

**FEDERAL-PROVINCIAL-TERRITORIAL
ADVISORY COMMITTEE ON HEALTH SERVICES (ACHS)
WORKING GROUP ON CONTINUING CARE**

**The Identification and Analysis of Incentives
and Disincentives and Cost-Effectiveness of
Various Funding Approaches for Continuing Care**

**Technical Report 3: Case Study on the Hospital
and Home Care Interface**

May 2000



**Hollander
Analytical
Services**

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Prepared by:

Marcus J. Hollander, PhD

May 2000



**Hollander Analytical Services Ltd.
308 - 895 Fort Street
Victoria, BC, V8W 1H7**

**Tel: (250) 384-2776
Fax: (250) 389-0105
info@hollanderanalytical.com**

EXECUTIVE SUMMARY

This case study on the hospital and home care interface is composed of three “mini” case studies in three different sites across Canada. The first site, the Carelinks Program in the Simon Fraser Health Region in British Columbia, is an example of a specific, targeted program to facilitate the movement of clients from the hospital to home care. Specific funding was obtained to initiate this program. The second site was the Alberta East Central Regional Health Authority. Regional health authorities have hospitals and home care under one administration. Thus, while not a specific hospital to home care initiative, regional health authorities have the potential to move funds, and innovate, at the hospital and home care interface. The third site was the East York Community Care Access Centre in Toronto, Ontario. This site provided examples of innovative activities which can take place even in a more traditionally structured model of health care service delivery.

One of the unique features of **Carelinks**, and the philosophy which underlies it, is that Carelinks is designed to be a community “inreach” into the hospital. The model provides a more consistent approach to care because the community approach to care starts right in the hospital and carries on as clients are transferred to the community.

Carelinks was officially started in February of 1999 in the Eagle Ridge (ERH) and Royal Columbian Hospitals (RCH). However, the start of the program was not without incident. In order to establish Carelinks the region submitted a proposal to the BC Ministry of Health to borrow \$2 million to launch the program. In order to pay back the loan, a ward of 30 beds was closed at the RCH. In addition, a few social workers who had been doing discharge planning were let go. This created some tension and ill will which lingers to this day.

Carelinks staff and physicians noted that there did not always appear to be adequate resources in the community to care for the people discharged from the hospital. While the Carelinks client coordinators recognized the challenges of their positions and of fitting into a large pre-existing hospital system, they were generally positive about the progress being made.

Physicians were asked about how successful or unsuccessful Carelinks coordinators were in facilitating a smoother discharge from the hospital, ensuring better home support and reducing the length of stay. Responses were on a five point scale with the mid-point being neither successful or unsuccessful (about the same as before Carelinks). In terms of facilitating a smooth transition, initial findings were that 31 percent of physicians felt it was about the same while 64 percent thought that the coordinators were very or somewhat successful. Physicians who had daily or weekly contact with Carelinks had the highest proportion of scores of very successful (24 percent). With regard to the provision of better home health care support, 46 percent of physicians thought Carelinks had been very or somewhat successful and 43 percent thought things were about the same. The comparative proportions for achieving reductions in hospital stays were 47 percent and 42 percent respectively.

In terms of lessons learned from staff, the clear message was that the implementation of Carelinks was made more difficult by bed closures and job losses. It was also noted that while home care services often have to justify the cost-effectiveness of new initiatives, the same standard is generally not applied to other services such as hospitals.

It was felt that there had not been an adequate involvement of physicians from the beginning of Carelinks and there was a recognition of the key role physicians play in the care process. Furthermore, it was also noted that more services are needed particularly during evenings and weekends to handle the flow of clients discharged from the hospital. Finally, the point was made that hospitals have to take clients seven days per week and twenty-four hours per day and that home care needs to recognize this reality and try to factor it into their policies and practices.

East Central Health is a very rural area with a number of small villages and towns. There are no major urban centres or tertiary hospitals and the population is spread out over 38,000 square kilometers. There are 58 municipalities in the region and approximately 104,000 inhabitants. The rural nature of the region provides a number of challenges for delivering health care services that are generally not found in more urban environments. East Central Health has the “oldest” population profile in Alberta with around 14 percent of the population being aged 65 years or older compared to ten percent for Alberta as a whole.

Regionalization brought about significant changes in the health system. When regionalization was implemented 14 hospitals boards and three community health boards were disbanded and the positions of the 17 Chief Executive Officers of these organizations were terminated. Most administrative services such as materials management, payroll and human resources were centralized under the new regional administration. Hospitals were turned into Health Centres and, typically, a senior nurse was promoted to the position of Health Centre Administrator.

In 1995 when regionalization started, there were cuts to most components of the health system. However, since that time there has been a clear priority on strengthening home and community services. While hospital beds were reduced by about half, (from 624 in 1995 to 313 in 1999) and continuing care beds by about ten percent (from 902 to 819), home care received significant budget increases.

When asked why the different parts of the health system were able to work together some respondents noted that the severe cuts forced people to collaborate to increase the efficiency and effectiveness of health services. It was noted that in areas where there was less pressure, there had also been less collaboration. The role of the Board and the leadership it provided was also felt to be a key factor by all levels of staff. Home care seems to be working as an alternative to acute care and residential long term care in East Central Health. However, the work between hospitals and home care also served to reveal the next major need which is housing. Supported housing plus home care is seen to be a way by which the rate of institutionalization can be further reduced.

With regard to the perspectives of care coordinators and home care staff, they felt operations worked reasonably well during regular hours, Monday to Friday. However, care coordination was seen to be more of a challenge in the evenings and during weekends. For example, a client may be slated for discharge on Monday but actually be discharged on Saturday. In this situation, home care may not be notified in time or it may be difficult to connect with home care.

Care staff felt that a consulting physician located in home care would increase coordination between home care and physicians in the hospital. It was also noted that over time home care may need to become a seven days per week, 24 hours per day service. In addition, as some clients may try to use politicians and lawyers to obtain the care they think they need, there should be some way to provide support to home care staff in such circumstances as they feel under increased pressure.

The **East York Community Care Access Centre** serves the community of East York which has a population of approximately 107,000 people. It is one of six Community Care Access Centres (CCACs) in the Toronto area, and it serves a multi-cultural, multi-ethnic population. There is one hospital in East York, the Toronto East General Hospital, which has 340 inpatient beds and admits over 18,000 people per year. It serves an area which is larger than East York. Services in Ontario are organized in a somewhat traditional manner in which the Ministry of Health and Long-Term Care funds various sectors of the health system directly.

Staff of the East York Access Centre and the hospital work closely together. Access Centre staff work at the hospital seven days per week to enable clients to go home quickly from the emergency department and inpatient wards. Care coordinators work with hospital staff to develop a discharge plan for clients to go back home or to be placed in a long term care facility.

A key finding for East York was that in the absence of a more formally integrated system, such as regionalization, administrators and health care providers can still take the initiative to promote a more integrated and systems-oriented approach to care delivery. Such initiatives are, however, dependant on the individuals involved and their willingness to work together to ensure better care for the people they serve. There are generally few structural or financial incentives for collaboration, although there is an incentive regarding the quality of patient care. In fact, there are often disincentives for collaboration. This is illustrated in East York where the Access Centre has a fixed budget but there has been increasing pressure to take on more clients from the hospital.

In this environment, one method of integration is that of developing pilot projects on matters of mutual interest such as clinical pathways that continue across both sectors. One example of such clinical pathways is the Integrated Community Care Pathway for Transurethral Prostatectomy (TURP) Clients. This clinical pathway provides an integrated and system-wide approach across hospital care and home care. Another major initiative is a Cardiac Care Pathway that goes from the hospital to the community.

The nursing shortage which seems to have developed across Canada is starting to impact the ability of the Access Centre to meet its obligations as it is becoming increasingly difficult for home care agencies to recruit new nurses. This problem has been further compounded by the salary differentials between nurses in the hospital and those providing care in the community. Also, with the pressure to take on more clients, particularly from the hospital, the Access Centre and home care agencies have increasingly moved to providing care seven days per week and, at least on an on-call basis, 24 hours per day.

In East York, a number of steps have been taken to facilitate the hospital and home care interface. Formal mechanisms of communication have been established at the senior management levels. There is joint work on discharge planning and on the development of clinical pathways which span the hospital and home care continuum. There are other special programs which have been established such as a close working relationship between the oncology clinic in the hospital and home care such that some individuals who would otherwise have been admitted to the hospital can go directly to home care.

The main issue with regard to funding which emerged was the difficulty of transferring money between different components of the health system at the local level. One suggestion was to see if the Ministry of Health and Long-Term Care could develop some way of tracking costs on a full case cost basis and develop some mechanisms for re-allocating dollars based on the actual site(s) of service. Another point was that there did not appear to be any method of rewarding superior performance in the existing funding models. It was suggested that some form of envelope funding could be developed which could include hospitals, home care and other related areas. Having a funding envelope would facilitate the transfer of resources between sectors because there would be one overall budget instead of several different budgets. It was also noted that there should be incentives for the development of more broadly based and integrated information systems and for the incorporation of new technologies into clinical practice.

Envelope funding was also suggested at the micro-level so that care providers could best match the needs of clients with the resources available. This is harder to do with current policies on maximum hours of care and care eligibility (e.g., one can only get subsidized equipment if one is formally on the home care program). It was also suggested that there could be additional funding targeted to post-hospital discharge clients to facilitate the movement of clients from hospitals to home care. Currently, CCACs have fixed budgets and have no financial incentive to admit such clients.

In terms of **lessons learned** from the three mini-case studies, the following points appear to be key elements in developing a more integrated continuum of care between hospitals and home care:

- The Board and senior management should exhibit vision, leadership and commitment to the initiative. This is probably a critical success factor.
- There should be some degree of separation in how funds are shifted between hospitals and home care. If the transfer is too direct and people lose jobs as part of the transfer there may be ill will that can linger for a long time.
- Transitional beds may be a useful component of a hospital and home care initiative because they allow people to recover to the point where they can go home instead of to a long term care facility.

- Developing initiatives on a direct cost recovery basis may cause some problems. It is also a questionable option in that other sectors of the health system, such as hospitals, generally do not have to justify new investments.
- Services are connected in an overall system of health care. Thus, one should consider whether proposed changes to acute care services may have a negative effect on continuing care services before such changes are implemented.
- Effective discharge planning is a key to the effective transfer of clients from the hospital to continuing care services.
- Finally, it is a good idea to involve physicians actively and from the beginning of an initiative. They have a great deal of influence about how and when clients can move from the hospital back to their homes. There may also be some benefit to a greater involvement of physicians in home care.

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1. INTRODUCTION

In order to bring a more concerted policy focus to continuing care, the Federal/Provincial/Territorial (F/P/T) Ministers of Health set future priorities for work related to “supporting high quality integrated acute, continuing and community-based health services” at their meeting in September 1998. As a response to these priorities, a work plan was developed by the F/P/T Working Group on Continuing Care (WGCC) which included this project on financial incentives and disincentives within the continuing care sector. The WGCC workplan was approved by the F/P/T Advisory Committee on Health Services (ACHS) in November 1998. A competitive bidding process was established for the conduct of the project. The project was launched in September 1999 and project activities were overseen by a Project Advisory Committee (PAC) made up of members of the WGCC.

As noted in the Request for Proposal, the specific goals or purposes of this project were as follows:

- Document the current situation with respect to continuing care budgets, client coverage/entitlements, and the public/private mix;
- Identify intended and unintended incentives and disincentives both within continuing care and operating elsewhere in the health system but impacting on continuing care services, and analyze the effects of these incentives/disincentives on actual service delivery and cost-effectiveness; and
- Produce selected case studies which compare, for example, different funding approaches relative to similar clusters of services, or different coverage/entitlements and service mix for certain client groups (e.g., elderly, clients with complex needs), or the cost-effectiveness of care in hospitals versus the community.

With regard to the third goal noted above, case studies were conducted for this project on the public/private mix, funding mechanisms to facilitate the hospital and home care interface, and decision making processes related to allocating continuing care resources, under constraints, in different models of service delivery.

This report presents the findings of the case study on the hospital and home care interface. The case study is compared of three “mini” case studies. One is on a specific, funded initiative to assist in the transition of clients from hospitals to home care. One is an analysis of the hospital and home care interface in a regional health care system, and one is an analysis of this interface in a more traditional model of services delivery.

2. THE CARELINKS INITIATIVE OF THE SIMON FRASER HEALTH REGION IN BRITISH COLUMBIA

2.1 Introduction and Context

The Simon Fraser Health Region was developed during the period 1993 to 1997. The full transfer of funding to regions occurred in the 1997/98 fiscal year. The Simon Fraser Health Region has a mix of urban, suburban and rural areas and its western boundary is at the border with the City of Vancouver. It includes: the city of New Westminster, the original capital of British Columbia; two relatively suburban areas, Burnaby and Coquitlam; and a somewhat rural area called Pitt Meadows. The major hospital in the region is the Royal Columbian Hospital (RCH). It is a non-teaching tertiary hospital which usually operates at, or above, capacity. The Burnaby Hospital (BH) is located in Burnaby and the Eagle Ridge Hospital (ERH) is located in Coquitlam. They are both community hospitals in built up suburban areas. The Ridge Meadows Hospital (RMH) serves a more rural area but one that is experiencing ongoing growth and expansion.

With the advent of regionalization, there was more opportunity, and more of an impetus, to try to streamline care. Most of the hospitals operated at capacity and it was noted that there were a number of long stay clients in hospitals who could be cared for in the community or in residential facilities. These clients are referred to as Alternative Level of Care (ALC) clients.

Two significant initiatives were undertaken at the Eagle Ridge Hospital to try to move ALC clients out of the hospital. One was a pilot project entitled the Acute Bridging Care (ABC) program and the other was an audit of ALC clients at the Royal Columbian Hospital to determine whether or not there were other options for their care.

The ABC program is best understood as the predecessor of, and model for, the Carelinks program. Its objectives were to:

- Provide an alternative to hospitalization by initiating immediate, short term intensive support services for those people who have a medical/health problem that could be safely managed at home;
- Facilitate the timely discharge of patients from acute care once they no longer require acute care hospitalization . . . by supporting “at home” convalescence; and
- Facilitate attitude and practice shifts within the health care community.

2.2 The Carelinks Initiative

While the early development of Carelinks focussed on moving ALC clients from hospitals back into the community, the full Carelinks program has a number of components. As noted, Carelinks client coordinators work inside the hospital to facilitate the discharge of clients to their homes or other appropriate sites such as long term care facilities.

Another program called the Prevention and Early Discharge Program (PED) is also considered to be under Carelinks. PED coordinators facilitate the transfer of clients who live in long term care facilities between these facilities and the hospital. That is, they work to ensure a smooth transfer from the facility to the hospital and an efficient discharge from the hospital back to the facility.

Carelinks client coordinators are also located in the emergency departments to work at re-directing clients who would otherwise be admitted to the hospital back to their homes where they may receive additional supports to assist them until they recover. This is similar to a Quick Response Team model of care.

Carelinks was officially started in February of 1999 in the Eagle Ridge and Royal Columbian Hospitals. However, the start of the program was not without incident. In order to establish Carelinks the region submitted a proposal to the Ministry of Health to borrow \$2 million to launch the program. In order to pay back the loan at the RCH a ward of 30 beds was closed. In addition, a few Social Workers who had been doing discharge planning were also let go. This created some tension and ill will which lingers to this day. Given the turmoil at RCH about bed closures and layoffs, the ERH Carelinks program was started without bed closures. The estimated savings from RCH appeared to be adequate to cover the operation of Carelinks at ERH as well.

One of the unique features of Carelinks, and the philosophy which underlies it, is that unlike the earlier ABC program and other programs which are seen as a form of hospital outreach into the community, Carelinks is designed to be a community “**inreach**” into the hospital. This again may cause some tensions with hospital staff and administrators as they are used to having control over “what goes on in the hospital.” However, the model provides a more consistent approach to care because the community approach to care starts right in the hospital and carries on as clients are transferred to the community.

Another aspect which is important both philosophically and conceptually is that the administrators of Carelinks see it not as a type of program which is separate and distinct but, rather, as an organizational process redesign within an integrated continuum of care services.

It is important to distinguish the role of the client coordinators from more traditional discharge planners. The role of the Carelinks client coordinators brings together the role of the hospital liaison nurse, and the role of Social Worker in liaising with continuing care case managers, and adds responsibility for any unallocated activities not covered by the liaison nurse or social worker. It also includes assessment for short term home support and any other activities related to the transfer of clients from hospital. Thus, Carelinks has expanded the pre-existing case management model to include short stay clients as well as long term clients. It is an inclusive service model which is based on client risks and needs. Social Workers still maintain their counselling role in the hospital. Clients are admitted through a single intake process using the care coordinators and care is facilitated to a variety of targets including the home, facility, adult day care centre and convalescent care in specially designated units. These convalescent beds have gained increasing importance as a way to

move clients out of acute care beds and as a way for clients to spend the time to recover so that they can go home, rather than to a long term care facility.

2.3 Outcomes and Lessons Learned¹

2.3.1 General Outcomes

Given the innovative nature of the Carelinks program funding was applied for and received from the Health Transition Fund, Health Canada to conduct a comprehensive evaluation of Carelinks. This evaluation is being conducted by KPMG. It is ongoing and will be completed by the early fall. While one must await the final results of the evaluation, it is possible to report a few initial and preliminary findings as part of this case study. (We thank the Health Transition Fund, KPMG and the Simon Fraser Health Region for allowing us to present some preliminary results in this case study). This section will note the views of management about outcomes, some relevant data from the ABC project about potential cost savings, and some findings from interviews with care staff and surveys of clients and physicians.

Management staff note that there has been a reduction in the number of Alternative Level of Care (ALC) days in hospital. For example at ERH a 28 bed ward which regularly had 6 to 8 ALC clients before Carelinks has about 2 ALC clients after Carelinks. Emergency room overflows, while always variable, were reduced to almost none, at one point, after Carelinks. It must, however, be recognized that these are anecdotal reports. The issue of ALC days and patterns of emergency room admissions will be addressed in the larger evaluation.

There are some positive results from the evaluation of the ABC program which indicate that that initiative was relatively successful. Whether these results have carried over to Carelinks itself remains to be seen but given the similarity of the programs one can have some sense of what may be achieved with Carelinks.

The ABC program at ERH was in place from August 5, 1997 to December 5, 1997. It was a pilot project which included 105 clients. The average age of clients was 73.4 years and one third were males and two-thirds were females. Comparing lengths of stay, by case mix, it was found that there was a reduction of 3.81 days after the ABC program was initiated. This resulted in an estimated annual reduction in the length of stay for ABC type clients of 2.98 days. Extrapolated to the RCH it was found that the savings in bed days would allow for the closure of 25 beds. The ABC program also showed a small reduction in the length of stay in the emergency room. Given the pressure on beds, the ERH hospital also had “flex” beds which could be opened or closed based on demand. While for the August 5 to December 5, 1996 period flex beds were used 50.5 percent of this time, a year later under the ABC program, from August 5 to December 5, 1997, they were only used ten percent of the time.

¹ This case study is based on formal interviews with two senior managers, discussions with a wide range of staff and managers and the results of a larger evaluation. Written materials were also reviewed.

Client and physician surveys were conducted which revealed satisfaction for both groups with the ABC program. Hospital nursing staff and the care coordinators believed that the ABC program had resulted in positive effects on attitudes and outcomes. Social workers, who traditionally did discharge planning, felt that the program resulted in a less streamlined approach and recommended that they be given more resources to expedite the discharge process.

The findings of the audit of the 39 ALC clients were that:

- Approximately 1/3 could be returned home with a variety of community services;
- Approximately 1/3 could have an accelerated return to facility; and
- Approximately 1/3 required bed placement in long term care, rehabilitation or convalescent beds.

Based on the findings of the ABC program and the audit, a proposal was developed for a larger, ongoing initiative to be called Carelinks.

In terms of finances, the following constitutes a short version of the financial justification for the Carelinks project based on estimates derived from the ABC program.

Additional Resources for Coordinators and Enhanced Community Services		\$1.5 million
Bed closures	(30 beds at RCH) @ \$60,000/bed (10 beds at ERH) @ \$60,000/bed	\$1.8 million \$0.6 million
Reduction of Acute Care Social Workers	(RCH, 3 @ \$60,000) (ERH 2 @ \$60,000)	\$0.18 million \$0.12 million
Total Savings		\$2.7 million
Net Savings		\$1.2 million

Similar estimates were developed for the Burnaby and Ridge Meadows hospitals. As noted earlier, given the significant disruption caused by the layoffs of social workers at RCH, Carelinks was adopted at ERH without bed closures. As can be seen, the added expense of \$720,000 for not closing beds or reducing staff still allowed for an estimated annual saving of half a million dollars for both hospitals.

The closure of beds and laying off of social workers has caused tensions which remain to this day. Nevertheless, it appears that the Carelinks program is now well entrenched at ERH and RCH. Due to the pressure on hospitals in the winter of 1999, the Ministry of Health provided some

additional funding to the region so that similar problems could be avoided or mitigated in the future. The decision has been made to use some of these funds to start Carelinks at the Burnaby and Ridge Meadows Hospitals.

In terms of the preliminary results of the evaluation of Carelinks, it was found that staff felt that Carelinks worked best where there was a head nurse or team leader who could liaise with the care coordinators (these positions were eliminated for most wards at the RCH). While staff did not perceive that Carelinks reduced admissions to emergency they did feel that they were able to divert clients, who may have otherwise been admitted to hospitals, back to their homes. In terms of reducing ALC clients staff felt that there was some limited success at RCH which is large and complex. They felt that there was more success at ERH.

Carelinks staff and physicians noted that there did not always appear to be adequate resources in the community to care for the people discharged from the hospital. While the Carelinks client coordinators recognized the challenges of their positions and of fitting into a larger pre-existing hospital system, they were generally positive about the progress being made. Social workers, as in the ABC evaluation, still seemed to retain some reservations and a belief that they plus the liaison nurses were able to do as good, or better, a job than the Carelinks staff.

In terms of client perceptions, preliminary data from a small set of clients per group were available from the larger evaluation. The groups are Carelinks clients at ERH, Carelinks clients at RCH who live in the Simon Fraser Health Region, Carelinks clients who were seen at the RCH but do not live in the health region, and clients who passed the Carelinks screen for eligibility but were not Carelinks clients at Burnaby Hospital and Ridge Meadows Hospital. When clients were asked if they felt that they had been discharged too soon, a higher percentage of Carelinks clients answered yes (23 % to 33%) compared to BH (22%) and RMH (5%). This may mean that the client coordinators are able to move people out of the hospital faster but that clients may perceive that they should have stayed in hospital longer. Clients were asked if someone at the hospital arranged for their care before they left the hospital. The highest percentage of yes scores were at ERH and BH (76%) and the lowest was at RMH (38%). Finally, clients were asked to rate the quality of the coordination between the hospital and home care. The scores were quite positive across all hospitals. Thus, the results on client perceptions at this early stage are somewhat mixed between Carelinks and more traditional approaches. One must wait for the full results of the survey before one can draw any significant conclusions.

Physicians were also surveyed about their perceptions of Carelinks. Some 99 of 256 surveys were returned (a list of physicians who were believed to have some relation to Carelinks served as the universe for the sample). Physicians were asked about how successful or unsuccessful Carelinks coordinators were in facilitating a smoother discharge from the hospital, ensuring better home support and reducing the length of stay. Responses were on a five point scale with the mid point being neither successful or unsuccessful (about the same as before Carelinks). In terms of facilitating a smooth transition some 31 percent felt it was about the same while 64 percent thought that the coordinators were very or somewhat successful. Physicians who had daily or weekly contact with Carelinks had the highest proportion of scores of very successful (24 percent). With regard to the

provision of better home health care support 46 percent thought Carelinks had been very or somewhat successful and 43 percent thought things were about the same. The comparative proportions for achieving reductions in hospital stays were 47 percent and 42 percent.

When asked about the degree of coordination of care services before and after Carelinks, 44 percent said services were more coordinated and 4 percent said they were less coordinated. Finally, when asked to rate how easy it is to access client coordinators on a ten point scale from not very easy to easy the mean score was 6.24. However, 63% of physicians who worked with Carelinks on a daily or weekly basis scored in the range of 8 to 10 while this was only so for 8 percent of physicians who dealt with Carelinks less than once per month.

2.3.2 Lessons Learned

In terms of lessons learned the clear message was that the implementation of Carelinks was made more difficult by bed closures and job loss. It was also noted that while home care services often have to justify the cost-effectiveness of new initiatives, the same standard is generally not applied to other services such as hospitals. There should be a different way of funding home care services to avoid issues of job loss and paybacks.

It was also felt that there had not been an adequate involvement of physicians from the beginning of Carelinks and there was a recognition of the key role physicians play in the care process. Furthermore, it was also noted that more services are needed particularly during evenings and weekends to handle the flow of clients discharged from the hospital. Finally, the point was made that hospitals have to take clients seven days per week and twenty-four hours per day and that home care needs to recognize this reality and try to factor it into their policies and practices.

2.4 **Key Policy Issues**

2.4.1 Facilitating the Hospital and Home Care Interface

With regards to care providers it was noted that it would be helpful to foster mechanisms for people to work together and improve collaboration. Increased knowledge of roles and responsibilities and enhanced communication were also thought to be useful. With regard to the overall system, goals to work on included a greater understanding of the continuum of care by all staff, increased accessibility to a range of care alternatives, improved linkages with community agencies and identification and resolution of system barriers.

With regard to the ERH, there were no ward closures. This took off the pressure and led to a relatively smooth implementation of Carelinks. Also, there are some team leaders or head nurses on the wards at ERH and there is a sense that care coordination is improved if these persons are in place.

2.4.2 Impact of User Fees

The major issue about user fees had to do with the cost of drugs and dressings which are free in the hospital but which generally require some degree of co-payment in the community. This is particularly an issue for palliative care clients and those who need expensive drugs. As is the case in some other jurisdictions, informal arrangements may be made to provide expensive drugs or dressings through the hospital for people who leave to go home and would face a financial hardship. In addition, under certain circumstances Carelinks may also pay for such items.

2.4.3 Perceptions of What Hospitals and Home Care can do to Work More Closely Together

It was noted that it is important to continue to work to identify and overcome system barriers. At RCH some consideration could be given to re-instituting a team leader or head nurse on wards. This is an example of what one respondent said hospitals should do and that is to look at their own policies and procedures and to see what they can do to facilitate more seamless care for clients. It was also noted that individuals and groups could be less territorial.

With regard to home care, it was stressed that it is important for home care to recognize that hospitals are continuously open and are required to admit clients at all times. In the past home care staff believed that they were not an emergency service and only needed to operate during regular working hours. Staff need to recognize that the trend is to evening and weekend work. Thus, service hours can be expanded and responsiveness to client needs can be improved. Home care needs to adjust to an integrated model of care delivery which operates seven days per week and 24 hours per day.

2.4.4 Suggestions for Funding Options to Enhance the Hospital and Home Care Interface

It was noted that the transfer of resources from the hospital to home care may have been too direct at the RCH. One group of staff lost jobs and new people who did somewhat similar work were hired. One of the respondents noted that it was easier when decisions were made at the provincial level because they were more removed (and everyone could band together and blame the Ministry of Health). At a regional level, it may be preferable to find a more indirect way of transferring resources between program components.

It was also noted that additional funding from Health Canada would be helpful if some form of national home care program is developed. This may mitigate problems related to resource transfers based on cost recovery models such as the one used for Carelinks. There also needs to be a recognition that home care clients are much sicker than they used to be and resources should reflect this shift in the care needs of clients. Finally, it was noted that home care is still vulnerable due to the pressure for increased resource use in acute care and that there should be specific targeted funding for home care services nationally, provincially, and, perhaps, regionally.

3. THE ALBERTA EAST CENTRAL REGIONAL HEALTH AUTHORITY

3.1 Introduction and Context

The East Central Health Region (call East Central Health) was established on June 24, 1994 under the *Regional Health Authority Act*. Members of the Board were, and still are, appointed by the Minister of Health. The Board was mandated to take the necessary steps to prepare for regionalization which was implemented on April 1, 1995.

East Central Health is a very rural area with a number of small villages and towns. There are no major urban centres or tertiary hospitals and the population is spread out over some 38,000 square kilometers. There are 58 municipalities in the region and some 104,000 inhabitants. The rural nature of the region provides a number of challenges for delivering health care services which are generally not found in more urban environments. East Central Health has the “oldest” population profile in Alberta with some 14 percent of the population being aged 65 years or older compared to ten percent for Alberta as a whole.

Geographically, the northern part of East Central Health starts a bit to the east of Edmonton and goes to the Saskatchewan border. The southern part starts somewhat east of Red Deer and goes to the Saskatchewan border. The major communities are Camrose in the north west part of the region, Stettler in the south west and Lloydminster in the north east of the region.

Regionalization brought about significant changes in the health system. When regionalization was implemented some 14 hospital boards and three community health boards were disbanded and the positions of the 17 Chief Executive Officers of these organizations were terminated. Most administrative services such as materials management, payroll and human resources were centralized under the new regional administration. Hospitals were turned into Health Centres and, typically, a senior nurse was promoted to the position of Health Centre Administrator.

There were numerous small hospitals across the region, many with fairly low occupancy rates. Given the rural nature of the region people felt that they wanted health services that could be fairly easily accessed. Thus, these hospitals were built by Alberta Health to accommodate the needs of a rural population. The hospitals were small and often included long term care facility beds.

While there was some variation, some areas such as Camrose had developed close working relationships between hospitals and home care services even before regionalization. For example, a shared discharge planning position was established that was jointly funded by the hospital and home care before regionalization came into place. In the case of Camrose, the relationship was between Saint Mary’s hospital and the home care service. Saint Mary’s is what is referred to as an “affiliate partner.” These are health services, typically run by religious or charitable organizations, which have been allowed to remain independent. They have their own Boards and administrators and are funded by the health region through contractual arrangements.

As noted, while there were differences across the region, home care was a well established program prior to 1995. It has continued to be a highly valued part of the health system. Over time various champions of home and community based care have appeared in the region. For example, the first Board chair, and another Board member came from the former community health boards and were familiar with the benefits of home and community based services. In addition, East Central Health took very seriously the policy framework provided by Alberta Health to place a priority on the delivery of home and community services.

The early days of regionalization were difficult. The initial hospital bed targets set for regions were challenging. Again, East Central Health took these challenges seriously and, as shall be seen in the next section, made major cuts in services, while still enhancing home care services. As will be seen, the story in East Central Health is, overall, a positive one in which challenges were met, adversity was overcome and the development of a new road to a more integrated health system was started. It must be noted, however, that there is no guarantee of positive results from implementing a regional model. A neighbouring health region which was very similar to East Central Health did not make the hard cuts and did not integrate services. Their deficits grew and their response was to ask for more money. The result was that the CEO was dismissed, the Board was disbanded and a public administrator was put into place until a new Board could be appointed. Eventually, some additional funding was provided to all regions by Alberta Health.

3.2 Outcomes and Lessons Learned²

3.2.1 General Outcomes

Conducting a comprehensive outcome evaluation was beyond the scope of this project. However, there are a number of findings which are related to the hospital and home care interface. Perhaps first and foremost is the commitment of the Board and senior management to developing more integrated health services. In terms of the development of home care and its integration with hospital services and long term residential services, senior management is of the view that there is a high level of integration in some areas. Overall, throughout the region, it is felt that they are at about 75% of where they would like to be. However, they also want to go further and integrate all hospital, home care, residential care and public health services and perhaps apply the single entry, care coordination model from continuing care to the whole health system. The management team is currently being strengthened in order to achieve, over time, a fully integrated health system.

One of the notable points made was that home care has clearly had ongoing support. Staff at all levels gave credit to the leadership of the Board of Directors for focussing on home care. The Board and the current CEO have placed a priority on meeting the “un-met need” for home and community services. They have worked to separate clinical and fiscal concerns at the front lines. Case managers have the latitude to meet the needs of clients, within a given fiscal framework, but

² This case study is based on interviews with three senior managers, three care staff and three clients and their informal caregivers. Written materials were also reviewed.

the framework can be exceeded, if required, and management will find ways to free up the money required to ensure people get the service they need. Thus, case managers are protected from acting as “fiscal policemen.”

In 1995 when regionalization started, there were cuts to most components of the health system. However, since that time there has been a clear priority on strengthening home and community services. While hospital beds were reduced by about half, (from 624 in 1995 to 313 in 1999) and continuing care beds by about ten percent (from 902 to 819), home care received budget increases. However, it must be noted that there was considerable spare capacity in the hospital sector and some spare capacity in long term care facilities. Thus, it is more appropriate to compare changes in budgets rather than in bed capacity or service utilization. The following indicates that home care has had considerable support over the past several years.

Year	Increase/Decrease in Home Care Budgets (%)	Increase/Decrease in LTC facility Budgets (%)	Increase/Decrease in Hospital Budgets (%)
1996	-10.10	5.66	-3.43
1997	40.59	1.39	-6.00
1998	19.56	6.12	2.31
1999	5.65	4.22	4.29
2000	13.73	3.33	4.67

Changes in budget allocations have meant an increase in the community and home care budget from \$6.952 million in 1995 to \$12.584 million in 2000 or from 5.7% to 9.8% of the total budget for the region. The acute care budget has remained relatively flat at about \$32 million while the long term care facility budget has gone from \$29m to \$36m from 1995 to 2000. The costs of administration has gone down from 4.7% to 4.6% during this same period.

During the 1995 to 2000 period there have been reductions in the overall length of stay in hospitals and a reduction in the proportion of Alternate Level of Care (ALC) days in hospitals. The average wait for a long term care bed is six weeks. Some of these achievements may be related to the fact that home care expanded its services to evenings and weekends since the advent of regionalization.

3.2.2 The Client Perspective

Three clients and their informal caregivers were interviewed as part of this case study. One is always reminded of the hardships clients face on a daily basis and of the strength, courage and perseverance of informal caregivers when one directly interviews clients and family members. In general, clients had felt the negative effects of cuts in the hospital sector. One client in his mid-80s who had been quite healthy was reported to have been denied access to an MRI in Edmonton when he had a stroke because this service was, by policy, restricted to those 79 years of age or younger. The same client was under consideration for placement into a long term care facility while in hospital

but his wife insisted on continuing rehabilitation until he could walk up and down stairs so that she could take him home. It may be that the spare capacity in the hospital made his extended stay possible. The client and his wife were happy with the home care they received and generally received service from the same person. They were less satisfied with their respite care because there was constantly a different worker who came to provide this service.

Another issue is that it is sometimes difficult to provide a full range of home care services for people living on their farms. Thus, people have often gone to long term care facilities once their care needs have become more severe. This happened to one of the other clients interviewed. He went into the hospital and, given his care needs, he was eventually placed in a long term care facility. He did not do well in the facility. He was lonely, felt he had been abandoned, could not sleep and had trouble eating because the food was too bland. He lost weight and described his stay there as a “visit to hell.” His wife finally rented a place to live in one of the larger communities, moved from the farm and took her husband out of the facility. They were able to get the home care they needed right away and the staff in the facility were able to coordinate with the home care staff to allow for a fairly smooth transition. The husband’s health has improved somewhat since he started on home care.

The third client had severe arthritis and still lived on the farm. However, she had to come into town fairly regularly for care in the health centre and hospital and found each trip very tiring. She had complex needs and in the past had been able to stay in the hospital to get care and had her needs attended to, however, with the cut backs in hospital services this was no longer possible.

3.2.3 Lessons Learned

When asked why the different parts of the health system were able to work together some respondents noted that the severe cuts forced people to work together to increase the efficiency and effectiveness of health services. It was noted that in areas where there was less pressure there had also been less collaboration. The role of the Board and the leadership it provided was also felt to be a key factor by all levels of staff. Home care seems to be working as an alternative to acute care and residential long term care in East Central Health. However, work with home care has also served to reveal the next major need which is housing. Supported housing plus home care is seen to be a way by which the rate of institutionalization can be further reduced.

Management made efforts to encourage people from home care and institutional care to work together by, for example, encouraging joint meetings and by other means of bringing people together. Home care services have been encouraged to adopt the same care model across the region. Standardized policies, principles and practice guidelines have also been developed.

The people interviewed took pains to point out all of the things which still needed to be done to improve the system. One of the key areas noted was the further development of partnerships between hospitals, facilities, home care, and physicians. It was recognized that physicians play a key role in moving clients through the system and in providing care. It was felt that more work needed to be done with physicians to develop ongoing partnerships and closer working relationships.

3.3 Key Policy Issues

3.3.1 Facilitating the Hospital and Home Care Interface

It was recognized by respondents at all levels of the system that more could still be done to facilitate the smooth transition of clients from hospitals to home care. Management stated it was addressing this issue, and the larger issue of overall service coordination, by strengthening the management team to provide leadership in this area. While it was felt that coordination may be fairly good within a community, it was noted that further improvements could be made when clients go to a hospital in another community, or region, and then come back home. Home care may not always be notified that clients have been sent back home. It was also felt that better information systems were required to give all parts of the health system access to the client record as the client moved through the system.

With regard to case coordinators and home care staff, they felt things worked reasonably well during regular hours, Monday to Friday. However, care coordination was seen to be more of a challenge in the evenings and during weekends. For example, a client may be slated for discharge on Monday but actually be discharged on Saturday. In this situation, home care may not be notified in time or it may be difficult to connect with home care.

3.3.2 Impact of User Fees

It was noted by respondents at all levels of the organization that there were certain structural disincentives to discharging clients. First and foremost was the fact that clients would have to pay at least a portion of the costs of drugs, dressings and assistive devices. Where this is found to be a hardship, hospitals may provide a supply of needed resources at discharge or find a way to continue to pay for needed drugs and other items even after the client has left the hospital.

It was also pointed out that clients now have to pay for services such as house cleaning, snow removal, mowing the grass and other such services which are necessary for maintaining clients in the community and which were provided by home care in the past. An interesting finding was that even if people had the money they sometimes refused to pay because they felt such services should be part of medicare. Another issue was that some three years ago a policy change was made to provide seniors with generic drugs. This confused some seniors because the scientific names were used on the labels and seniors were not sure of what drug they had been prescribed.

3.3.3 Perceptions of What Hospitals and Home Care can do to Work More Closely Together

It was felt that coordination could be improved by building better partnerships between home care and physicians working in hospitals. Also, new services such as quick response teams were seen as vehicles to further enhance coordination. As noted earlier, there was also a commitment by the Board and senior management to enhance overall coordination of the health system as a key policy priority. There was also an expressed need for a single client record. The development of clinical

pathways that start in the hospital but continue on into home care was seen as another vehicle for enhanced coordination as were standardized teaching packages and shared care plans.

Care staff felt that a consulting physician located in home care would increase coordination between home care and physicians in the hospital. It was also noted that over time home care may become a seven days per week, 24 hours per day service. It was noted that there is more pressure on staff as clients may try to use politicians and lawyers to obtain the care they think they need. There should be some way to provide support to home care staff in such circumstances.

3.3.4 Suggestions for Funding Options to Enhance the Hospital and Home Care Interface

It was noted that some legislated staffing levels in Alberta may not be required in all circumstances and that it may be better to try to meet real needs with required resources. For example, in a rural area like East Central Health there may be small facilities which are now required to be staffed at the level of a facility with twice the number of beds. It was also noted that there is still a focus in legislation, policy and practice in providing consistent services (the same for everyone) rather than adopting more innovative approaches which may improve the efficiency and effectiveness of care. Subacute or transitional care beds were seen to be potentially useful as a means to better rehabilitate clients and prepare for their return home, rather than sending them to a long term care facility.

The care staff had some innovative solutions for improving home care services. They felt that case coordination could be enhanced by establishing a consulting physician position in home care. They also noted that physicians are asked to provide input and advice on care and that they should be compensated for telephone calls, consultations and other care planning activities in regard to home care clients. It was also noted that care, particularly in the evenings and on weekends, could be greatly assisted if physicians were encouraged through funding and other means to do more house calls. This would also allow the physician to better appreciate the context in which the client lives and how this may impact on the client's health and care requirements.

4. THE EAST YORK COMMUNITY CARE ACCESS CENTRE

4.1 Introduction and Context

Services in Ontario are organized in a more traditional manner in which the Ministry of Health and Long-Term Care funds various sectors of the health system directly. This case study focuses on the hospital and home care interface in a system in which there are ostensibly no formal structural linkages between hospitals and home care. It was interesting to find that in the absence of formal, structural arrangements a number of informal and voluntary initiatives had been developed at the local level to facilitate the hospital and home care interface.

The East York Access Centre serves the community of East York which has a population of some 107,000 people. It is one of six Community Care Access Centres (CCACs) in the Toronto area,

the other five are Toronto, Etobicoke, York, North York, and Scarborough. East York is one of the smaller regions and is located in the eastern part of Toronto between Toronto and North York. Its eastern boundary is with Scarborough and it includes the Don Valley area of Toronto. There are 43 Community Care Access Centres (CCACs) in Ontario.

The mission of the East York Access Centre is to support residents of all ages living in East York and their caregivers at home and in the community by:

- Providing information about and access to individualized, community-based health and support services;
- Coordinating and monitoring the provision of these services; and
- Arranging admission for persons requiring residence in a long term care facility

The above services may be provided by home care programs in other jurisdictions.

The Access Centre was established on September 15, 1997 and moved to its current quarters on April 27, 1998. It serves a multi-cultural, multi-ethnic population of generally working class individuals, with some 24 percent of the population having low incomes. The 1996 census indicated that 15.4 percent of the population of East York was elderly compared to 13.8 percent for Metro Toronto. The proportion of people aged 85 years or older is more than double the average of the other Toronto CCACs and in some communities within East York the population of seniors exceeds 20 percent.

There is one hospital in East York, the Toronto East General Hospital. This regional, acute care general hospital which was opened in 1929, has 340 inpatient beds and admits over 18,000 people per year. It serves an area which is larger than East York and has half a million people in its primary and secondary catchment areas, of which some 40 percent are immigrants. The hospital has over 1,837 employees and some 400 medical doctors on staff. It has three service delivery units (emergency services, diagnostic imaging/laboratory medicine, and operative services) and provides seven major health services:

- Adult and elder care
- Muskuloskeletal
- Surgery/Gynaecology
- Maternal/Newborn/Child
- Mental Health
- Cardiorespiratory
- Gastrointestinal/Urology/Nephrology

Staff of the East York Access Centre and the hospital work closely together. Access Centre staff work at the hospital seven days per week to enable clients to go home quickly from the emergency department and in-patient wards. Care coordinators work with hospital staff to develop a discharge plan for clients to go back home or to be placed in a long term care facility.

A number of initiatives have been undertaken to enhance service coordination. The Toronto East General Hospital and community partners developed an initiative called “Partners for Health” in the mid 1990s when the Ontario Ministry of Health and Long-Term Care was supporting the development of integrated health delivery systems. Partners for Health has served as an umbrella vehicle for facilitating coordination between the hospital and community services and for launching research and demonstration projects. There is also a CCAC council made up of the Chairs of the Boards and Directors, and Executive Directors, of the six Toronto CCACs. The CEO of the East York Access Centre also sits on various hospital and hospital/community committees. These coordinating mechanisms have been developed at the front lines to try to bring about a more integrated system of care.

4.2 Outcomes and Lessons Learned³

4.2.1 General Outcomes

A key finding for East York was that in the absence of a more formally integrated system, such as regionalization, administrators and health care providers can still take the initiative to promote a more integrated and systems oriented approach to care delivery. Such initiatives are, however, dependant on the individuals involved and their willingness to work together to ensure better care for the people they serve. There are generally few structural or financial incentives for collaboration, although there is an incentive regarding the quality of patient care. In fact, the opposite is often true. This is illustrated in East York where the Access Centre has a fixed budget but there has been increasing pressure to take on more clients from the hospital. The numbers of referrals to the Access Centre from the emergency department doubled between 1998 and 1999 but there was no commensurate increase in funding to the Access Centre.

This issue of funding was noted by respondents from the hospital and the Access Centre. Services are funded on a service by service basis from the Ministry of Health and Long-Term Care. Thus, while there is potential for greater integration at the Ministry level, there are no local structures through which funds can be re-allocated across sectors at the community level. In addition, funding is provided in blocks and it would be difficult for Ministry staff to address the number of small local adjustments which could be requested from the CCACs across Ontario. The approach has been to fund sectors on some form of population based planning and resource allocation basis to ensure that each sector is adequately funded.

Another aspect of integration is that of developing pilot projects that span the hospital and home care continuum. While there are a number of initiatives in place in East York, two are worthy of particular mention. One way to better integrate care between the hospital and home care is to develop clinical pathways that continue across both sectors. Care can start in the hospital and continue on into the community, or in the community and continue on into the hospital. One example

³ This case study is based on interviews with two senior executives and three staff from the East York Access Centre and three senior executives from the hospital.

of such clinical pathways is the Integrated Community Care Pathway for Transurethral Prostatectomy (TURP) Clients. This clinical pathway provides an integrated and system-wide approach across hospital care and home care. The goal of the project is to implement a client focussed and population based community pathway that integrates care across hospitals and home care. The success of the project will be measured in terms of:

- Improved quality of life for clients and families;
- Gains in clinical efficiencies, including reductions in length of stay in hospital;
- Gains in the cost-effectiveness of care for TURP clients; and
- Enhanced collaboration between home care and the community hospital.

Another major initiative is an evaluation of the costs and outcomes of a hospital and home care Cardiac Care Pathway. A clinical working group with representation from all major sectors and disciplines, led by a cardiologist, spent over three months to develop a “community pathway” for cardiac patients. The evaluation of this pathway is being conducted as part of a one year randomized clinical trial in which clients are assigned to usual care or to a program in which they will be eligible to receive six home care visits from a cardiac trained nurse. The home care protocol includes a comprehensive in-home assessment, medication instruction and assessment of compliance, written and safety instructions, community referrals, necessary lab work, and referrals to family physicians and cardiologists. The main outcome measures for the study are:

- Primary short term outcomes: readmission days for ambulatory care sensitive conditions (ACS) per 1,000 follow-up days, and estimated costs from the perspective of institutional health and community care agencies; and
- Secondary outcomes: readmission days for all causes per 1,000 follow-up days.

Another matter which emerged in discussions which affects the ability of home care to provide needed services is that the nursing shortage which seems to have developed across Canada is starting to impact the ability of the Access Centre to meet its obligations. It is now difficult for home care agencies to recruit new nursing staff because of the nursing shortage. This problem is further compounded by the salary differentials between nurses in the hospital and those providing care in the community.

Finally, it should be noted that with the pressure to take on more clients, particularly from the hospital, the Access Centre and home care agencies have increasingly moved to providing care seven days per week and, at least on an on-call basis, 24 hours per day.

4.2.2 Lessons Learned

From the perspective of the Access Centre, it is important for community agencies to ensure that they have a balanced relationship with the hospital or hospitals with which they work. There are unique skills related to providing care in the community and one should work to ensure that the contribution community agencies can make is both recognized and respected by hospital administrators. Once recognized and accepted, hospitals and community agencies can work together

to provide more **seemless** care across the hospital and home care **continuum** such as the TURP and the Cardiac Care Pathways. Better integration can be achieved by working with hospitals on joint initiatives, providing access to community care seven days per week and hiring a medical advisor for home care to work with the physicians in the hospital. The East York Access Centre has retained the Chief of Family Practice in the hospital to work with them for one half day per week to streamline relations between physicians and the Access Centre and home care agencies.

It was noted that by placing Access Centre staff in the hospital, seven days per week, coordination has been enhanced and hospital staff communicate with staff of the Access Centre with greater regularity. This, in turn, has allowed people in the hospital to be discharged more quickly and has insured that patients requiring care at home are identified as part of the discharge process.

Another lesson learned was the need for more integrated information systems between hospitals, the Access Centre and home care providers. Currently each sector has its own information systems but one can not easily integrate all relevant data into one file.

As mentioned above, the nursing shortage has had an impact on the ability of home care agencies to hire nurses. Payment for nurses has been relatively flat for several years and may even have decreased in some agencies due to the tendering process in which agencies have to bid to gain contracts to care for clients. It appears that agencies which pay less also have more difficulty in recruiting staff. Salaries are also an issue in mental health.

It was noted by administrators of the Access Centre and the hospital that relations between the sectors seemed to be very good. This may be partially attributed to the fact that in East York there is one Access Centre and one hospital. There is a cost pressure which provides an incentive for both sectors to work together to streamline care and there appear to be progressive leaders in both sectors who recognize the value of a systems perspective and the necessity to work together to provide the best overall care for clients. Hospital administrators also recognized that having good relations with the Access Centre would be of benefit to them. For example, the CEO of the East York Access Centre worked to bring together the leaders of the four Access Centres which work closely with the Toronto East General Hospital to facilitate discussion and the ability to deal with a range of issues between the hospital and the CCACs.

Access Centre, and hospital, administrators made efforts to build personal relations and to develop joint projects as mechanisms which would serve to better integrate care across the two sectors. They agreed that formal and informal communication at both the senior management and staff levels are a key to success. When asked what prompted the cooperation of the hospital with the Access Centre a number of reasons were given but an important factor was that some 15 percent of beds in the hospital were occupied by long term care clients. In addition, the Toronto East General Hospital has traditionally been a very community focussed hospital so working together to move people out of the hospital and into home care or long term care facilities was made easier by a long tradition of community involvement. While this collaboration does not appear to have reduced the number of Alternate Level of Care Beds in the hospital, more rapid discharge has had the effect that more people can be cared for in the hospital. In addition, because home care is able to care for people

in the community, the people now entering and staying in the hospital have much higher care needs than was the case in the past. Thus, from a systems perspective one might say that the overall system of care may have become more efficient.

4.3 Key Policy Issues

4.3.1 Facilitating the Hospital and Home Care Interface

In East York a number of steps have been taken to facilitate the hospital and home care interface. Formal mechanisms of communication have been established at the senior management levels. There is joint work on discharge planning and on the development of clinical pathways which span the hospital and home care continuum. There are other special programs which have been established such as a close working relationship between the oncology clinic in the hospital and home care such that some individuals who would otherwise have been admitted to the hospital can go directly to home care. Overall, there seemed to be a consensus that working relationships between the Access Centre and the hospital were very good.

4.3.2 Impact on User Fees

There seemed to be less of an issue in East York than in other jurisdictions about the impact of user fees on the hospital and home care interface because drug costs are covered for people on the home care program in Ontario. However, user fees remain an issue for people not on home care and for expensive drugs which are not listed in the Ontario Drug Benefit Formulary. The cost of supplies are also fully covered through the CCACs for people receiving CCAC services. In addition to drugs, the cost of needed home support services such as homemaking and personal support services are also fully covered, in Ontario, by the home care program.

Care staff did note, however, that it may be better if there was some form of envelope funding for client needs because sometimes people may need some services such as equipment but may not need home care. This sometimes places staff in the position of having to authorize home care for clients so that they will be eligible for needed equipment, supplies or drugs. Staff also noted that it may be useful to provide better explanations to clients about what is, and is not, covered by government.

4.3.3 Perceptions of What Hospitals and Home Care can do to Work More Closely Together

From the perspective of the hospital administrators, it was felt that more could be done to inform physicians about their clients once they go back to the community as physicians typically have relatively short visits with clients. For example, one could provide physicians with a brief overview of the client's status and the list of medications taken by the client. It was also felt that home care could have more staff that specialized in matters such as speech therapy and rehabilitation. It was noted that there should be more support for informal caregivers to prevent burnout and it was recognized that more "softer" services such as house cleaning, meal preparation

and homemaking should be provided to maintain people at home. It was also noted that there was considerable unmet need in the mental health system.

With regard to their own services, hospital administrators noted that hospitals could perhaps do a better job in preparing staff and clients about what hospitals and home care do and the discharge planning process. One idea which was presented was that it may be useful to establish a “flex” unit in the hospital for people on home care who may need to go back to the hospital for a short period of time. Such units could provide a better response to clients with needs which fluctuate over time. Other ideas included staff exchanges and joint training opportunities.

In terms of the Access Centre, administrators felt it was important to get over the we/they dichotomy between home care and hospitals and to think, and plan, in terms of a larger health system. Current funding arrangements were seen as an inhibitor to different sectors working together because there is no easy mechanism for the transfer of dollars between sectors.

It was also noted that it was important for all sectors to review their own policies and procedures with respect to the impacts they may have on other components of the health system. Ongoing meetings and communication between the hospital and the Access Centre were also seen as a key to positive working relationships. Finally, it was noted that it may be useful to have greater physician involvement in home care.

4.3.4 Suggestions for Funding Options to Enhance the Hospital and Home Care Interface

The main issue which emerged was the difficulty of transferring money between different components of the health system at the local level. One suggestion was to see if the Ministry of Health and Long-Term Care could develop some way of tracking costs on a full case cost basis and have some mechanisms for re-allocating dollars based on the actual site(s) of service. Another point was that there did not appear to be any method of rewarding superior performance in the existing funding models. It was suggested that some form of envelope funding could be developed which could include hospitals, home care and other related areas. Having a funding envelope would facilitate the transfer of resources between sectors because there would be one overall budget instead of several different budgets. It was also noted that there should be incentives for the development of more broadly based and integrated information systems and for the incorporation of new technologies into clinical practice.

Envelope funding was also suggested at the micro level so that care providers could best match the needs of clients with the resources available. This is harder to do with current policies on maximum hours of care and care eligibility (e.g., one can only get subsidized equipment if one is formally on the home care program). It was also suggested that there could be additional funding targeted to post-hospital discharge clients to facilitate the movement of clients from hospitals to home care. Currently, CCACs have fixed budgets and have no financial incentive to admit such clients. One administrator advocated population based funding for the whole health system and the establishment of integrated health service delivery systems. Such organizations could easily re-allocate resources and, possibly, increase the efficiency and effectiveness of service delivery. They

would also have built in incentives to improve the quality of care, and client satisfaction, by streamlining the flow of client services between hospitals and home care.

5. DISCUSSION

There were a number of common themes which emerged in the three mini case studies conducted for this project. The quality of leadership seems to be important. It appears that a combination of fiscal pressure, good leadership, and a larger system of care perspective, can be a catalyst for planning and developing more integrated services between hospitals and home care.

There are also issues related to implementation. It appears that fiscal transfers between sectors should not be too direct, that is, a direct and visible transfer of funds from one group to another group, as this may cause some ill will among the “losers” in such a transfer. Using new money, or the funding envelope for annual increases, may be more effective ways to transfer resources. This is also related to the issue of whether or not a hospital and home care initiative has to be cost recoverable. The home care community appears to be subject to greater demands for cost recovery and cost-effectiveness than other components of the health system such as hospitals.

The mini case studies also revealed a sense among home care staff that it may be useful to involve physicians more actively and perhaps have a consulting physician working for the home care program. Such a physician could work with physicians in hospitals and in the community to facilitate the smooth transfer of clients between hospitals and home care.

In terms of lessons learned, from the three mini care studies, the following points appear to be key elements in developing a more integrated continuum of care between hospitals and home care.

- The Board and senior management should exhibit vision, leadership and commitment to the initiative. This is probably a critical success factor.
- There should be some degree of separation in how funds are shifted between hospitals and home care. If the transfer is too direct and people lose jobs as part of the transfer there may be ill will that can linger for a long time.
- Transitional beds may be a useful component of a hospital and home care initiative because they allow people to recover to the point where they can go home instead of to a long term care facility.
- Developing initiatives on a direct cost recovery basis may cause some problems. It is also a questionable option in that other sectors of the health system, such as hospitals, generally do not have to justify new investments.

- Services are connected in an overall system of health care. Thus, one should consider whether proposed changes to acute care services may have a negative effect on continuing care services before such changes are implemented.
- Effective discharge planning is a key to the effective transfer of clients from the hospital to continuing care services.
- Finally, it is a good idea to involve physicians actively and from the beginning of an initiative. They have a great deal of influence about how and when clients can move from the hospital back to their homes. There may also be some benefit to a greater involvement of physicians in home care.