Overview of the National Evaluation of the Cost-Effectiveness of Home Care

Presented by

Marcus J. Hollander, PhD

&

Neena Chappell, PhD

Co-Directors, National Evaluation of the Cost-Effectiveness of Home Care

Presented at the 17th Congress of the International Association of Gerontology

Vancouver, British Columbia

July 1-6, 2001

National Evaluation of the Cost-Effectiveness of Home Care

308 - 895 Fort Street, Victoria, BC, V8W 1H7 Tel: (250) 389-0123 Fax: (250) 389-0105

info@homecarestudy.com www.homecarestudy.com

What is the National Evaluation of the Cost-Effectiveness of Home Care?

- A national, Canadian, program of research with 15 interrelated substudies.
- Six substudies focus on the cost-effectiveness of home care as a substitute for residential long term care and 9 substudies focus on the cost-effectiveness of home care compared to acute care.
- Substudies have been conducted across Canada by senior experts and academics in the field of home care and health economics.

What is the National Evaluation (continued)

- Funding of $1.5 million from the Health Transition Fund, Health Canada.

- Overall Principal Investigators:
  Dr. Neena Chappell, Director, Centre on Aging, University of Victoria, and Dr. Marcus Hollander, President, Hollander Analytical Services Ltd.

- To be completed by August 2001.

Major Objectives of the National Evaluation

- To directly evaluate the extent to which home care is a cost-effective substitute for care in long term care facilities, and under which conditions it is, or is not, a cost effective alternative, and

- To directly evaluate the extent to which home care is a cost-effective substitute for acute care, and under which conditions it is, or is not, a cost-effective alternative.

What Are Some Key Issues in Doing a Study of the Cost-Effectiveness of Home Care?

- The key issue is that of substitutability. If home care is not an actual substitute, it may be an add-on cost.

- Another major issue is the actual comparative costs of home care versus residential care, assuming a substitution can take place.

- Comparisons must be made across home care and institutional care for people with similar levels of disability, that is, by level of care.

Strategic Approach

- The program of research has an overall strategy which is based on several themes.
- The 15 substudies are like pieces of a puzzle which when taken together reveal a picture about the cost-effectiveness of home care in Canada.

Major Themes

Theme I Building on What Exists

- Utilize Unique Information.
- Expand on Canadian Research.
- Build on the Scientific Literature.

Major Themes (continued)

Theme II Efficient Knowledge Integration

- Timely: Studies conducted in parallel rather than sequentially.
- Synergistic: Findings can be combined from two studies to produce new knowledge.
- Efficient: The results from one study can be used in another study without having to incur the costs of replicating key measures.

Major Themes (continued)

Theme III Informing Policy Makers

- Inform policy makers about home care.
- Inform policy makers about the relative cost-effectiveness of home care.
- Inform policy makers about new opportunities for cost-effectiveness.
- Inform policy makers about key issues to be addressed in designing and implementing programs which increase the cost-effectiveness of home care services.

Expert Advisors

A number of Expert Advisors have assisted the Co-Directors of the National Evaluation and the Principal Investigators for the 15 substudies by providing advice and consultation, and by reviewing reports and other materials. The Expert Advisors came from several areas:

<u>Decision Makers</u>

- Steve Petz
- Terry Kaufman

Expert Advisors (continued)

Experts in Policy and the Organization and Management of Services

- Steven Lewis
- Evelyn Shapiro

Special Topics

- Dr. Murray Brown (Health Economics)
- Dr. John Hirdes (Measurement)

Substudy 1 : Comparative Cost Analysis of Home Care and Residential Care Services.

Investigator: Marcus J. Hollander, PhD

Background: To determine the relative costs to government of home/community based services versus residential long term care services, by level of care.

What Was the Research Question?

In the British Columbia continuing care sector, is home care for the elderly a cost-effective alternative for government funders to care in facilities, by level of care?

What Was The Sample For This Study?

- Four cohorts of new admissions to the BC Continuing Care System: 1987/88, 1990/91, 1993/94 and 1996/97 fiscal years.
- Data from linked database at the University of British Columbia, including data on home care, residential care, physicians, hospitals and pharmaceuticals.

What Was The Sample For This Study? (continued)

- Data for one year prior to first assessment and for three years post-assessment.
- Costs compared overall and by the five care levels used in BC.

What Was The Sample For This Study? (continued)

- Inclusion criteria:
  - 65+ at first assessment
  - Long term care client
  - New assessment
  - Received care within one year of assessment

Were There Any New Findings Which Add To The Current Store Of Knowledge?

Yes, there appeared to be several new findings:

- The cost is in the transitions. Home Care costs are much lower for clients who are stable in their type and level of care than those who change their type and/or level of care. The costs for stable clients are about one half of the cost of clients who are in transition.

Were There Any New Findings Which Add To The Current Store Of Knowledge? (continued)

- Home care for the dying does not appear to be cost-effective as home care costs more than facility care for all levels of care.

- About 50% to 60% of costs for home care clients are for hospital care, traditional services only account for about one third of overall home care costs.

Were There Any New Findings Which Add To The Current Store Of Knowledge? (continued)

- On a comparative basis, 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 with PC and IC1 clients costing about 40%, IC2, and IC3 clients about two-third and EC clients about three quarters of the cost for comparable facility clients.

Were There Any New Findings Which Add To The Current Store Of Knowledge? (continued)

- There is a very significant drop in hospital utilization, on average, for clients who are admitted to facility care.

- It appears that many clients are admitted in a state of crisis as service utilization is at its greatest just before entry to care.

Comparative Cost Analysis - Overall (Fiscal 1990/91)

Level of Care	Community	Facility
	Average Cost	
Personal Care	5413.16 n=3609.54	12504.54 n=30.52
IC1	10241.82 n=1727.44	20185.97 n=159.87
IC2	16081.34 n=689.73	23597.33 n=300.91
IC3	21786.06 n=210.02	29000.83 n=293.11
Extended Care	33579.41 n=94.84	41022.56 n=352.58

Comparative Cost Analysis - Same Type and Level of Care (1990/91)

	Average Cost	
Level of Care	**Community**	**Facility**
Personal Care	4524.91 n=3243.51	11476.88 n=20.27
IC1	7714.59 n=1356.52	17901.81 n=84.63
IC2	10603.89 n=456.25	20913.81 n=151.78
IC3	13936.41 n=112.12	26723.47 n=159.83
Extended Care	19538.94 n=45.80	40541.28 n=248.14

Comparative Cost Analysis - Clients Who Died (1990/91)

	Average Cost	
Level of Care	**Community**	**Facility**
Personal Care	31672.83 n=38.16	20524.14 n=0.51
IC1	41435.72 n=50.79	28566.97 n=4.81
IC2	48935.84 n=35.58	38187.94 n=13.34
IC3	50114.88 n=19.40	32276.00 n=13.94
Extended Care	54287.22 n=13.77	42839.88 n=31.40

How Robust Are The Findings?

The findings seem to be fairly robust.

- Additional analysis revealed that the results were similar if one analyzed individuals and tracked their service utilization over time based on their type and level of care at the point of their first service.

How Robust Are The Findings? (continued)

- An analysis was conducted of home care and residential costs for clients who received both types of services. Overall, costs for home care clients were still somewhat lower than for facility clients. They were only about 60% of the cost of residential care for the highest care levels (IC3 and EC) for clients who were stable.

Comparative Cost Analysis - Individual Clients (1990/91)

	Average Cost	
Level of Care	**Community**	**Facility**
Personal Care	6643.68	13869.85
IC1	12875.95	22882.3
IC2	18737.67	27217.61
IC3	21902.5	30897.03
Extended Care	29370.45	38743.97

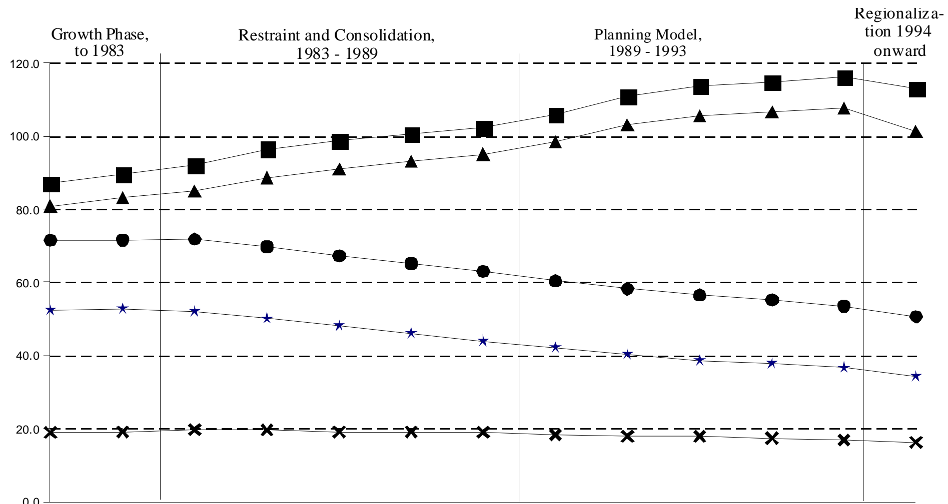
Comparative Cost Analysis for Clients Who Received Both Community and Facility Care - Same Care and Level (1990/91)

	Average Cost	
Level of Care	**Community**	**Facility**
Personal Care	9221.26	11159.98
IC1	10499.86	18274.03
IC2	13072.42	20922.47
IC3	15100.79	26751.28
Extended Care	17925.97	40591.31

Even If Home Care Is Cost-effective, Is There Any Evidence That Savings Can Be Obtained In The Real World?

Yes, this was demonstrated by the BC Planning and Resource Allocation Model developed in 1989. There was a significant shift of clientele from residential care to home care, while the overall utilization rate remained relatively constant.

Major Phases In The Utilization Of Home Care & Residential Care



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
■ Community	87.2	89.5	92	96.5	98.7	100.7	102.4	105.8	110.8	113.8	114.8	116.2	113
▲ Homemakers	80.9	83.1	84.9	88.7	90.9	93.3	95.1	98.4	103	105.5	106.5	107.6	101.2
● Residential	71.5	71.6	71.7	69.7	67.2	65.1	63	60.4	58.2	56.5	55.2	53.5	50.7
★ LTC Facilities	52.5	52.7	52	50.1	48.1	46.1	44	42.1	40.3	38.6	37.8	36.7	34.4
✖ EC Hospital	18.9	19.1	19.7	19.6	19.1	19.1	19	18.3	17.9	17.9	17.4	16.9	16.3

Utilization rates per 1,000 population aged 65 and over by fiscal year and type of care.
Fiscal year 1983 is for the period April 1, 1982 to March 31, 1983.

Substudy 2: Care Trajectories, the Natural History of Clients Through the Continuing Care System

Investigators: Dean Uyeno, PhD, University of British Columbia

Marcus Hollander, PhD, Hollander Analytical Services Ltd.

Background

The University of British Columbia data base was used to track the movement of clients through the British Columbia continuing care system. This analysis has implications for both clinical practice and resource planning.

Simple Patterns

Pattern	% of Total Patterns	Average Days in Care
Community/ Died	24.7	1082
Community/ Facility/ Died	16.2	1749
Community/ Still in Care	9.5	3650
Facility/ Died	9.3	1280
Community/ No Care	7.1	1744
Community/ Facility	5.1	3650

Complex Patterns Overall

	Percent
Other Patterns Occurring less than ten times	41.4
Community (Personal Care)/ Died	6.6
Community (Personal Care)/ No Care	4.6
Community (IC1)/ Died	3.7
Community (IC1)	3.2
Facility (Extended Care)/ Died	3.2

Complex Patterns, Community (Personal Care)

	Percent
Community (Personal Care)/ Died	20.5
Community (Personal Care)/ No Care	14.2
Community (Personal Care)/ Still in Care	10.0
Community (Personal Care, IC1)/ Died	9.1
Community (Personal Care, IC1)/ Still in Care	6.7

Complex Patterns, Community (IC3)

	Percent
Community (IC3)/ Died	40.8
Community (IC3)/ Facility (IC3, EC)/	30.6
Community (IC3, EC)/ Died	28.6

Complex Patterns, Facility (IC2)

	Percent
Facility (IC2)/ Died	32.3
Facility (IC2, IC3, EC)/ Died	28.3
Facility (IC2, IC3)/ Died	21.2
Facility (IC2, EC)/ Died	18.2

Most Common Pattern by Type and Level of Care

Level	% Community/ Died	% Facility/ Died
1	20.5	N/A
2	29.3	35.5
3	36.8	32.3
4	40.8	53.2
5	54.0	92.3

Substudy 3: Cost Implications of Informal Supports

Investigator: Konrad Fassbender, PhD

Background

A unique data set of over 5,000 clients from the Capital Health Region (Edmonton, Alberta) was used to study the comparative resource utilization of formal and informal home care services.

Results

- It was found that formal and informal care are complimentary, not substitutive. In general, if a client gets more of one type of care (formal or informal) they will also receive more of the other type of care. Thus, increasing formal care does not decrease informal care.
- Overall a $1 increase 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 of $0.30 in informal care.

Results (continued)

- However, for higher levels of care, increases in informal care still elicit significant increases in formal care, but increases in formal care only elicit modest increases in informal care.

Level of Care	N	Increase in Formal Costs for a $1 Increase in Informal Costs	Increases in Informal Costs for a $1 Increase in Formal Costs
A (low)	1,564	1.17	0.51
B	1,827	1.30	0.54
C	655	1.08	0.31
D	395	0.74	0.24
E	356	0.80	0.16
F	134	0.66	0.10
G (high)	31	0.76	0.01

Substudies 4 & 5: The Costs and Outcomes of Home Care and Residential Long Term Care

Investigators: Dr. Marcus Hollander

Dr. Neena Chappell

Dr. Betty Havens

Dr. Carol McWilliam

Sites and Samples for Substudy 5

- Two sites, Winnipeg and Victoria/Gulf Islands (Capital Health Region).
- Targets of 200 home/community clients, 200 residential clients for each site.

Data Collection

- Extensive set of data collection instruments.
- If client is cognitively impaired, data collected from proxy, usually family member.
- Project interviewers collected data.

Data Collection (continued)

- Clients and family members asked to record diaries about costs and informal care provided.
- Diaries also used to record provision of formal health care services.

Results

- The major finding to date is that on measures of client satisfaction and quality of life, for comparable clients, home/community based clients had comparable levels of satisfaction and quality of life. This is consistent with the existing scientific literature. Thus, the main factor is comparative costs.
- Formal care costs are generally lower for home care clients. Out of pocket costs are usually moderate particularly when compared to facility co-payments. The critical issue is how to cost the dollar value for the time of informal care providers.

Substudy 6: Decision-Making: Home Care or Long Term Care Facility

**Investigators: Denise Alcock, RN, PhD
Elaine Gallagher, RN, PhD
Elizabeth Diem, RN, PhD
Douglas Angus, MA
Jennifer Medves, RN, PhD**

Background

- Qualitative study, primarily focused on groups of case managers in BC, Alberta, Saskatchewan, Ontario and PEI.
- Key objective was to study the decision-making process of case managers regarding whether clients are cared for in home care or in residential care.
- Team led by Dr. Denise Alcock, Dean of the Faculty of Health Sciences, University of Ottawa.

Factors Allowing Clients To Be Cared For At Home

- Community support for clients on home care, e.g., help people get home if wandering outside.
- Basic community based supportive programs such as meal programs, night programs.
- Availability of supportive housing and seniors apartments helps seniors remain in the community and increases the efficiency of home care providers.

Factors Allowing Clients To Be Cared For At Home (continued)

- Individual and/or family finances, additional purchased services may allow people to remain at home longer.
- Adequate respite care to prevent burn out of informal care providers and emergency respite care.
- Day programs and steps to more fully utilize day programs for socialization and care.

Factors Allowing Clients To Be Cared For At Home (continued)

- Night programs for wanderers and people requiring supervision.
- Transportation, particularly in rural areas.
- Access to affordable home maintenance services.
- Adequate funding for home care services so people can actually receive the care they need.
- Availability of informal supports.

Factors Influencing Facility Placement

- Most clients in facilities are appropriately placed but there is room for further efficiencies.
- Clients placed into facility care due to “too hasty” decisions at the hospital discharge planning stage.
- Inadequate availability of convalescent or transitional care in hospitals, also inadequate respite care.
- Unsafe home environment.

Factors Influencing Facility Placement (continued)

- Client requires 24 hour care or needs very heavy care.
- Incontinence and inability to transfer.
- Assessment tools indicate need for facility placement.
- Problems with home care, e.g., constant change of personnel prompt clients to seek facility care.
- Lack of understanding of comparative costs of home care and facility care, think residential care is free.

Factors Influencing Facility Clients to Return Home

- Respite from caregiving allows family members to recover and lobby for discharge back home.
- Client's residence has been adapted to needs.
- Strengthening of home care/home support sector to provide full range of needed care.
- Client chooses to return home due to rigid policies in facilities, e.g., no alcohol.

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

Investigators: John P. Hirdes, PhD
Erin Y. Tjam, PhD
Brant E. Fries, PhD

Background

- A study of 60 case managers from seven provinces across Canada who were asked to rate 16 different vignettes and indicate the level and type of care for which the person in the vignette would be eligible in regard to home care, residential care and hospital care. The study provides information on resource allocation patterns across jurisdictions.

Results

- Generally, it was found that there were differences across jurisdictions in regard to eligibility and access to services.
- Finding that while there is some consistency, there are also real differences in the types of services to which clients are allocated and the types of workers who would be assigned to clients. For example, the percentage of vignettes with an expected involvement of Registered Nurses ranged from 93.8% - 54.4% across jurisdictions.

Substudy 9: Economic Evaluation of Home Care

Investigator: Dr. Philip Jacobs

Background

- Alberta data for hospitals and home care for 1996 to 1998 used to generate data on care episodes for people in hospital, those with inter-hospital transfers and episodes which included both hospital care and home care services. Data were analyzed by Case Mix Groups (CMG). The purpose of the study was to look at the cost-effectiveness of home care compared to acute care and to determine if there were additional opportunities for cost savings or for increasing system efficiencies.

Results

- Admissions with inter-hospital transfers 1.75 times more costly than those without transfers.
- Thus, costing should be done by episode of care and current hospital costs by CMG or RIW may be under-estimates.
- Most combinations of hospital and home care were more expensive than hospital alone, but care needs (number of diagnoses) were also higher.
- New patterns of hospital to home care service use were identified.

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

Investigators: Michael Tousignant, PT, PhD

Réjean Hebért, MD, MPhil

Johanne Desrosiers OT, PhD

Background

- The goal of this study was to investigate whether the benefits related to a geriatric hospital day program exceeded the costs using a cost-benefit analysis based on changes in functional autonomy.

Results

Functional autonomy was measured at admission and discharge to the Geriatrics Unit at Sherbrooke University.

- Conducted detailed cost estimation.
- Dollar allocation of benefits based on a previous study which had a formula relating SMAF scores to dollars.
- Finding was that for each dollar invested in care $2.14 of benefits were derived in terms of improvement in functional status.

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

Principal Investigator:	Peter C. Coyte, MA, PhD, CHSRF/CIHR
Co-Investigators:	Edward G. Jamieson Allison McGeer, MD, FRCPC

Natalie Milkovich, BSc, MSc (cand)
Andrew Morris, MD, MSc, FRCPC
Howard Ovens, MD, CCFP(EM)
James Read, MD, CCFP(EM)

Background

- This study was designed to examine the costs and outcomes of antibiotic intravenous (IV) therapy for individuals with cellulitis, focusing on a comparison between hospital versus home care locations.

Results

- Study of costs and effects of home care intravenous (IV) therapy compared to care in hospital.
- Problem in getting adequate sample as many people treated with repeat visits to Emergency as home care not available in a timely way.
- While sample was small, main findings are:
  - Home Care and Emergency cost about one half of care in the hospital
  - Quality of life scores in hospital about one half of other two approaches
  - Clients in Home Care and Emergency had fewer complications and higher rates of resolution of the problem

Substudy 12: Cost-Effectiveness of Home Versus Hospital Support of Breast Feeding in Neonates

Co-Principal Investigators: Bonnie Sevens, RN, PhD
Patricia McKeever, RN, PhD

Co-Investigators: Peter C. Coyte, MA, PhD
Stacey Daub, BA
Michael Dunn, MD, FRCPC
Sharyn Gibbins, RN, MSc, PhD(cand)
Denise Guerriere, RN, PhD
Jo MacDonell, RN, MSc
Arne Ohlsson, MD, MSc, FRCPC
Karen Ray, RN, MScN

Background

- This study was designed to examine the costs associated with breast feeding of term and pre-term infants in both home and hospital contexts as well as the efficacy, safety, level of maternal satisfaction and resources involved in the management of breast feeding.

Results Regarding Term Infants

- Using a societal costs perspective, the experimental group (those with home care) had significantly higher post-discharge costs. There were no differences in indirect family costs, hospital delivery costs or total system costs.
- In terms of outcomes, the experimental group had significantly higher rates of babies being breast fed on an exclusive basis.

Results Regarding Pre-Term Infants

- There were no differences in costs or outcomes between the experimental group which received home care and the standard care group.
- The finding may be attributed to a small sample size and the lack of a substitution effect as the infants in the experimental group only stayed in hospital for an average of two hours less than the infants in the standard care group.

Substudy 13: The Geriatric Outcome Evaluation Study (GOES)

Investigators: Holly A. Tuokko, PhD
Theodore Rosenberg, MD

Background

- This study explores the utilization of services within a system of care developed for a geriatric services program. The study examines how a geriatric day hospital fits into a broad spectrum of services in Victoria, British Columbia.

Results

- Clients studied in five settings: a geriatric outpatient clinic, a geriatric day hospital, post-acute geriatric inpatient rehabilitation, residential geriatric rehabilitation for people admitted from the community and inpatient psychogeriatric rehabilitation.

- Persons admitted to each service component were different in regard to mental and physical health, daily functioning and bodily pain.

Results (continued)

- Thus, this finding supports the notion of an integrated hospital-based system of outpatient and inpatient services for geriatric clients.
- Within each of the five services, health status appeared to improve for the period in which clients received care.

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

Investigators: Joanne M. Franko, MSc

Background

- This study examines the costs of a community based model of re-directing clients who would otherwise be admitted to hospital from the Emergency Department, back to their homes.

Results

- It was found that the existing system of re-directing clients to home was effective as there were only two hospital admissions which were deemed to be non-acute using the InterQual® ISD-A screening tool.
- The cost per QRP client for care in the community for the 30-day period after visiting the Emergency Department was $358.
- This was considerable less than the cost for the two non-acute hospital admissions which averaged $1964.
- Thus, the use of a QRP in a non-efficient system could be considerable.

Substudy 15: An Analysis of Blockages to the Effective Transfer of Clients from Acute Care to Home Care

Investigators: Caryl Arundel
Sholom Glouberman

Background

- Interviews and focus groups in BC, Saskatchewan, Ontario, Québec, New Brunswick and PEI.
- Focus on how roles, relationships and structural boundaries between the home care and hospital sectors impact on patient discharge.
- Report Prepared by Caryl Arundel and Dr. Sholom Glouberman, Canadian Policy Research Networks.

Key Findings

- Systems Barriers to Working Together: barriers related to differences in definitions of roles and responsibilities, and the scheduling, availability and assignment of human resources.
- Family/Caregiver/Patient Barriers: barriers related to resistance to change, lack of education/awareness of benefits of early discharge and lack of family or caregiver capacity to provide support to discharged patients.
- Geographic Barriers: barriers related to rural access to services, supports, equipment and supplies. Interjurisdiction barriers also evident in 'out of region' patient discharge.

Key Findings (continued)

- System Management and Control Barriers: inflexible governance structures; rigid systems, processes or controls; lack of common patient information; incompatible performance measures; and different sets of financial controls and incentives.
- Constant System Change: barriers related to the development of external formal and informal relationships to facilitate care provision.
- Resource Barriers: adequacy of resources; shortage of trained health care professionals related to discharge; and limited community supports for discharged patients.

Best Practices to Guide the Hospital to Home Care Discharge Process

Formal System Factors

- Legitimize relationships between acute care and home care.
- Provide access to compatible and/or common information systems.
- Facilitate the flexible use of resources.

Best Practices to Guide the Hospital to Home Care Discharge Process (continued)

Relationship and Informal Network Factors

- Facilitate opportunities for formal communication and the development of working relationships.
- Facilitate continuity and stability of staff assignments.
- Enhance boundary spanning positions.

Best Practices to Guide the Hospital to Home Care Discharge Process (continued)

System Capacity Factors

- Enhance program resources.
- Enhance access to home care - availability of assessment and referral services.
- Enhance home care supports.
- Enhance community supports.
- Enhance the continuum of care.

National Evaluation Learnings Regarding Process

- Very difficult environment in which to conduct original research. Administrators and staff "burned out" and "studied out". Probably due to years of restraint and being asked to do more with less.
- It is possible to conduct a national, integrated, and strategic program of research to yield new information.
- It always takes longer than you think and while time lines seemed tight, but all right at first, time was a pressure point.

Learnings Regarding Process (continued)

- The model of parallel studies is promising, although we were not able to achieve as much crossover between studies as anticipated (e.g., Substudies 1 & 2).

Policy Issues

- Home Care does not exist in isolation. It would make sense to consider home care as part of the broader continuing care service delivery system. There needs to be policy discussions regarding the best way to organize health services in Canada and the role of home care in the broader health system.
- People are implementing efficiencies in the hospital setting to meet fiscal pressures and thus it is difficult to mount studies to determine cost-effectiveness.

Policy Issues (continued)

- There is still no national data base on home care and different jurisdictions are using different assessment and classification systems. We need to develop greater consistency in data collection in order to compare and contrast different systems in order to learn from each other (e.g., reporting of chronic care data).
- There are major anomalies across Canada with regard to user fees. In Atlantic Canada people may have to pay up to the full cost of facility care while in the rest of Canada the user fee is capped at an estimated room and board cost.

Policy Issues (continued)

- Clinicians are challenged to develop new and innovative models of care to care for the dying at home and to monitor and intervene quickly to re-stabilize clients who begin to have problems.
- There should be a greater recognition of the role of informal care providers and the role they play in caring for people with functional deficits.
- It may be helpful to truly embrace evidence-based decision making to ensure that key decisions are made based on good information and that the infrastructure exists to provide targeted and timely analysis of key issues.

Policy Issues (continued)

- Current methods of economic analysis may have a bias against the elderly. For example, quality of life years scores are dependent on the number of years of life that are left. It would be helpful to have funding to develop appropriate methodological tools for economic evaluations of the elderly population.

For more information about the National Evaluation of the Cost-Effectiveness of Home Care, please visit our Web site at:

www.homecarestudy.com