is a substitute for long-term and acute care services, or an add-on cost, and to begin determining the financial role informal caregivers play in providing services. “Improving

Services to Underserved Populations" involves projects that sought to explore how home care could move beyond the traditional model of care for elderly and disabled populations to reach Aboriginal communities, mental health patients, dementia patients, and palliative care patients. Projects that looked at obstacles impeding the best and most appropriate use of home care, encountered as a result of provincial policies and systemic issues, are discussed in "Barriers to the Appropriate Use of Home Care." The discussion in "Substituting Hospital Service with Home Care" involves a series of studies seeking ways to provide services outside the hospital setting and of reducing acute care use. "Resistance to Change" raises the issue of professional attitudes to innovations and changes in traditional roles. Finally, a major clustering of projects looked at means of "Evaluating, Improving, and Reorganizing Existing Home Care Programs." These studies attempted to provide a foundation of evidence regarding those who are served by home care and to test ideas about how existing services might be improved.

Since the HTF initiative was relatively unique in Canada in its funding structure, its time limitations, and its involvement of non-traditional groups in research, there was some variability in the methodological quality of the studies, and some demonstration and evaluation projects were challenged not only with developing initiatives and evaluating them but also with meeting relatively tight time frames. Nevertheless, many reports have led to significant insights worthy of discussion.

A complete list of the HTF studies appears in Appendix A.

4. Discussion of the Findings and Lessons Learned

4.1 Improving Assessment Tools and Coordinating Data Systems

There is a discernible trend in Canada toward the use of the two most essential components in ensuring equitable and appropriate service delivery decisions: uniform, standardized home care assessment tools and case management practices. This trend heralds a major advance and, given the findings in two key projects, merits further review in Canadian jurisdictions that have not yet thoroughly implemented these tools into their service decision-making process.

A Manitoba project (MB121) tested and compared a locally designed assessment tool with the internationally designed InterRAI tool and recommended adoption of the latter with, however, the integration of several items from the former tool. InterRAI is a non-profit, international consortium of some 40 researchers and clinicians who conduct multinational collaborative research to develop, implement, and evaluate Residential Assessment Instruments (RAI). InterRAI has been tested and demonstrated to be reliable, and this project found that the InterRAI MDS-HC tool was the best tool for home care in Manitoba. If more standardization of tools occurred in Canada, it would be much easier to do research and make comparisons across the provinces about home care needs and services.

It is important to note, however, that regional resource and policy differences will play a role in undermining a systematically uniform approach, even with the use of standardized screening instruments. Project NA101-08 used a standardized screening instrument and asked 60 case managers from seven provinces to use a series of hypothetical vignettes to decide which services would be provided to a specific individual under varying circumstances. A key learning from this study is that contextual issues must be taken into consideration.

A fundamental component of home care in the assessment for services is the informal caregivers, who generally provide most of the care. Therefore, including data on their health, social circumstances, and concerns is critical to maintaining their continued involvement. One project (NA145) sought to increase the visibility of and sensitivity to the needs of these caregivers by incorporating their needs in screening and assessment tools. This approach was tested in seven sites in Quebec and Nova Scotia; the two tools were found reliable, helping to increase home care assessors' responsiveness and awareness of what it means to be a caregiver and to identify caregivers who were "at risk." However, heavy caseloads were thought to be an obstacle to incorporating a lengthy caregiver assessment form into their work routines. Nevertheless, the short screening tool could be useful for training and staff development purposes.

There are also moves toward developing a comprehensive national data system that would provide Canada-wide information and permit regional comparisons of home care clients, programs, outcomes, and expenditures. The *Evaluation of Information Standards for Home Care* project (NA128) reports on the RAI series of instruments. This holds promise in helping decision-makers to compare client characteristics and service utilization across reference groups, track health indicators to devise population health strategies, and perhaps eventually implement an integrated information system. Likewise, the project made significant improvements in its data gathering and analysis capability but noted that further work is essential before it will be able to make valid interprovincial comparisons. However, in order for the information to make sense, improvements in the usefulness of a national data system must ensure that the data gathered reflects the policy context in which each jurisdiction functions.

Home care information systems are essential to every level of decision-making. Data on service delivery provide information on the amount and type of service use and their costs, facilitate planning, ensure quality and efficiency, and help ensure cost-effectiveness. Although only four projects dealt with home care data systems as a whole, the fact that projects that relied on quantitative home care data often had to start by gathering baseline data attests to the need for valid and reliable home care information systems.

4.2 Examining the Cost-Effectiveness of Home Care

A fundamental research question is whether, for government funders, home care for the elderly is a cost-effective alternative to various levels of care in facilities. The intuitive belief has been that treating the client at home would be the more cost-effective route, but numerous studies in the United States have concluded home care was an additional cost, not a saving, to governments.

The *National Evaluation of the Cost-effectiveness of Home Care* (NA101) and its 15 interrelated substudies set out to directly evaluate the extent to which home care is cost-effective. Six of the substudies focused on home care as a substitute for residential long term care, and nine substudies compared costs with acute care. The implications of the project's findings for the organization, management, legislation, service delivery, resource allocation, and data systems in regard to home care are fundamental.

Substudy 1, *Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services*, set out to determine the relative costs to government of home/community-based services versus residential long-term care services, by level of care, in British Columbia. This is one of the first systematic evaluations of the cost-effectiveness of home care versus residential care. Using a unique linked database, researchers found that home care is generally cheaper, at all levels of care, than is care in residential facilities. This key study highlights several significant findings:

- On average, the overall costs to the province for home care clients are about one half to three quarters of the costs of facility care.
- The costs differ by type of client – the lowest home care costs are for individuals whose type and level of care was stable over time.
- For persons who die, home care costs are higher than residential care costs.
- About one half of the health care costs for home care clients, especially when their type and level of care needs change, results from their use of hospitals.
- About 30 to 60 per cent of costs for home care clients is for hospital care, whereas traditional services, such as home care nurses and home support workers, account for about one third to one half of overall home care costs.

The study also found that, overall, home care costs less than residential care and provides at least an equivalent quality of care. Proportionally, savings are greater at the lower levels of care. However, the study suggests that residential care may be better in keeping clients stable and out of hospital.

Another key question is whether the savings being made in home care costs result from shifting the costs to families. Two substudies attempted to answer that question, although obtaining written information from already stressed family caregivers proved problematic. The major findings were that formal care costs are generally lower for home care clients. Out-of-pocket costs are usually moderate, particularly when compared with facility co-payments. However, a critical issue is how to assess the dollar value of the time provided by informal care providers.

Substudy 3, *Cost Implications of Informal Supports*, found that formal and informal care are complementary, not substitutive: in general, if a client gets more of one type of care (formal or informal), he or she will also receive more of the other type of care. Thus, increasing formal care does not decrease informal care. In addition, the study concludes that an overall increase of $1 in informal care has a commensurate increase of $1.09 in formal care, while an increase of $1 in formal care has a commensurate increase in $0.30 in informal care.

Another question facing home care service providers is whether services normally provided in acute care hospital settings might be cost-effective and beneficial in the home setting. One study compared the provision of intravenous therapy for cellulitis patients at home and in hospital. The sample size proved small, and many people received treatment through repeat visits to emergency rooms because home care was not available in a timely way. However, the findings indicate that home care and emergency services cost about half as much as care in the hospital and that the quality-of-life scores in hospital were about half as good as the other two treatment approaches. As well, clients in home care and emergency had fewer complications and higher problem resolution rates.

Substudy 14, *Evaluation of the Cost-Effectiveness of the Quick Response Program of Saskatoon District*, sought to examine the costs of a community-based Quick Response Program (QRP) model in Saskatoon, which redirected clients who would otherwise be admitted to hospital from the emergency department back to their homes. That model was also found to be effective: home care costs less than a hospital stay – but it does not save total dollars unless hospital beds are closed. Similar initiatives and evaluations elsewhere had resulted in similar findings. However, substudy 12, *Cost-Effectiveness of Home versus Hospital Support of Breast Feeding in Neonates*, showed that the post-discharge costs associated with home care services provided to an experimental group of women breast-feeding their term infants at home proved to be higher than the costs associated with breast-feeding in a hospital context.

As noted above, research regarding the cost-effectiveness of home care as a substitute for acute care has generally been mixed. Substudy 9, *Costs of Acute Care and Home Care Services*, using three years of Alberta data, found that in high-volume home care cases the costs for hospital patients who used home care were higher than for those who did not. However, further study indicated that this group had more diagnoses per person (more co-morbidity) than did the comparison group, suggesting that patients discharged with home care were in fact more ill.

Finally, substudy 10, *Economic Evaluation of a Geriatric Day Hospital: Cost-Benefit Analysis Based on Functional Autonomy Changes*, which undertook an evaluation of a geriatric day hospital, found that the benefits of the service outweighed its costs (for each $1 invested, the benefit was $2.14), although the researchers caution that their estimates are based only on functional autonomy changes and that further research is necessary.

A key learning resulting from these studies shows that home care is a very difficult environment in which to conduct original research, particularly given the lack of a national database, but that it is possible to conduct a national, integrated, and strategic program of research to yield new information. Researchers found it a major challenge to mount studies to determine cost-effectiveness in Canada in an environment where efficiencies in the hospital setting are being implemented quickly and savings are generally not transferred to the home care sector. This quick adoption of efficiencies also inhibits research because changes are made before research can be conducted that compares costs and benefits before and after the implementation of a new initiative.

4.3 Improving Access to Underserved Populations

4.3.1 Introduction

While home care services have traditionally been targeted for the elderly and people with disabilities, there is increasing recognition that similar types of services might be applied to other populations. Indeed, this was a discernible trend in the HTF projects, which showed increasing efforts being directed to reorganizing the management and/or delivery of home care services in order to improve their access to the underserved and to experiment with specialized services or technological advances to improve outreach.

4.3.2 Aboriginal Communities

Three projects attempted to meet the needs of remote and scattered First Nations communities as well as urban Aboriginal residents. The *First Nations Home Care Pilot Project* (NA108) was a concerted effort by five Aboriginal communities and Health Canada to develop a home care framework and program to lay the groundwork on which other First Nations and Inuit communities can implement their own comprehensive and integrated home care programs. The result was a planning resource kit that incorporated tested tools and a list of “lessons learned.” Key learnings from the three studies indicate the need to incorporate culturally appropriate program components and an awareness, as demonstrated in the *Diabetes Community/Home Support Services for First Nations and Inuit* project (NA1012), that the type of model used in a community is less important than how well the model fits with the community’s need.

4.3.3 Mental Health

The *Home Care and People with Psychiatric Disabilities* study (NA149) conducted a national evaluation of existing home care services and found that people with a primary diagnosis of mental illness rarely receive services from home care programs and that, for those who do, the services are too often not as effective or appropriate as they should be. Another study, *Home-Based Program for Treatment of Acute Psychosis* (BC121), assessed the results of a 10-month pilot project to treat acutely ill persons at home instead of in hospital. It found that the project achieved good outcomes and modest cost savings: of those treated at home, only three of 29 clients were hospitalized or readmitted to hospital and both clients and their families were satisfied with their care. Indications are that home care for such clients can reduce dependence on hospitals, but three barriers must be addressed: changing the fee-for-services schedules for psychiatrists that currently pay them more for hospital inpatient visits than for office visits; changing the perception that the primary goal of home treatment is to save money for an underfunded health care system; and finding experienced mental health workers to provide the required specialized care at home.

4.3.4 Dementia

Since studies show that about half of those with dementia live at home, the accessibility and outcomes of home care services merit attention. The *Enhanced Case Management* project (BC124) had two objectives: to improve the home care services delivered to dementia clients and their families and to reduce their dependence on hospital resources. This required increasing the knowledge about dementia among case managers, home care workers, and caregivers, and improving the hospital discharge process by hiring a dedicated hospital-based case manager. The report's findings indicate that confidence in dealing with dementia clients increased among both formal and informal care providers. However, the self-rated health of family members did not improve and visits to hospital emergency rooms did not drop. The barriers noted to improving services include the constant change in home support workers, and the separate locations of home care case managers and home support staff, which reduced opportunities for informal information-sharing about clients that might have improved efficiency. Ways of eliminating these barriers need to be addressed and evaluated.

4.3.5 Telehealth

Some studies sought to incorporate technological tools to determine if services could be improved. In this category, the *Integrated Cardiac Home Monitoring Pilot Project* (ON121) attempted to more intensively monitor elderly persons discharged from hospital after an acute hospital episode for acute congestive heart failure with the goal of reducing hospital readmissions. It used monitoring technology to record and transmit vital signs by telephone to a central repository for review by the project's staff nurses. Results indicated that the one-month rate of hospital readmissions for both the control and the experimental group was 4 per cent; that the experimental group had more changes in medical management and higher levels of satisfaction than did their counterparts; and that the program could handle substantially more patients with the same manpower, thereby increasing efficiency. However, the primary goal of reducing hospital readmissions was not achieved, and it was too early to clearly determine cost-effectiveness.

The lack of encouraging findings to date regarding technological innovation in this area suggests that a wider adoption of these innovations is unwarranted but that further experimentation is desirable.

4.3.6 Palliative Care

Clinicians are increasingly challenged to develop new and innovative models of care to care for the dying at home and to monitor and intervene quickly to restabilize clients who begin to have problems. Two studies sought to determine the role of home care services in delivering palliative care. The *Palliative Care Services Review* in Saskatchewan (SK121) indicated that informal caregivers were satisfied with the services provided by a comprehensive palliative care program that was integrated with home care, acute care, and long-term care. Most staff and community members thought the program was reaching the target group and that it was of benefit.

The second study, *Rural Palliative Home Care Demonstration Project: A Collaborative Project Between Nova Scotia and Prince Edward Island* (NA131), was a coordinated and ambitious plan to initiate a collaborative, single-entry palliative care project in two Nova Scotia sites and in one Prince Edward Island site. This project developed a common palliative care assessment tool and assigned a case manager and an interdisciplinary service team that had received enhanced education. However, the project did not achieve its major objective of reducing dependence on hospital use: survey responses indicated that although 76 per cent of the clients wanted to die at home, only 33 per cent did die there. One barrier noted as a possible reason for the high rate of hospitalization was a lack of 24-hour access and support.

4.4 Barriers to the Appropriate Use of Home Care

The most recurrent theme in the projects' findings is the obstacles encountered as a result of provincial policies and systemic barriers that impede the best and most appropriate use of home care, particularly in substituting for hospital and long-term facility care.

Some of these provincial policies predate the implementation and subsequent expansion of home care; others are the result of the long-standing tradition of making health care policy and planning decisions in "silos," with little or inadequate attention being paid to the potential spillover effects on other sectors. Although this tradition is gradually being abandoned, there is still a lingering insensitivity to the need to change policies that hamper the achievement of best practices. *Improving the Effectiveness and Efficiency for Programs for Aged, Disabled and Chronically Ill Individuals* (NT401) points out that current funding policies promote the inappropriate use of long-term care facility beds. The project on the *Home-Based Program for Treatment of Acute Psychosis* (BC121) reports that one of the barriers to treating such persons at home is that the fee schedule for psychiatrists rewards them more for hospital in-patient visits than for office visits. Several reports note that the shortage or absence of convalescent beds too often leads to premature decisions to transfer a patient to long-term institutional care. One of these reports, *Decision-Making: Home or Long-Term Facility Care* (NA101-06), also found that differences in charging policies led people to choose institutional care rather than pay for the additional support service required for them to remain at home. The Rural Palliative Home Care Demonstration Project (NA131) noted that one of the reasons for the poor uptake of palliative home care was a policy that did not provide access to 24-hour support when necessary. The *Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care* (NA101-15) points out that current inadequate funding policies hamper effective improvements in hospital-to-home transfers; it also highlights a considerable list of systems barriers that affect the hospital-to-home transfer process.

Up to now, many, if not most, of the projects to improve the system have been initiated by home care programs that sought and received hospital approvals. One example is the placement of home care workers in hospital emergency rooms to avoid the admission of persons who could be cared for at home. Another example is the advocacy role played by home care programs in pressing for the adoption of the single-entry system that limits admissions to long-term facility beds.

In addition, there is a need to tackle issues such as the pressure by hospitals to have home care arrange for transfers to long-term care facilities when assessors are not sure that these transfers are in the patient's best interest.

4.5 Substituting Hospital Services with Home Care

One of the major trends in home care has been the move to substitute hospital services with home care. Several studies attempted to reduce the use of hospital emergency rooms and in-patient resources, but a key finding is that comparatively few achieved that goal. The *Enhanced Case Management Project* (BC124) did not reduce hospital emergency room use; the *Integrated Cardiac Home Monitoring Pilot* (ON121) (without a full complement of subjects for the experiment) found that the experimental and control groups had the same rate of hospital readmissions. The *Rural Palliative Home Care Demonstration Project* (NA131) reported that although survey responses indicated that 76 per cent of the patients preferred to die at home, only 33 per cent did so. Of all the clients, 43 per cent were admitted to hospital through the emergency rooms, and 30 per cent were admitted directly to hospital.

There were, however, three exceptions that did reach this goal. The *Home-Based Program for Treatment of Acute Psychosis* (BC121) reduced hospitalizations and hospital readmissions among those receiving home care services, although it achieved only modest savings. The *Frail Seniors Delivery Model Evaluation* (BC123) reported that their experimental clients spent more days at home than did their control group, although there was no significant difference in health outcomes. The most notable exception was the *Carelinks project* (BC421), but its success in reducing hospital use and in saving money was intimately connected to the simultaneous timing of the closure of hospital beds and the transfer of resources to this project.

Likewise, there are serious implications for home care services that seek to substitute hospital services that require many intensive and specialized home care resources, especially when this entails relinquishing some of the responsibility to provide long-term care to persons requiring services to remain at home. It is noteworthy that the *Carelinks* project, of all the hospital substitution projects in this synthesis, was premised on cost savings resulting from the transfer of hospital resources to home care.

These studies and their results (both positive and negative) have important implications for decision-makers and managers. The claim that enhancing case management, enriching service delivery, or using new technologies can reduce dependence on hospital use needs to be thoroughly pilot-tested by using good data and analytical methods before deciding whether a project needs to be dismantled, whether it needs further testing (e.g., to estimate real costs), whether it should be included in future budget plans, or whether it warrants expansion to other sites. Furthermore, in making such decisions, it should be recognized that even if hospital use declines but the hospitals' bed stock is not reduced, the costs for both hospitals and home care programs are likely to rise. Thus, such pilots are more likely to be beneficial if they involve simultaneous hospital bed closures and the transfer of resources to the home care program.

This is not to imply that reducing hospital use by vulnerable clients is not desirable even if it does not save money. Factors such as the high risk of contracting in-hospital infections, the preference of many elders to go home as soon as possible, and the satisfaction among the home care clients reported by these studies also need to be taken into account in the decision-making process.

Finally, the increasing preoccupation with hospital substitution should also raise serious concerns that home care is being led into acting as a substitute for public health services. Good examples of this type of substitution are the neonatal projects, the telehealth projects, and the project on diabetic education and follow-up in the community. Public health programs are mandated to provide post-hospital care for neonates as well as primary and secondary preventive services to all segments of the community. Provincial policy-makers, therefore, must ensure that public health is fulfilling these responsibilities instead of looking to home care to fill this gap.

In sum, concern is warranted about the increasing pressure exerted by hospitals to speed up hospital-to-home transfers. This trend ignores the question as to whether home care should assume the role of a hospital-at-home program at the expense of its mandate as a continuum-of-care program, and if so, the question as to whether the cost of this shift in focus from care to cure makes sense.

4.6 Resistance to Change

A number of studies demonstrate that change is likely to engender resistance from those who are directly or even indirectly affected by it. The implementation of a formal, standardized assessment form encountered resistance from home care staff in, for example, the *First Nations and Inuit Home Care* (NA108) *and Improving the Effectiveness and Efficiency for Programs for Aged, Disabled and Infirm* (NT401) projects because it changed previous service decision-making processes and practices. Changes in professional responsibilities and the lack of authority among the service coordinators to direct other professional providers of service in the Impact of the Single-Window Approach in the CLSCs project (QC101) were a source of dissatisfaction among the agencies' professionals. The split in the responses by physicians to the Carelinks project survey, indicating that as many physicians approved as disapproved of the change, suggests that the simultaneous closure of hospital beds to provide the resources for Carelinks may have influenced their responses. Finally, even though clients were generally satisfied with the results of the flexible services provided by cluster care, some clients preferred the past practice of getting their own block of service time on a specific day.

The *Analysis of Blockage to the Effective Transfer of Clients from Acute Care* to Home Care project (NA101-15) used interviews and focus groups with hospital and home care administrators and practitioners in seven sites to identify structural and systems barriers that impeded effective hospital-to-home transfers and the achievement of best practices. It found that barriers to working together related to differences in definitions of roles and responsibilities, and it also noted significant family, caregiver, and patient barriers related to resistance to change.

Such resistance will not surprise policy-makers, managers, and service providers. They usually hear about it directly or indirectly and hope that both providers and users of service will adapt to the change over time, especially if that change is considered to have achieved its goals. However, the resistance to innovation highlights the need for managers to identify its likely sources in advance and to develop strategies to encourage "buy-ins" that minimize it.

4.7 Improving, Evaluating, and Reorganizing Existing Home Care Programs

Innovative shifts in structuring home care services have shown how significant results in patient satisfaction, cost savings, and service provision may result from rethinking traditional approaches. Similarly, evaluating existing programs to determine why a service may or may not be working can yield important insights.

For instance, it was found that seniors' housing may play an important role in affording older elders an environment that, in addition to addressing housing needs, also provides both a social milieu for interaction and an informal support network. The *Exploratory Study of the Impact of Home Care on Elderly Clients Over Time* project (SK101) found that seniors receiving preventive home care services were at a 50 per cent greater risk of dying or of entering a long-term care facility than were residents of seniors' housing who did not receive such services; this finding suggests that housing arrangements may affect health outcomes.

A key factor in determining how services may best be applied is to determine who the hospitalized elderly are and what needs to be done to reduce non-acute hospital use. A Saskatchewan study, *Hospital and Home Care for the Elderly Client in Saskatoon* (SK124), took steps toward an evidence-based foundation in answering that question by collecting data on 967 of 1,502 patients aged 75 years and more who were hospitalized over a nine-month period. It found that about one quarter of the patients had a delayed discharge due to their need for an alternative level of care (ALC) and that readmissions within 30 days of discharge, poor physical health, and the receipt of home care services increased the risk of hospital readmission. However, the study found that home care clients had lower physical health scores and higher levels of disability, justifying the need for the service, and that the cost of providing home care was less than providing ALC in hospital.

The question of whether current organizational and funding structures will meet the future needs of vulnerable elders as their numbers increase over time was at the heart of projects seeking to test current models against alternative models that may offer better and more integrated services at a similar or lower cost.

The development of a model in Mechanism for *Co-ordination of Geronto-Geriatric Services in Bois-Francs* (QC403) to deliver services to the frail elderly through a case-management approach, ensuring a streamlined and coordinated management of clients' needs, yielded positive results in reaching target audiences and satisfying caregivers. This demonstration project found that patients stayed at home longer and had more positive health outcomes and less interest in long-term facility care, but more visits to doctors than in the control region. However, the model had no effect on the use of emergency rooms, hospitals, or pharmaceuticals. The researchers noted that the project succeeded within the current parameters without making other radical changes, such as capitation.

Likewise, the major *Establishment and Start-up of Integrated Care Model* (NA/QC404-SIPA) project also tested a new model by implementing a geographically based reorganization of home care for community-dwelling frail elders in two Montreal sites. A control group received the usual care provided by the two CLSCs' home care programs while the experimental group received care within the new model that provided enhanced case management and assumed responsibility for the delivery and funding of all community-based health and social services in order to help frail elders remain in the community. Despite two years of preplanning, the implementation phase of the project took about a year because of delays and obstacles encountered during the latter phase, including the project's difficulty in involving private-practice physicians. The report provides important insights into the problems associated with introducing innovations within a program as complex as home care.

Nevertheless, the results of the evaluation indicate that the SIPA group, when compared with the control group, had a better opinion of the quality of care provided and a greater sense of security. SIPA did not reduce hospital emergency room visits or short-term hospital stays, but a higher proportion of the experimental group returned home after an emergency room visit. The average per person cost of the SIPA group was somewhat higher than that of the control group, and the increase in the SIPA group's use of community services has not been balanced by a decreased use of hospitals up to this point. The study continues, and researchers suggest that when the lower rate of institutionalization is taken into account over the longer haul, the SIPA model may save money. The researchers support the integration of long-term facility care funding with home care funding and suggest that hospitals, long-term care institutions, and home care services need to be conceived as an "ensemble" whose function it is to adequately meet the needs of frail elders from human, clinical, and financing perspectives.

The challenge of integrating fragmented essential services, delivered by a variety of community agencies and hospitals, into a coordinated home care program was taken up by a New Brunswick initiative. *A New Approach to the Delivery of Rehabilitation Services* (NB102) assessed the impact of the initiative, implemented after almost three years of planning, which assigned the role of managing, coordinating, and delivering all rehabilitation services in the community and in nursing homes to the provincial home care program. The move was seen to strengthen the links between hospitals and the community, and nursing homes noted that their residents were now receiving rehabilitation services in their facilities instead of having to use hospital outpatient services. The negative impacts included higher work-stress levels, increased staff-competency requirements, the need for rehabilitation support personnel, and the need for additional resources, despite the creation of 105 new positions by the transfer of personnel or equivalent dollars.

The fact that a significant number of elderly people live in high-density buildings presents a prime opportunity to rethink the delivery of home care services. Rather than sending a home care worker to each client, the *Cluster Care Pilot Program's* (BC121) seven-month project used a team of two full-time home support workers from an external service provider to address the needs of all home care clients in two high-density buildings. Care was based on assessed need, but the time spent with each client was flexible. The evaluation found that the approach was suitable for these clients and that clients used 74 per cent of the maximum hours authorized by the home care program. However, care levels required by clients increased during the life of the project, and the average cost per client was $422.50 per month, $20.50 more than it was the year before the pilot was implemented. Nevertheless, client, caregiver, and care provider surveys indicated a high level of satisfaction with the pilot, and care providers noted especially that flexible time allocations permitted them to respond quickly to unanticipated needs for attention. The project required a lead time of about six months to set up and to create a cohesive team, and the external agency providing the support staff teams had to implement a different billing arrangement, a problem that is still not fully resolved.

Home care projects similar to cluster care are not uncommon across Canada and are relatively easy to set up when the program employs both case managers and service providers. What is special about this project is its commitment to a formal evaluation that offers decision-makers and program managers insights on costs and program prerequisites based on data gathering and analysis.

The fact of hospital bed closures resulting in increased home care funding across Canada is not new. Neither is the hospital in-reach approach used in the *Carelinks* study, nor the setting up of in-hospital transitional care units. However, the British Columbia *Carelinks* project included a direct linking of hospital bed closures with the Carelinks initiative and, even more importantly, the project's commitment to a formal evaluation that will also yield future benefits. This project focused on assessing the impact of a 1999 regional health care restructuring that involved the simultaneous closure of 30 acute hospital beds and setting up transitional care units for persons requiring a longer recovery period. It also reduced hospital staff while increasing home care case coordinators to speed up discharges from hospital emergency rooms and in-hospital patients. Preliminary indications are that:

- about half the physicians reported that *Carelinks* was successful in facilitating more timely discharge and in improving the support for clients once they got home;
- post-hospital interviews at 2-3 weeks and 4-6 weeks revealed greater health status improvement among Carelinks clients than among the control group; however, these clients did not have a significantly lower proportion of hospital days, and the project did not reduce hospital emergency room, in-patient, or physician use;
- andoverall savings from restructuring were close to $1 million.

A major contribution of this evaluation is that it has created baseline data that will be useful in this and future investigations.

Using case management models and increasing service coordination are essential in meeting the needs of clients, particularly in responding to the complex needs of frail elders. This was found to be the case when, in 1998, Montreal CLSCs were directed to implement a single access point for elders requiring multiple services from the public community health and social service sector. However, the assessment study *Impact of the Single-Window Approach in CLSCs: Use of Services, Costs and Experience of Workers* (QC101) found that superimposing this reorganization on the CLSCs resulted in problems such as heavy case manager caseloads and the case managers having no authority to direct other practitioners providing the services that the managers were charged with coordinating.

In addition to recommending the formulation of clear and precise criteria for identifying frail elders, the report makes two recommendations that merit special attention because the project departs from the usual practice of having case managers who work exclusively for the home care program. The first recommendation stresses the importance of providing focused and specific training in the skills and competencies required by case managers. The second proposes that case managers should not provide direct services to clients. Decision-makers would be well advised to question the wisdom of a reorganization that mandates any professional working in any capacity in a health and social service setting to become a case manager who is responsible both for assessing and coordinating the care of the most vulnerable elders and for providing hands-on care.

5. Health Human Resources

5.1 The Public/Private Split in Service Delivery

Support services are the services most frequently used by home care clients. Yet scant attention has been focused on how they are organized and delivered and on the impact of these factors on case managers and clients. It is, therefore, interesting that a recurrent theme in these reports is dissatisfaction among both case managers and clients with home care policies in jurisdictions that purchase these services from external non-profit or for-profit agencies.

Two projects (*Cluster Care* (BC121) and *Frail Seniors Delivery Model Evaluation Service* (BC123) chose to purchase the services of full-time support workers – a departure from the current provincial policy to refer each client requiring service to an external organization for service delivery – and made special billing arrangements with the external source on the grounds that receiving services from the same workers over time was important in achieving their objectives. The *Cluster Care* report also noted that, even though the project was successful in making this arrangement, the problems resulting from this unusual billing arrangement are not yet resolved. The project (BC124) found that the current scheduling practices of external sources are one of the main barriers to achieving the continuity of support service personnel required by their clients, in this case dementia clients. At the Loose *End of the Continuum* (SK123) noted that their clients expressed satisfaction with the commitment the non-profit agencies chose to make to provide continuity of support services personnel to their clients. *Decision-Making: Home Care or Long-Term Facility Care* (NA101-06) reported that one factor influencing the choice of long-term facility care rather than home care was the client's inability to cope with the discontinuity of formal care providers. Two of the foregoing projects also noted that the separate locations of case management and service delivery workers reduce opportunities for informal information-sharing, which can have a positive effect on the efficiency and quality of care.

Recurring concerns about continuity in support services providers, the special arrangements that had to be made by several projects to solve this problem in order to achieve their goals, and the satisfaction reported among clients who received help from the same worker over time indicate that policy-makers and managers in jurisdictions that purchase support services from external sources should consider changing the way in which these services are currently funded, organized, and delivered. These changes could involve one of the following:

- allowing home care programs in provinces that use external providers to deliver services to hire their own workers, as is the case elsewhere;
- requiring external organizations to sign on to a clause in their contract that commits them to provide continuity of service personnel to individual home care clients; and
- launching an experimental project with the specific objective of comparing the efficacy, cost-effectiveness, and client satisfaction of maintaining the current organization and delivery of support services by external agencies with one that provides for the continuity of service delivery to clients.

Home care administrators and managers might also want to consider encouraging external providers to locate in or near case-management offices to encourage more informal communication.

5.2 Staffing Resources

As home care service delivery faces new challenges in meeting the needs of a wider variety of clients and in playing the role of the "hospital-at-home," issues of human resource training, management, and wages are becoming of crucial importance. In cases where savings in staffing are achieved in one sector, these savings might be transferred to home care with the goal of avoiding increases in staffing or additional staff training for innovations implemented there. For instance, in meeting the needs of clients with acute psychosis at home, one approach would be to reassign some experienced mental health workers from acute psychiatric wards in hospitals to the home care program, instead of providing additional training to home care nurses.

In addition, the complex nature of home care and the specialized skills of home care management must be recognized. It is a mistake for a regional authority to decree that any professional working in a particular office can assume the role of a home care case manager for frail elders, for instance, especially when one of the findings of the Impact of the *Single-Window Approach in CLSCs: Use of Services, Costs and Experience of Workers* study (QC101) indicates that professionals themselves reported the need for special training.

6. Implications of Findings

The HTF has made two significant contributions to home care: encouraging innovations and requiring that they be evaluated to assess their capacity to improve the effectiveness, accessibility, and cost-effectiveness of programs. Although many projects either fell short of completing their evaluations, had serious methodological shortcomings, or did not succeed in achieving their primary goal, the projects' reports offer decision-makers and managers important insights into the array of experiments being tested across Canada as well as ideas to develop their own strategies for creating new initiatives and involving researchers in the crucial task of evaluating their outcomes.

However, caution must be exercised in adopting any of the projects' innovations unless the evaluations meet the following criteria:

- They are methodologically sound.
- They have been completed.
- They show positive results in achieving their goals.

Caution is also warranted in interpreting the results of multi-site studies as indicative of the national scene: they generally do not adequately reflect differences in the histories, policies, management, and practices of individual jurisdictions. Finally, further experimentation is essential even when a project's evaluation indicates that it has successfully accomplished its goals if it was launched in a jurisdiction with different home care policies in regard to user charges, service limits, and service delivery.

Nevertheless, the key to further progress now rests with the willingness and interest of funders in continuing to provide adequate and assured funding for implementing and evaluating innovations in home care and with senior decision-makers' willingness to revise policies and programs.

Most of the following recommendations arise directly from the project reports. In some cases, however, they address gaps and priorities that arise from an overview of all the projects.

6.1 To Senior Federal and/or Provincial Policy-Makers

6.1.1 A National Home Care Program

The absence of a federal/provincial agreement on a national home care program means that where Canadians live, rather than what they need, determines whether they will have access to services or whether they will have to meet residency requirements, whether they will pay user charges for support services and on what basis they will pay for them, and whether they will be able to count on the continuity of service providers. This situation runs counter to the principles of universality, accessibility, comprehensiveness, portability, and public administration that underpin the policies, administration, management, and delivery of other health care services. It is, therefore, high time for both levels of government to implement a national home care program that treats all Canadians equally and equitably.

6.1.2 The Public/Private Split

The public/private split in home care services is hampering the efficiency, cost-effectiveness, and the quality of care delivered to clients. One of the major challenges, well represented in these project reports, is the split between the public case management function that determines eligibility, level, locus of service delivery, and cost, and the service delivery function that is often performed by private provider organizations. This split means that case managers do not have adequate control over determining who services are delivered to and on what basis those services are delivered. This results in a lack of continuity of service providers to individual clients, as well as a lack of adequate opportunities for informal contact between case managers and direct service providers. The current separation between case managers and service providers is in urgent need of policy resolution.

6.1.3 Discriminatory User Fees

Another issue resulting from the public/private split in home care management and service delivery is the imposition of user charges for some services but not for others. User fees discriminate between persons with functional deficits whose needs are primarily for support services, for which charges may be levied, and those whose primary need is for medical services, for which they usually pay no charges. User fees also create perverse incentives to use a more costly alternative even when home care is a more appropriate choice. The substantial differences between the provinces in regard to user charges have historical, rather than rational, roots. *A national home care program should ensure universal access based on a professionally assessed need for health and social services without financial barriers that restrict eligibility and without user charges that create barriers to the use of the most appropriate services.*

6.1.4 Plugging the Gaps in Health Care

Home care programs should not be pressed to assume the responsibility of filling a number of gaps in health care service delivery. The HTF projects illustrate an increasing trend to make home care the vehicle for delivering services that are costly and that, in some cases, should be provided by other sectors. This was illustrated in a number of projects that demonstrated how home care is being pressured to speed up in-hospital or hospital emergency room discharges even when persons need complex, intensive, and, therefore, costly care at home. As well, home care is being pressed to speed up transfers from hospital to long-term care facilities of persons who require alternative resources for a period of convalescence that might result in their being able to return home. Finally, there is a disquieting increase in the number of initiatives that make home care the vehicle for delivering services that have traditionally and appropriately been within the mandate of public health.

Provincial policy-makers should review legislation governing the regional health authorities to clarify both their own role and that of their regions as to which level is responsible for ensuring that gaps in resources such as public health and convalescent care are addressed by the most appropriate health care sector. They should also ensure that the increase in referrals for complex care is adequately funded, so that long-term care recipients who need a continuum-of-care approach are not penalized by being placed on waiting lists or denied access.

6.1.5 Jurisdictional Authority

Decisions about waiting lists and “raising the bar” of eligibility for home care services are often made at the local or regional level, sometimes apparently without formal authorization by provincial policy-makers. This issue brings forward two other questions: what jurisdictional level is responsible for making such policy decisions, and why should people living in the same province differ from others either in their access to or in their priority of access to home care services? Policy-makers in each province need to clearly define access and priority admission policies to eliminate inequities within each province. All provinces also need to ensure that the legislation governing the regional authorities is clear on who makes overall policy and resource allocation decisions that have an impact on the fair access to and receipt of continuing care services.

6.1.6 Primary Care Reform

If policy-makers decide to reorganize primary care, they would be well advised to start by evaluating the results of taking such a step without changing the status or the mandate of home care until the evidence clearly shows that the reorganization makes a positive difference. The current discussion as to whether or not home care should be integrated with primary care is premature and ignores the many-faceted role that the program plays. Home care comprises front-line community-based services but is also responsible for coordinating services and for determining both access to long-term facility services and the level of service these facilities provide to their clients. Home care is not a primary health service but a unique blend of health and non-medical support services delivered at home or in long-term facilities. Differences in the home care and primary care functions in a multi-faceted, unique program must be maintained.

6.1.7 Data Collection

There needs to be assurance that the minimum data required to provide Canada-wide information and to make it possible for the provinces to compare themselves with each other are included in provincial data sets. The context in which services are provided must be clearly spelled out so that interpretations of the data validly represent what is occurring across the country. The number of projects that either did not use quantitative data or spent a great deal of time getting baseline data in order to do before-and-after comparisons (often with the result of not completing the study) attests to the problems inherent in not being able to access data or not being able to merge home care data files with those on the use of other health care sectors.

Although the provinces spend millions of dollars to install or upgrade their information systems, far too little attention is paid to the importance of:

- the data needed from the system to provide a ready source of information on the relationship of user characteristics to the kind and volume of use;
- the relationship of home care use to the use of other health care services; and
- employing analysts who provide regular reports on what is occurring.

6.1.8 Home Care Standards

In order to ensure the delivery of good quality care at home, it is important for senior policy-makers to address the issue of home care standards as well as the issue of who is responsible for monitoring them. This issue was not addressed by the assortment of HTF projects but is a crucial consideration in light of the fact that home care's clients are largely vulnerable older adults who often live alone or with an elderly spouse who provides all or most of the informal care. Decision-makers at every level should review current policies on standards, on monitoring adherence to them, and on determining which jurisdictional level has the responsibility for these functions.

6.2 To Regional and Home Care Managers

6.2.1 Overcoming Barriers

Home care has vital links with hospitals and long-term care facilities, but for these links to be cost-effective, ways must be found to eliminate or at least substantially reduce the barriers that impede the achievement of this goal. As the HTF studies note, some of these barriers consist of financial disincentives that discourage the use of the most appropriate locus of care, a problem requiring, in most instances, changes in provincial policies. For that to happen, regional managers must bring these disincentives to the attention of provincial decision-makers for resolution.

6.2.2 Strengthening Links

The project reports also outline the structural and systemic issues that impede the best use of hospital and continuing care resources. Regional managers need to assume a leadership role in enlisting the collaboration of the top managers of both sectors and in working with them to address and resolve these issues. As the *Impact of an Emergency Room Discharge Coordinator on the Successful Discharge of Elderly Patients* study (QC429) in one hospital emergency room suggests, the hospital's assumption of shared responsibility for more expeditious discharge, rather than relying on home care to solve the problem by itself, produced the added benefit of improving awareness among the hospital's staff of the availability and usefulness of community resources – a real bonus for the targeted patients.

The HTF project reports demonstrate a very noticeable improvement in incorporating best-practices principles into home care programs. However, further progress also depends on the commitment of home care managers to keep their regional managers well informed of their concerns, of the barriers they encounter, and of the steps that need to be taken to remove these barriers at the regional or provincial level.

6.2.3 Resource Allocations

Managers must also recognize that when a choice is made to enrich services to one target group or to expand a program's reach to serve more people, the likely consequence will be reduced services to another group unless additional resources are forthcoming. The Carelinks project (BC121) stands out for having recognized and acted upon this understanding when it increased home care's responsibility for hospital discharges. One cannot help but be struck by the additional resources that many projects consumed overall and by how few of them reached their goal of conserving the use of hospital resources. Both regional and home care managers must be careful to identify the potential "losers" if a decision is made to incorporate an innovation into their regular programs within their current budgets.

7. Conclusion

The number of people needing help at home is growing as the population ages and as hospitals more frequently release people earlier than they used to. Although government spending on home care across Canada has doubled in the past decade, it is criticized as inadequate and haphazard. Indeed, home care is perceived as underfunded, undervalued, and overstressed. The HTF projects synthesized in this document have added to our understanding of the issues facing home care in Canada. There is a need to live up to public commitments made by health ministers to strengthen home care by developing coordinated home care policies, strengthening home care's role in the health care system, and developing standards on minimum services and training.

References

Brownell M.D., Roos, N.P. & Roos, L.L. (2001). Monitoring health reform: a report card approach. Social Science and Medicine, 52, 657-670.

Commission on Medicare. (2001). Caring for Medicare: Sustaining a quality system. Regina: Government of Saskatchewan.

Hollander, M.J. (2001). Evaluation of the maintenance and preventive model of home care. Victoria: Hollander Analytical Services Ltd.

Lepnurm, R. & Lepnurm, M.K. (2001). The closure of rural hospitals in Saskatchewan: method or madness. Social Science and Medicine, 52, 1689-1707.

Parent, K. & Anderson, M. (2001). CARP's report card on home care in Canada 2001: Home care by default not by design. Toronto: Canada's Association for the Fifty-Plus.

Sheps, S.B., Reid, R.J., Barer, M.L., Krueger, H., McGrail, K.M., Green, B., Evans, R.G., Hertzman, C. (2000). Hospital downsizing and trends in health care use among elderly people in British Columbia. Canadian Medical Association Journal, 163(4), 411-412.

Appendix A: List of HTF Projects Relevant to Home care

This appendix provides summary information on the HTF projects which were reviewed in the preparation of this document. For further information, please refer to the HTF website (www.hc-sc.gc.ca/htf-fass).

(NA101) National Evaluation of the Cost-Effectiveness of Home Care

Recipient: University of Victoria

Contribution: $1,505,000

This project was a large, multifaceted research program consisting of 15 substudies that examined various aspects of the cost-effectiveness of home care compared with that of institutional care. The 15 substudies were conducted by teams across Canada; six studies examined home care as a substitute for long-term care, and nine examined home care as a substitute for hospital or acute care services. Like the pieces of a puzzle, each of the findings from the individual substudies, when combined with the other findings, will give a more complete picture of the cost-effectiveness of home care in all of its aspects.

(NA101-01) Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services

This first study of the National Evaluation of the Cost-Effectiveness of Home Care set out to determine the relative costs to government of home/community-based services compared with those of residential long-term care services, by level of care, in the British Columbia setting. Using a unique linked database at the University of British Columbia, the study followed four cohorts of new admissions to the British Columbia continuing care system between 1987 and 1997 and tracked subjects' use of home care, residential care, physicians, hospitals, and pharmaceuticals from one year before the first assessment and for three years after the assessment. The costs were compared overall and by the five care levels used in British Columbia. The study found that home care is generally cheaper, at all levels of care, than is care in residential facilities. The costs, however, are in the transitions. Home care is much cheaper for governments if the clients are stable in their type and level of care than for those who change their type or level of care. The costs for stable clients are about one half of the costs of clients who are in transition. The study found that 30 to 60 per cent of the costs for home care clients are for hospital care and that traditional services, such as home nursing, account for only about one third to one half of overall home care costs.

(NA101-03) Substudy 3: Cost Implications of Informal Supports

The third study used a unique Edmonton database of some 5,000 home care clients to examine the relationship between the amount of formal home care services clients receive and the amount of informal (family) support the clients have. In essence, the study asked whether those clients needing home care who had no family support received more formal service from the system than did those with family support at home. The first scenario is one in which formal care substitutes for informal care, and the second scenario is one in which formal care complements home care. If the sectors complement each other, an increased provision of formal home care will result in the need for more informal support. If, instead, one substitutes for the other, changing demographics (e.g., more working women, one-parent families, increasing aging population) will necessitate more resources being applied to formal care to offset future decreases in the availability of informal care. Using complex statistical analysis, the report found that formal and informal care are complementary, not substitutive.

(NA101-04) Substudy 4: Pilot Study of the Costs and Outcomes of Home Care and Residential Long Term Care Services

Substudy 4 was a small pilot study for a second, larger study (substudy 5) focusing on the costs and outcomes of care in the community and in long-term care facilities. In particular, it delineates the economic, social, and psychological burden borne by family members and informal caregivers when patients are in home care rather than in institutional settings. The purpose of the pilot study was to test instrumentation and determine the feasibility of data collection strategies for substudy 5. Three study sites were used: Winnipeg, rural Prince Edward Island, and London, Ontario. Information was collected both on clients and on informal caregivers through interviews and questionnaires. The pilot study enabled the research group to better refine its measurement tools, determine sufficient sample sizes, and resolve other issues that could affect the outcome of substudy 5.

(NA101-06) Substudy 6: Decision-Making: Home Care or Long-Term Care Facility

This qualitative study interviewed case managers in British Columbia, Alberta, Saskatchewan, Ontario and Prince Edward Island to delineate the decision-making process regarding the question of whether clients were cared for at home or placed in residential care and thus to determine ways of bringing about an effective substitution of home care for facility care. Eighty-nine case managers in both rural and urban settings completed questionnaires and participated in focus groups. Through this data collection, almost a dozen "factors" were identified that allowed patients to be cared for at home, including the availability of informal supports, adequate funding and staffing for formal home care services, community support, meal programs, supportive housing, adequate family finances, respite programs, day programs, transportation, and home maintenance. Likewise, a number of factors influenced the decision to place the client in facility care, including the need for transitional, convalescent, or respite care; heavy 24-hour care needs; an unsafe home environment; the presence of incontinence or an inability to transfer; client dissatisfaction with home care services; and the belief that facility care is cheaper.

(NA101-08) Substudy 8: Eligibility for Community, Hospital, and Institutional Services in Canada: A Preliminary Study of Case Managers in Seven Provinces

This study asked 60 case managers from seven provinces to rate 16 different vignettes and indicate the level and type of care they would recommend in regard to home care, residential care, and hospital care. Generally, it was found that significant differences existed across jurisdictions in regard to eligibility and access to services. Staff assigned to the clients also differed; for example, the expected involvement of registered nurses ranged from 93.8 per cent to 54.4 per cent across jurisdictions. Placement results also differed when case managers were blinded and then not blinded to information regarding informal support. The study makes policy suggestions, including one to standardize the understanding of "who is eligible for what" based on comprehensive assessment data, so that client needs are responded to in an effective and equitable manner.

(NA101-09) Substudy 9: Costs of Acute Care and Home Care Services

This study looked at the cost-effectiveness of home care compared with that of acute care to determine if additional opportunities existed for cost savings or increased system efficiencies. The study used Alberta data for hospitals and home care to generate data on care episodes for people in hospital, those with inter-hospital transfers, and episodes that included both hospital care and home care services. Data were analyzed on the basis of case mix groups (CMG), which categorize hospitalizations into groups of individuals that use approximately equal amounts of resources. The results showed that admissions with inter-hospital transfers were 1.75 times more costly than those without transfers. The report concludes that, as a result, costing should be done by episode of care (a set of contiguous inpatient and home care contacts) and that current hospital costs calculated by CMG or resource intensity weight (an index number that measures the relative cost of a CMG) may be under-estimates. The report found that most combinations of hospital care and home care were more expensive than hospital care alone, but that care needs (number of diagnoses) were also higher for persons who received home care. The author notes that case severity is an important indicator of home care assignment and that home care episodes are more costly because they have a higher degree of severity.

(NA101-10) Substudy 10: Economic Evaluation of a Geriatric Day Hospital: Cost-Benefit Analysis Based on Functional Autonomy Changes

This study investigated whether the benefits related to a geriatric hospital day program exceed the costs, using a cost-benefit analysis based on changes in functional autonomy (a means of measuring the ability to perform daily tasks). The latter was measured at admission and discharge to the geriatrics unit at Sherbrooke University. The study found that for each dollar invested in care, $2.14 of benefits were derived in terms of improvement in functional status. The report observes that a measurement of dollar benefits alone does not incorporate other important aspects for clients such as improvement in cognitive function, socialization, and well-being. As a result, the findings of a 118 per cent cost-benefit may in fact be the lower limit of the possible benefit of such hospitals. The authors also suggest health policy-makers will need to grapple with the issue of optimal length of stay for patients – too long or too short a stay may increase the costs and not the benefits.

(NA101-11) Substudy 11: An Economic Evaluation of Hospital-Based and Home-Based Intravenous Antibiotic Therapy for Individuals with Cellulitis

This study examined the costs and outcomes of antibiotic intravenous (IV) therapy for individuals with cellulitis, focusing on a comparison between hospital versus home care locations. (Antibiotic IV therapy is the most commonly prescribed IV therapy in Canada, and cellulitis is a major reason for such prescriptions.) The initial goal of a randomized control trial proved to be unattainable. The study was modified to an observational cohort study design, which the author notes is more prone to bias. As well, in several instances a lack of adequate home care services meant that many people were treated through repeat visits to emergency departments rather than strictly at home. However, the study's main findings showed that home care and emergency care cost about half of the care in hospital, afford patients a better quality of life, and result in fewer complications and higher rates of resolution of the cellulitis.

(NA101-12) Substudy 12: Cost-Effectiveness of Home versus Hospital Support of Breastfeeding in Neonates

This study examined the costs associated with breastfeeding term and pre-term infants in both home and hospital contexts. It also sought to examine the efficacy, safety, level of maternal satisfaction, and resources involved in managing breastfeeding. It showed no differences in indirect family costs, hospital delivery costs, or total system costs. In terms of outcomes, the group with home care had significantly higher rates of babies being exclusively breastfed. The qualitative data regarding maternal satisfaction appear to support early discharge from hospital accompanied by home visiting by the community nurses. The authors of the report suggest policy-makers consider home support for breastfeeding a viable option in terms of costs and clinical outcomes for mothers of term infants and suggest that mothers be offered a choice of either standard care or early discharge with home visits by a lactation consultant or nurse with breastfeeding expertise.

(NA101-13) Substudy 13: The Geriatric Outcome Evaluation Study

This study explored service use within a geriatric services program; specifically, it explored how a geriatric day hospital fits into a broad spectrum of services in Victoria, B.C.. Clients were studied in five geriatric care settings: an outpatient clinic, a day hospital, post-acute inpatient rehabilitation, residential rehabilitation, and inpatient psychogeriatric rehabilitation. The researchers wished to determine if patient needs could best be served by such specialized services, supporting the continuum of care concept, or if in fact inpatient and other services could be substituted. They found that each service did appear to address a particular need or constellation of needs, based on their study of mental and physical health, daily functioning and bodily pain. This finding supports the notion of an integrated hospital-based system of outpatient and inpatient services for geriatric clients. The study encountered several challenges, including time limitations and a restructuring of outpatient programs during the research period, leading to a substantial reduction in sample size. As a result, researchers could not complete a cost-effectiveness analysis.

(NA101-14) Substudy 14: Evaluation of the Cost-Effectiveness of the Quick Response Program of Saskatoon District Health

This study evaluated the cost-effectiveness and efficiency of Saskatoon District Health's Quick Response Program (QRP), which identifies vulnerable elderly patients in the emergency department and arranges appropriate community services to avoid unnecessary hospital admissions. Chart reviews were conducted for all people over the age of 60 who visited emergency departments during an 11-week period in 1999. The study identified only two patients out of 3,074 who were not seen by the QRP and whose hospital admission could have been avoided with appropriate care in the community – a finding that shows the QRP is working very efficiently. An unexpected finding was that 46 patients visited the emergency department repeatedly (up to 19 times.) The study confirmed that the costs of providing community-based services initiated by QRP are lower than the costs of providing hospital care; but unless hospital beds are closed, QRP is an add-on cost.

(NA101-15) Substudy 15: An Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care

This study examined the discharge process from hospitals to home care services to identify barriers and inefficiencies that impede the transfer to home care. It used a series of interviews and focus groups with hospital and home care providers in seven jurisdictions, as well as an expert panel to detail key problems to effective transfers. Six main types of systems barriers were found: barriers to working together, family/patient barriers, geographic barriers, system management and control barriers, system change barriers, and resource barriers. The report identifies three overarching principles of best-practices to bridge the gap: establishing formal systems that include common information systems and the flexible use of resources; building relationships and informal networks between hospitals and home care with boundary-spanning positions and the development of working relationships; and building system capacity with adequate budgets, resources, and programs to underpin the system.

(NA108) First Nations and Inuit Home Care

Recipient: First Nations and Inuit Health Branch, Health Canada

Contribution: $1,421,600

This evaluation of an 18-month pilot project influenced the development and implementation of the new national First Nations and Inuit Home and Community Care Program. The project undertook to assess and find new ways to meet home care needs in five geographically diverse First Nations sites. The project resulted in considerable practical and valuable information that has already been used by senior decision-makers at Health Canada to initiate home and community care programs in over 600 First Nations and Inuit communities. Home care program managers and administrators will find the commentary on time lines, communication challenges, and infrastructure for program delivery highly relevant to their work and program development.

(NA122) Safety of Persons Suffering from Dementia and Living at Home

Recipient: CLSC Côte-des-Neiges, Montreal

Contribution: $178,035

This project developed and validated a questionnaire to evaluate risks to elderly people suffering from dementia and living at home. The questionnaire aimed to identify and reduce risks by assessing appropriate interventions and the impact of counselling the informal caregiver. The questionnaire was developed in two versions (short and long) and in two languages (English and French) through pilot work in urban, semi-urban, and rural settings in Alberta, British Columbia, and Quebec. Health care practitioners who had referred patients to the project were asked to review their patients' questionnaires. The response rate from practitioners was over 50 per cent in Quebec, only 15 per cent in Alberta, and zero in British Columbia. The authors feel that this tool can be used in all provinces to provide a structured assessment interview, particularly on first meeting with a patient who has dementia and is living at home.

(NA128) Evaluation of Information Standards for Home Care

Recipient: Canadian Institute for Health Information

Contribution: $390,603

This project's goal was to develop a comprehensive, standardized set of indicators about home care that will make possible comparisons of home care clients, programs, and outcomes in various health regions across Canada. Using workshop and survey feedback, the project developed an initial set of 20 priority indicators that profile clients, costs, existing caregivers, and patterns of use. Researchers recruited 11 regional pilot sites with computerized data systems in urban and rural settings, evaluated the usefulness of the indicators, and tested a prototype home care report. An external field review and an expert working group assessed the relevance, clarity, and breadth of the indicators. Although the indicators are not ready for wide adoption, the project gave practical insights into the goals and difficulties of establishing a standard set of indicators and makes recommendations for improving both the indicators and the context in which they are presented.

(NA131) Rural Palliative Home Care Demonstration Project: A Collaborative Project Between Nova Scotia and Prince Edward Island

Recipient: Nova Scotia Department of Health
Contribution: $997,800

The Rural Palliative Home Care Project's goal was to implement and evaluate an integrated palliative care project in three rural areas: one in Nova Scotia and two in Prince Edward Island. The project report states that key components of the project included access and referral through a single entry point, the development of a common palliative care assessment tool and home chart, coordination by a case manager, care delivered by an interdisciplinary team, and enhanced education of nursing staff, doctors, and volunteers on palliative care issues. The project had a substantial educational initiative that included front-line education on palliative care issues for health care providers, clergy, and volunteers; resource team education; and continuing medical education for physician and faculty development. The front-line education was given to 226 individuals, and evaluation showed that it was well received and that these individuals retained the knowledge they gained three months after the workshop.

(NA132) Home Chemotherapy for Children with Cancer: An Evaluation of Costs and Health Services Utilization

Recipient: University of Toronto

Contribution: $63,105

This study compared a hospital-based chemotherapy delivery model and a home-based chemotherapy program by following 11 children, aged 2 to 16, with acute lymphoblastic leukemia (ALL). Treatment for ALL usually includes repetitive cycles of chemotherapy in hospital for a period of three years. The study's main goal was to see whether the quality of life for children and families was improved with home delivery without increasing adverse events, caregiver burden, or emotional stress. Cost-effectiveness and the acceptance of the service by families and health care staff was also evaluated. While noting that 11 children is too small a sample size to demonstrate significance, the study found that results of qualitative interviews found improvements in quality of life for both children and families with the home treatment and that home chemotherapy would appear to be safe and feasible. There was no difference in the nature and frequency of adverse events between home and hospital. Health care workers were generally supportive but were concerned about safety, accountability, qualified staffing, and ensuring that the home is still considered a "safe place" for the child with cancer when the home is also the locus of treatment.

(NA145) Development of Screening and Assessment Tools for Family Caregivers

Recipient: CLSC René Cassin, Montreal

Contribution: $383,105

This project developed two measurement instruments for use in home care settings: a one-page screening tool to assess the risk of caregiver burnout, and a 35-page detailed assessment of the caregiver's situation and the types of services and supports that would best help. The two assessment tools, both to be administered by professionals, were designed by culling information from literature searches, focus groups and key-informant interviews. They were tested at seven sites in Quebec and Nova Scotia. The caregiver risk screen was found to be valid and reliable, and the caregiver assessment tool was "for the most part" reliable. The report concludes that the assessment tool seems to consistently identify both the main areas of concern for the caregivers and the best focus for the service plan. It recommends that both instruments become widely used to help support the needs and concerns of family caregivers.

(NA149) Home Care and People with Psychiatric Disabilities: Needs and Issues

Recipient: Canadian Mental Health Association, Toronto

Contribution: $204,900

This national study explored the issue of how adults with serious mental illness (not including Alzheimer's) in Canada might benefit from publicly funded home care services. The project conducted a national evaluation of the accessibility, appropriateness, and effectiveness of existing home care services for adults with serious mental illness by reviewing completed surveys from 77 branches of the CMHA and

140 home care organizations, comments from patients and families in 13 cross-Canada focus group sessions, and information from face-to-face interviews with 142 key stakeholders. Concurrently, site-specific pilot programs were developed, implemented, and evaluated in Taber, Ottawa, and St. John's, showing that there is a variety of ways to integrate mental health and home care. The report recommends a series of changes to policy and practice that would relieve the "revolving door syndrome" of the mentally ill cycling in and out of hospital: making admission planning to home care part of hospital discharge planning, providing more support to caregivers and home care staff, and undertaking intensive case management. The report also makes the case for improving the integration of home care and mental health services in all parts of Canada.

(NA161) Tele–Home Care: Multi-Site Modelling Component

Recipient: The Hospital for Sick Children, Toronto

Contribution: $87,240

This report compares three regionally produced models of tele-home care, one (in Toronto) that was operational and the other two (in Calgary and St. John's) that were theoretical, pinpointing common elements and noting site-specific differences. The project enlisted local hospital and home care personnel to develop the two theoretical tele-home care models by identifying broad service concepts, defining a patient population, pinpointing essential service elements, and making recommendations about technology requirements. The models were then compared with one currently being tested at the Hospital for Sick Children in Toronto. The project developed a "blueprint" for a core Canadian tele-home care service that could enable higher-intensity care in the home for up to six months after hospital discharge: establishing an audio-visual connection between the monitoring centre and the patient, monitoring patients at least once a day, and offering tertiary support to the patient and the community care provider. Tele-home care is an adjunct to, not a substitute for, traditional home care. The result was a better understanding of the nature, advantages, and adaptability of a new model of service delivery, which may increase health system efficiency but may also help resolve access issues for patients in rural and remote regions.

(NA1007) The Effects and Expense of an Early Health Promotion/Rehabilitation Intervention in an Elderly Home Care Population

Recipient: McMaster University, Hamilton

Contribution: $223,201

This randomized controlled trial examined whether using occupational and physical therapists in the home setting prevented functional decline in elderly patients and improved their autonomy, reduced caregiver burden, and reduced the use of health and social services. Traditionally, older adults who require hospitalization are at risk of a long-term deterioration of health status, which can continue after discharge, as clients may become dependent on home care services. In this project, eligible patients (aged 60 and over) who were discharged from acute care hospitals and referred to the Community Access Centre of Halton for homemaking and/or nursing were randomized to receive either the usual home care services or early, individualized health promotion/rehabilitation intervention by occupational and physical therapists in addition to home care. A total of 201 patients was enrolled. The evaluation of the findings of this project is continuing, but preliminary analyses show that the rehabilitation services have improved functional abilities in clients' activities of daily living compared with those of the control group.

(NA1012) Diabetes Community/Home Support Services for First Nations and Inuit

Recipient: First Nations and Inuit Health Branch, Health Canada

Contribution: $650,000

This pilot project was designed to address the needs of people with diabetes and their families and to develop home care models. Four First Nations and Inuit communities hosted the program. Each represented different geographical and cultural settings, from the semi-remote to semi-urban. Each community identified gaps in three areas: diabetes education services, adequate coordination of services; and care and treatment. In response to these issues, each community developed unique models of home care diabetes services. Researchers found that the education and training of front-line staff was one of the first and most critical steps in creating community-based diabetes services. Although it is too early to assess the project's impact on rates of diabetes complications, a trend in reduced hemoglobin A1c results was noted, which can reduce the risk of diabetes complications.

(NA1022) A Grassroots Approach to Addressing the Home Care Needs of the Urban Aboriginal Population in Canada

Recipient: Quebec Native Women Inc., Montreal

Contribution: $133,245

This research project sought to help health department officials prepare culturally appropriate home care programs and services for Aboriginal people living in cities and other off-reserve settings. The project undertook a literature review to explore the existence of culturally appropriate home care programs, consulted 120 Aboriginal women living off-reserve in Quebec to identify home care-related needs, and received comments from more than 50 people in five friendship centres. The proposed model is an adaptation of Quebec's provincial home care model and Ontario's Life Long Care program. The most developed parts of the model are its principles, objectives, division of responsibilities, culturally appropriate program components, and framework for evaluation. The literature review contains some relevant details on the demographics and health status of Canada's Aboriginal people, Ontario's prototype home care program for those living off-reserve, and the role Aboriginal people play in setting health policy in Australia.

(BC121) Home-Based Program for Treatment of Acute Psychosis

Recipient: Capital Health Region

Contribution: $187,000

This 10-month trial sought to determine whether home care for acutely psychotic patients is an efficient and cost-effective alternative to hospitalization. In the experiment, 10 nurses working in a regional health setting received training that enabled them to manage 37 acute care episodes in private homes. Only three clients required a brief hospitalization or readmission. In a departure from conventional practice, five patients initiated Clozapine therapy in the home. No home support or social work staff beyond that ordinarily available to clients was found to be required. Although operating cost savings were modest, such programs avoid capital costs for additional psychiatric beds. Six months after the project was completed, the Capital Health Region announced funding for a permanent, expanded service based on this model.

(BC122) The Cluster Care Pilot Program

Recipient: South Fraser Health Region

Contribution: $84,000

This seven-month project looked at a team-based, flex-time approach (called cluster care) to seniors' home support services as an alternative to conventional one-to-one case assignments and fixed-period visits. At question was whether shorter, more frequent visits would result in better care, more efficient services, and increased client independence. After investigating related experiments in Waterloo and Kamloops, researchers selected two pilot sites and managed two teams of home support workers. Detailed comparisons of the traditional and cluster care models showed that the latter was suitable for most clients and most appropriate for those who live in high-density residential buildings and receive considerable home support hours. Care levels increased overall, particularly at the more complex levels; however, this may be a result of the fact that the same group of clients, the majority over age 80, was compared for 1998 and 1999 and that their health needs may have increased over that time. Better care and the team approach meant more hours and higher costs. Surveys revealed a high level of client, caregiver, and care provider satisfaction with the program.

(BC123) Frail Seniors Service Delivery Model Evaluation

Recipient: North Shore Health Region

Contribution: $139,875

This six-month project compared integrated home care services for frail seniors with non-integrated services. It also evaluated cost-effectiveness and relative health outcomes of integrated home care. Clients in the treatment group received continuing attention from a care coordinator, generous occupational and physiotherapy rehabilitation services, access to an adult day program, advice from mental health and geriatric outreach teams, recreation therapy, regular attention at interdisciplinary team conferences, and the services of a salaried home support worker. The program was found to be very cost-effective. In the six-month period, the total cost of services for the treatment group was $7,367 per client, compared with $11,279 per client for the comparison group. No significant differences existed in health outcomes between the two groups.

(BC124) Enhanced Case Management Project

Recipient: Upper Island/Central Coast Community Health Services Society

Contribution: $126,623

This initiative sought to boost the knowledge and confidence of service providers and family caregivers who support non-institutionalized persons with dementia. The project developed and delivered a series of education and on-site sessions to home support workers, case managers, and home support supervisors. After training, case managers increased the time spent with family caregivers. All members of the support team benefited from an experimental, dedicated case management position at a local hospital to screen, manage, and discharge patients with dementia. Researchers found that more home support workers than expected were interested in the program. Participants said their knowledge, confidence, and team pride “immeasurably increased” as a result of this project.

(MB122) Enhancing Capacity to Study and Evaluate Home Care: An Evaluation of Home Care Data Systems

Recipient: University of Manitoba

Contribution: $302,132

This study evaluated two home care client assessment tools (SACPAT and the InterRAI MDS-HC) used in a pilot project in Manitoba (MB121). In particular, it compared their effectiveness and relevance to the planning, analysis, and delivery of home care services. Researchers concluded that the InterRAI MDS-HC, a more standardized and validated tool, better addresses the data needs of administrators, planners, and program managers; the information it generates is more relevant to policy and planning. Since the InterRAI tool is being used by researchers in a number of countries, standardized data collection also permits comparisons across jurisdictions. The study also considered the potential for linking administrative data about home care (the Manitoba Support Services Payroll) to client assessment data. The researchers conclude that, although some difficulties would have to be overcome, such a link would provide additional useful information about home care use and expenditures.

(NB102) A New Approach to the Delivery of Rehabilitation Services

Recipient: Department of Health and Community Services, Government of New Brunswick

Contribution: $2,972,983

This study assessed the impact of the Rehabilitation Service Plan, developed in 1994 to improve the delivery of community-based rehabilitation services in New Brunswick by improving client access and coordinating service delivery. Lacking baseline data, the researchers measured perceived changes through qualitative evaluations. They conclude that rehabilitation services have indeed improved: they are seen as client-centred, and clients are generally satisfied; certain clients have access to a wider range of services; the referral process is easier; a new assessment process ensures that the neediest patients receive attention first; hospital and community services are better coordinated; and the Stan Cassidy Centre for Rehabilitation has taken a leading role in the province. The report also identifies remaining challenges, principally the need for sufficient human resources and funding for continuing training.

(NT401) Improving the Effectiveness and Efficiency of Programs for Aged, Disabled, and Chronically Ill Individuals

Recipient: Department of Health and Social Services, Government of the Northwest Territories

Contribution: $79,000

This project developed and implemented a new Continuing Care Assessment Package (CCAP) to assess clients requiring continuing care in the Northwest Territories. The use of the standardized tool helped direct clients to community-based services that provide a continuum of care as a cost-effective alternative to institutionalization. Data collected through the CCAP also facilitated better planning for service delivery, housing, and other resource needs. The report of this pilot project points out barriers such as resistance to change, but the principal problem was staff turnover. In small jurisdictions, the loss of expertise when a person leaves has a serious effect on program implementation. The authors suggest a written manual and continuing training as solutions to these concerns. They also point out the importance of supportive management in gaining acceptance of a new tool. The CCAP proved to be an effective way of making more objective, standardized assessments, thus making access to continuing care fairer and more effective.

(ON121) Integrated Cardiac Home Monitoring Pilot Project

Recipient: Scarborough General Hospital
Contribution: $650,000

The Cardiac Home Ambulatory Monitoring Project (CHAMP) was a randomized control trial of the home monitoring of patients with congestive heart failure (CHF) after their discharge from hospital following an acute cardio-respiratory episode. The study's primary aim was to see if more intensive, cost-effective monitoring at home could lower readmission rates and improve patient outcomes, functional status, and the cost-effectiveness of the cardio-respiratory program.

The study group received the standard care in addition to being educated about the symptoms of CHF, medication, exercise, and nutrition. Participants were given a "Life Signs System"® monitoring technology that could record and transmit vital signs via the telephone to a central repository where it could be reviewed by project staff registered nurses. Results showed the study group had statistically significant higher health satisfaction scores and that telephone consultation averted 32 per cent of emergency visits in the study group. The rate of readmission was 4 per cent in both groups, but the clinic reported that by monitoring the patients at home, it could increase its volume of patients assessed each week from 50 to 82.

(ON421) Integrated Health Information Systems for Community, Institutional, and Hospital-Based Care Based on the RAI Series of Instruments

Recipient: University of Waterloo
Contribution: $1,648,644

This study investigated the feasibility and usefulness of informatics tools (RAI instruments) that help health care providers and administrators see how their practice compares with that of reference groups. Researchers and administrators can use RAI instruments to track health indicators and therefore to guide population health strategies. There were four parts to this two-year study; all of the substudies involved the secondary analysis of data obtained from health organizations that voluntarily pilot tested one or more RAI instruments as part of their normal practice. Results were returned to clinicians, who could incorporate them in activities and care plans. The substudies successfully introduced assessment instruments that support integrated information systems (IHIS), home care quality indicators (HCQIs), and a new case mix classification system for in-patient psychiatry (RAI-MH). The fourth study reviewed and endorsed the results of using an instrument called RUG-III to fund long-term care and complex continuing care.

(PE121) An Integrated Mental Health Response for Seniors

Recipient: Prince Edward Island Department of Health and Social Services
Contribution: $140,000

This two-year study developed and field-tested a model of service delivery to integrate home care and community mental health services for seniors experiencing dementia or depression, the most common mental disorders among seniors. The main objectives were earlier assessment, care planning, and appropriate intervention. Planning of the model was cautious in order to allow key home care and mental health workers a chance to become comfortable with objectives. Once launched, the project undertook to increase the confidence and competence of front-line staff with workshops (for home care workers) and intense training on seniors' health (for mental health personnel). Researchers developed a "screening tool flow chart" for identifying early signs of illness during home visits and a multidisciplinary diagnostic protocol for client and caregiver assessments. The project improved the accessibility of mental health expertise for home care staff; challenges included staff retention and gaining support from family physicians.

(QC101) Impact of the Single-Window Approach in CLSCs: Use of Services, Costs, and Experience of Workers

Recipient: CLSC René-Cassin
Contribution: $242,663

In late 1996, CLSCs in Montreal were instructed to implement a *guichet unique* (single-point access) approach to providing services to maintain aging clients in their home. This study evaluated that implementation and its impact on practitioners and their professional practice. The researchers obtained their data through focus groups, questionnaires, and individual interviews. They conclude that responding to the complex needs of an increasingly aged population requires an integrated approach. They note, however, that a number of problems have occurred in the introduction of case management in the CLSCs studied: workers have heavy caseloads; case managers risk burnout because of an increasing number and complexity of tasks; and case managers do not have the authority to give direction to practitioners in all the services that they must coordinate. They recommend training for case managers in their new tasks; training for the partners in the hoped-for “continuum of services” (e.g., doctors, hospitals, community organizations) to ensure a clear understanding of their roles; clear criteria for definition of the clientele; and caseload standards that do not overburden workers. Although the *guichet unique* approach aims in part to reduce hospitalization and institutionalization of the aging population and thus reduce public expenditures, this study did not address the issue of relative costs. Regarding the process of change itself, the researchers note that the contingency-management style facilitates the change process.

(QC121) Development of an Information and Training Guide on Home Care and Services for Persons with Cancer and for Natural Helpers

Recipient: CLSC-CHSLD La Pommeraie

Contribution: $42,500

This evaluation project distributed booklets to cancer patients and their informal caregivers, giving them information on caring for cancer patients at home, exercising choices in treatment, maintaining patient autonomy, and avoiding caregiver burnout. The effectiveness of the guides was measured to determine the uniformity of information provided from different medical and non-medical services, the knowledge of patients and caregivers concerning the disease, and the continuity of services across the region. It found that the information was welcomed by the users and that the efficient organization of oncology services and a high degree of collaboration among service providers are essential.

(QC123) Development and Implementation of a Cost System for Home Care and Home Services in Connection with the Demonstration Project for an Integrated Services Network in the Bois-Francs, with Coordination of Services through Case Management

Recipient: Université Laval

Contribution: $199,290

This project developed a system of cost analysis to evaluate the results of coordinating services to the frail elderly in the Bois-Francs region of Quebec. (See QC403 for an evaluation of this project as it relates to implementation and patient outcomes.) Costs were calculated for home health care and services to the elderly and to the public health and social services network. The economic analysis of costs assumed by the elderly themselves and by their families was not available. The results show that overall costs to the public system are comparable over time between the two regions that were tested, though there were differences in the services used. The researchers conclude that the coordinated services initiative is economically viable because it brings significant benefits to patients without requiring increased expenditure from the public system. Furthermore, they suggest that their model for imputing costs could be used to evaluate other integrated services projects for other client groups.

(QC403) Mechanism for Coordination of Geronto-Geriatric Services in Bois-Francs

Recipient: Université Laval

Contribution: $250,700

This project evaluated a model of coordinated care for the frail elderly that was developed in 1997 in the Bois-Francs region of Quebec. Services to the elderly were coordinated by using one point of entry, case management, and personalized service plans ranging from health promotion to palliative care. A system of electronic clinical files was designed to facilitate interdisciplinary communication. The evaluation showed that the program succeeded in reaching the frail elderly, and that the *intervenant-pivot* (key practitioner) fulfilled the intended role of case manager. The computerized sharing of information was less successfully implemented because not everyone in the network was adequately equipped. The evaluation of patient outcomes showed a tendency for patients to stay longer in their homes in the Bois-Francs region than in the control region; family caregivers also reported a reduced burden for the first two years of the evaluation. No effect could be shown on the use of the emergency department, on hospitalization, or on medication usage. The companion project (QC-123) looks at the relative costs of the coordinated services and a control region; it concludes that costs were no higher for what appear to be generally improved outcomes for patients and their families.

(QC429) Impact of an Emergency Room Discharge Coordinator on the Successful Discharge of Elderly Patients

Recipient: Sir Mortimer B. Davis Jewish General Hospital

Contribution: $453,637

This project created a nurse discharge coordinator position to oversee the discharge of elderly patients from the emergency department of the Jewish General Hospital in Montreal. Researchers wanted to determine the impact on returns to the emergency department and hospitalization in the short term, as well as patient satisfaction and compliance with treatment plans. Discharge planning included forging links between the CLSC network, family physicians, the emergency department, and the hospital system. There is some indication that doctors may have been willing to discharge elderly patients more quickly if they knew that the nurse would follow-up within 24 hours. This factor and the reduced use of emergency department services would presumably result in savings to the hospital; however, no analysis of cost-effectiveness could be done because of a lack of adequate measures for some of the variables. However, the hospital administrators have expressed confidence in the study's results by establishing the position of nurse discharge coordinator, dedicated to the emergency department, to work with the population identified by the project's experience as being at particular risk.

(SK101) An Exploratory Study of the Impact of Home Care on Elderly Clients Over Time

Recipient: Health Services Utilization and Research Commission

Contribution: $80,000

Using provincial statistics, this study explores the question of whether home care and social housing do in fact contribute to longer life and independence for senior citizens. Researchers collected eight years of provincial data on 26,490 Saskatchewan seniors regarding their hospital use, medication, medical attention, and patterns of care. They compared the health care costs of service recipients with those of non-recipients. After adjusting for health status and use of other services, they found the total health service costs for home care recipients were approximately triple the costs of non-recipients, whereas the costs for social housing residents were at the same level as non-residents. These findings suggest that seniors' housing is more effective than preventive home care in keeping seniors alive and out of nursing homes and that it results in lower overall health service costs. However, the authors caution that their work faced significant limitations and suggest that additional studies should be undertaken to confirm and extend the findings.

(SK121) Palliative Care Services Review

Recipient: Moose Jaw–Thunder Creek Health District

Contribution: $8,870

This study responded to a growing local need to integrate home care, acute care, and long-term care into a comprehensive palliative care program. During two months in 1999, researchers identified resource and service deficiencies by interviewing a sample of clients and service providers and surveying other staff and community stakeholders. They found there was a need for an interdisciplinary approach to develop any new policies and systems. They also identified a considerable communications gap and dissatisfaction with available information provided to the public, staff, and physicians.

(SK122) Home Care Client Satisfaction Survey

Recipient: Moose Jaw–Thunder Creek Health District

Contribution: $5,800

This study is the first formal evaluation of a Saskatchewan health district's home care program, which was launched in 1962 but which, as a result of health reforms, experienced a 272 per cent increase in client load between 1992 and 1997. It includes commentary recorded in personal interviews with 100 clients, one tenth of the program's client list. Researchers found a high level of satisfaction with services; clients believe the program is meeting their needs and expectations. The researchers were, however, somewhat surprised by the low level of public awareness of the program, in rural areas more than in urban ones, and concluded that there was a need for new communication strategies.

(SK123) At the Loose End of the Continuum: A Study of Two Saskatchewan Non-Profit Organizations Delivering Preventive Home Care Services

Recipient: University of Regina

Contribution: $10,303

This report focuses on the provision of home care services by "the third sector" – non-profit organizations and cooperatives – in Saskatchewan. It provides detailed historical and political context and evaluates two established service providers, recommending ways in which policy-setters and organization administrators could boost operational effectiveness. These ways include more public recognition, better funding, and a variety of organizational upgrades. From a service delivery standpoint, these organizations' advantages include their offer of continuity of service rather than a seniority-based system for assignments and their success in collaborating with a network of public, private, and third-sector partners.

(SK124) Hospital and Home Care for the Elderly Client in Saskatoon

Recipient: Saskatoon District Health

Contribution: $242,888

This study followed the admissions of elderly patients aged 75 years and older to three Saskatoon hospitals over a nine-month period to undertake a "process and outcomes evaluation." Researchers analyzed admissions, the need for acute care, the timeliness of discharge, the use of home care, and physicians' perceptions of admission and discharge factors. For outcomes, the researchers analyzed the status of participants, including functional and disability measures, after the hospital episode; the caregiver burden; and the costs of all services. Data were collected on 967 patients, from a pool of 1,502 potential participants. This project conducted a census-like collection of data that systematically defines this elderly population and its characteristics, needs, care trajectories, and the appropriateness of care received by this population. The study is particularly revealing about the proportion of hospital days (11.8 per cent) in which this population remained in acute care beds when an alternative level of care (ALC) would have been appropriate. The home care findings were also revealing: 29 per cent of the sample received some home care after discharge, and 54 per cent of those people had received some home care before admission.

(YT421) Adult Day Program

Recipient: Yukon Government

Contribution: $71,400

This pilot project provided a community-based day program to both people with physical impairments and people with cognitive impairments. The challenge was to meet the diverse needs of these different populations in the same program, as required by the budget of a small jurisdiction. Evaluation after one year indicated a high level of client satisfaction, including appreciation from family caregivers for the respite the day program offered them. The day program saved money by delaying institutionalization and decreasing the number of hours of home care provided to these clients. The report concluded that such a program can work; indeed, longer-term funding has subsequently been obtained to continue the program.