

Saskatchewan Health, Community Care Branch

Home Care Program Review

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| Executive Summary |
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Prepared by
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EXECUTIVE SUMMARY

Introduction

Responsibility for the Saskatchewan Home Care Program rests with the Minister of Health through Saskatchewan Health. Regional Health Authorities (RHAs) are responsible for planning, administering and delivering health services, including home based services, in accordance with *The Regional Health Services Act*, and other provincial policies.

The purpose of the Saskatchewan Home Care Program Review was to examine the vision, services and strategic directions of home care services in Saskatchewan.

The goals of the Program Review were:

- To assess the program design and vision, range and mix of services, capacity to meet need, and financial resources (including value for dollars) of home care programs delivered in Regional Health Authorities.
- To identify strengths as well as shortcomings, and to recommend potential changes and future directions to improve program effectiveness and efficiency.
- To link within the review to other important initiatives, including the Short-term Acute Home Care initiative as committed to by First Ministers in the 2003 FMM Accord and 2004 FMM Agreement, and the CIHI End-of-Life Care Study.

Project Activities

Several activities were conducted in regard to this review including: a review of home care related documents from Saskatchewan Health and RHAs; literature reviews on models of care delivery and the cost-effectiveness of home care; analysis, and projections, of demographic data; analysis, and projections, of service utilization data; analysis of service costs; interviews with officials from Saskatchewan Health and Saskatchewan RHAs; and interviews with representatives of Ministries of Health and Regional Health Authorities across Canada.

Findings From the Literature Reviews

A literature review was conducted in regard to integrated models of care delivery which include home care. Six models are described in this report. In addition a best practices framework for integrated service delivery models, which include home care, is described.

All of the models described have some form of single, or coordinated, management and a single funding envelope. They all operate as a system with a variety of services, including at least home/community care and residential long term care, coordinated through system level case management. They also all seem to have a single entry process. By having a single, or coordinated, administrative structure, and a single funding envelope (either through capitation or a budget process), one has, at least in theory, the administrative, fiscal, policy and program levers

to obtain greater efficiencies through the planned substitution of less costly services for more costly services, while still maintaining service quality.

An extensive literature review was also conducted on the cost-effectiveness of home care. A key finding of the review was that there seems to be a small, but reasonable, body of evidence to indicate that it may, in fact, be cost-effective to provide more basic (i.e., preventative and maintenance) home support services as a means of delaying institutionalization both for people with lower level care needs, and as a substitute for residential care services for people with higher levels of need for services. In addition, there seems to be some evidence to indicate that home care can function as a cost-effective alternative to residential care.

Another relevant finding was that there is some evidence to indicate that home care can indeed perform a substitution function for hospital services, through early discharge, with well designed programs. In addition, there is a growing body of evidence to indicate that there are a wide range of programs which can be put into place to reduce future hospital admissions and/or readmissions.

Based on the above, it appears that it may be possible to think of home care not only as an important program in its own right, but also, as a key vehicle for increasing the efficiency and effectiveness of the broader health care system.

Findings Form the Analysis of Demographic Trends

Our analysis of the demographic data indicated that pressures on future resources may be somewhat mitigated in the near term as the cumulative growth rates between 2001 and 2021 will be moderate for the 85+ group, and negative for the 75-84 group. These age groups typically use proportionately more home care and residential care resources. The real demographic pressure may actually begin in 2021 when the first wave of baby boomers becomes 75 and go through to about 2046 when those born in 1961 become 85 years of age.

Findings From the Analysis of Service Utilization

An analysis was conducted of the distribution of the types of services received by home care clients. The bulk of services are provided to clients needing on-going, supportive care (63%). This percentage, however, differed considerably across Regional Health Authorities (RHAs). It appears that some RHAs are focusing more on acute care home care, while others focus more on supportive home care. However, there does not appear to be a clear pattern, for example by size of region, for these differences. Thus, the differences may be related to differences in strategies about how home care is used within the broader health care system between the RHAs.

Overall, home care and residential care services are allocated reasonably consistently across RHAs. Opportunities for cost reductions from freezing new bed allocations in higher bed use RHAs and reallocating future bed dollars to lower use RHAs, or to home care, appear to be possible but modest. Furthermore, some RHAs which may, in isolation, appear to be under-bedded, and over serviced in home care, may, in fact, have made strategic program decisions to

increase efficiencies by enhancing home care and minimizing residential care. Thus, any efforts to re-allocate resources needs to carefully consider the full system of care rather than just home care or residential care services by themselves.

An analysis of costs was also conducted. It was found that the average cost for an Extended Care home care client (the highest level of care) was less than the average cost of facility care. Thus, there may be a potential to achieve cost-effective substitutions of home care services for residential care services.

Findings From the Interviews with Saskatchewan Health and Regional Health Authority Officials

In terms of overall organization and funding, Saskatchewan Health provides a global budget to RHAs. However, there are clear expectations that appropriate funds will be allocated to home care services. There is an accountability framework which is used by the RHAs to provide quarterly and annual reports on service utilization, costs and key indicators to Saskatchewan Health. There are two separate funding envelopes, one for acute and palliative home care, and one for supportive care. Actual expenditures can vary by +10% to -10% of the budget allocation in each funding envelope but permission is required from Saskatchewan Health to move money from one envelope to another. It was noted by respondents that funding may not have kept up with the increase in clientele over the past years and that, on a comparative basis, Saskatchewan has a relatively low per capita expenditure on home care, compared to other jurisdictions.

With regard to how the various components of home care should be organized, there was a strong consensus that all home care services should be under one administrative umbrella, as is currently the case. It was, however, also noted that creative and/or collaborative approaches may need to be adopted in regard to home care for mental health clients.

In 2005, for most of the province, all clients paid a user fee of \$6.36 for the first 10 units of services per month (e.g., a meal is one unit). After the first 10 units, fees are assessed based on income, to a maximum of \$383 per month. In the three northern RHAs client paid \$2.50 per unit up to a maximum of \$75.00 per month. This difference exists for historical reasons. Professional services such as case management, nursing and rehabilitation are provided without any co-payments.

A number of strengths and weaknesses of the current home care program in Saskatchewan were noted by respondents. In addition, there was a reasonable consensus on key themes/issues/challenges which should be addressed going forward. Themes noted by Saskatchewan Health and RHA officials included the following:

- The challenge of providing consistent and comprehensive services in a sparsely populated, mostly rural province;
- The human resources challenges of recruiting and retaining care staff;
- The need for enhanced information systems, analysis and accountability;
- The issue of client charges, or user fees;

- The method of organizing care services;
- The challenges of service provision related to special populations such as children with special needs and mental health clients;
- Challenges posed by the current collective agreements;
- The perception of a shifting emphasis from preventive and supportive care to acute care home care;
- The perception that home care has a lower status, and priority, than acute care;
- The challenge of increased coordination with other components of the health care system such as hospitals, primary care and public health;
- The need to better define and/or communicate what exactly are the vision, core services, and model of care delivery, for home care, and to ensure buy-in from the senior management of the RHAs;
- The challenge of obtaining adequate resources for home care; and
- The overall sustainability of the Home Care Program.

There were some additional issues that were raised by respondents from the RHAs that were not, or not as directly, raised by Saskatchewan Health officials. The following themes were noted:

- The need for, and desire for, more provincial involvement in home care issues;
- The need for greater clarity about the vision, direction and care model of the Home Care Program;
- Federal/provincial issues in care provision in the north;
- The need to place home care into a broader systems perspective;
- The concern that home care may not be well understood by politicians, the public and senior executives; and
- Issues of overlap between home care and primary health care.

Interviews were also conducted with officials from jurisdictions across Canada. These jurisdictions included provincial Ministries of Health and Regional Health Authorities. We initially intended to document which home care services are provided in which jurisdictions. However, it turned out that there were a large number of caveats and explanations, about a large number of services. Thus, a direct comparison was not possible. It is, however, fair to say, that most jurisdictions offered a similar range of services to those in Saskatchewan.

It was not possible to obtain detailed financial or service utilization data from other jurisdictions through the interview process. However, Saskatchewan Health conducts an excellent annual survey on critical items related to cost and utilization for home care and residential care. This material is collected on a confidential basis so only summary information can be noted here. However, the data collected in the survey seem to indicate that Saskatchewan has a high rate of residential care utilization at some 113 beds per 1,000 persons, 75 years of age or older, and a low, annual, per capita expenditure for home care of some \$86. Thus, to the extent that one may wish to do so, it appears that one could reduce bed utilization and increase home care services. In contrast to Saskatchewan, two similar provinces have ratios of beds per 1,000 population 75+ in the 90 – 100 range. While we do not necessarily advocate such rates of bed utilization for Saskatchewan, there is a big difference between the low 90s and 113 beds per 1,000 population 75+. In contrast, the same two jurisdictions have home care annual per capita

expenditures ranging from about \$120 to \$130 compared to \$86 in Saskatchewan, a difference of some 40%.

Discussion

One can think of home care as one type of service. Using this approach home care would essentially compete for resources on its own merits and could be part of any broader organizational framework. There is also another policy stance which could be adopted, that is seeing home care not only as a program in its own right, but also, as a vehicle for increasing the efficiency and effectiveness of the broader health care system.

The choice that is made about what role home care is to play is fundamental as everything else flows from it, that is, what services are in home care; how it is funded; what its vision, mission and mandate are; what level of resources will be expended on it; and what expectations people will have for the impacts and outcomes of the program. It is our view that there is a great, untapped potential for home care to be the engine that begins to address many of the challenges faced by the health care system today. It is also our view that Saskatchewan is well suited by its history and its current health care system to realize much of this potential.

There are many strengths to the current Home Care Program, including knowledgeable and experienced leadership at the provincial and RHA levels. In addition, having the home care staff be regional employees, and often having case managers and home care providers co-located, provides for a higher level of care coordination than would be possible if care services were contracted out. Given the structure of RHAs, there are also opportunities for co-location with primary care and public health staff. In addition, there is a solid range of services under the home care umbrella. These are just some of the positive aspects of the Home Care Program.

It is always difficult in a regional model to find the right balance between leading and respecting the independence of RHAs. There are currently committees that allow the province and the regions to move forward together. Thus, structures already exist for moving forward in a balanced and collaborative manner.

Some respondents called on Saskatchewan Health to take on a more active role in driving change and/or improving the system. It is our view that such comments signal a green light for a more active collaborative process between Saskatchewan Health and the RHAs to improve the Home Care Program. A collaborative change process will become even more important in regard to any next steps which may flow from this report. Perhaps existing, or new, provincial/RHA committees could identify key issues, set priorities, and take on one or two issues at a time and work actively to find acceptable solutions, and implement these solutions. We recognize that this already takes place, but it is likely that more could be done, particularly in light of the comments made by respondents.

With regard to future changes, it is our view that home care should be conceptualized as having three, related components. The first would be in-home care delivery by professionals and home health aids or assistants. The second component would be all of the services which require coordination or facilitation. This would include transportation, SAIL, housing options and so on.

The third component is a community development function which may require some funding but would not require the addition of actual staff. Existing community agencies could be asked to take on the provision of a range of services to assist individuals to maintain their independence. Such services would be deemed to be part of the home care program, but the actual service provided by home care would be a coordination/facilitation/community development service.

There are also a number of more specific issues that have been raised in regard to potential changes to service delivery. It is our view that there is enough emerging evidence to argue for a broadening of the functions of the Home Care Program in two directions, that is, a greater emphasis on medical home care, and on preventive home care. While short term home care can move people out of hospitals faster, the benefits of this service may not achieve the desired result of reducing pressures on hospital beds if steps are not also taken to reduce the rate of hospital admissions by ensuring adequate longer term home care services in the community. Such services allow people to maintain their independence for as long as possible, and prevent admissions to hospitals and residential care.

Some enhancements related to case management could be considered. The first is an enhanced community development function in regard to facilitating access for home care clients to preventive services from community agencies. The second is to further strengthen linkages with hospitals, long term care facilities, primary care and social services. The third is to become more knowledgeable about health and community related services for palliative care, children with special needs and mental health. Case managers will need to know a great deal about a wide range of services in order to maximize the match between client needs and the services to meet those needs. Thus, case management could change from case management for home care *per se* to case management for a broader system of care. This type of change has already started in the urban RHAs. This broader notion of case management leads to a form of specialization. In smaller RHAs it may still be possible for case managers to also provide hands on care. However, in larger RHAs it is likely that it will be difficult for any one person to maintain their skills and expertise in case management, as well as in increasingly complex and specialized care provision.

Adult day care services are an important part of any broader home and community care program. They provide an opportunity for clients to receive needed health and social services, and an opportunity for socialization for individuals who are otherwise isolated. They also provide an opportunity for respite for family caregivers. While Saskatchewan has adult day care services, they are currently part of the residential care sector, even though they only provide services to people who live in the community. While structural arrangements can vary, it will be important to ensure that adult day care services are seen as an integral part of home and community care services.

Group homes and adult foster care are alternatives to residential care services and could be provided to clients at all levels of care, particularly in more rural and remote areas of the province.

It is our view that, given the high proportion of the aboriginal population in the three northern regions, and the differences between the Saskatchewan Home Care Program and the on-

reserve, Health Canada funded Home Care Program, that some type of forum for discussion regarding more consistent care delivery between these two programs be considered, or other steps be taken to reduce discrepancies between the two programs.

There is a great deal of interest in, and a wide variety of opinions about, home care user fees. It is certainly an option to leave fees as they are. We suspect, however, that existing policy on fees will come under increasing strain over time for a variety of reasons. There will be continued and perhaps increasing strain due to comparisons with Health Canada (for on reserve First Nations) and Manitoba models, where no user fees are charged. Further challenges arise when short term home care, palliative home care and/or short term mental health home care clients do not have to pay some user fees, but supportive home care clients still have to pay fees. We also expect that there is, at best, a very modest net financial benefit from having the user fees.

Based on our interviews, there appear to be some challenges with regard to health human resources in the home care sector. Recruitment and retention are major issues. Community infrastructure in the north is also an issue as there are few, if any, amenities in these communities for people and, thus, the communities are not attractive to prospective employees, particularly as there is no northern and isolation allowance. Current labour agreements may also inhibit the more flexible and innovative use of home care staff.

Information systems is a complex area and there are very few jurisdictions which seem to have gotten this right to date. There seems to be a misconception that by simply adopting new information tools one will have an integrated information system. This may, or may not, be the case. For example, in an integrated information system, home care data would be merged with other data on staff, hospitals, primary care, costs and so on.

The issue of funding and financing is very complex. Even if home care continues to be seen as a distinct service, there are still, in our view, logical arguments for increased funding. Saskatchewan does appear to have a relatively low per capita expenditure on home care compared to the other western provinces. If one adopts a broader systems perspective, and if greater efficiencies are valued, one could make significant increases in home care to enable it to become a key driver of increased value for money for the overall health care system. We are simply pointing out that re-investments are possible and could provide greater efficiencies. The literature seems to indicate that such substitutions of home care for residential care, and acute care, can be cost-effective.

Change is complex and difficult. In this report we have tried to present a picture of the Saskatchewan Home Care Program. We have noted the strengths of the program and the areas which may require further enhancement. Our recommendations focus on the areas which we believe should be addressed to further improve an already sound program. Operationally, in our view, the Home Care Program can best be enhanced by developing “made in Saskatchewan” solutions through the collaborative efforts of Saskatchewan Health and the RHAs.

Recommendations

The following is a consolidated list of our recommendations.

Recommendation 1: Ensure that the policy manual continues to provide a broad and comprehensive policy framework for the delivery of home care services in Saskatchewan, and that it is updated on a regular basis.

Recommendation 2: Develop a written description (or enhance existing descriptions), of the Home Care Program and how it works. The resulting document should be agreed upon by Saskatchewan Health and the RHAs and be widely used and distributed to officials, senior executives in RHAs, politicians, the public and other interested parties, to ensure a greater understanding of the home care program by all key stakeholders.

Recommendation 3: Build on existing structures to ensure high level collaboration about home care matters between Saskatchewan Health and the RHAs.

Recommendation 4: Saskatchewan Health and the RHAs should actively review the adoption, or expansion, of more medically related home care interventions such as IV therapy, respiratory therapy, and other related services, and determine safe and appropriate procedures for adopting promising approaches. The adoption, and/or expansion, of preventative home care initiatives should also be reviewed.

Recommendation 5: Consideration could be given to expanding case management from home care *per se* to having case managers work at the broader systems level to ensure the best fit between client needs and services delivered, on an ongoing basis. In smaller RHAs, it may, nevertheless, still be appropriate to have nurses do both case management and hands-on care, as appropriate.

Recommendation 6: Consideration should be given to the desirability, and feasibility, of having adult day care go beyond socialization and provide a single location which can address a wide range of needs for health and social services.

Recommendation 7: Saskatchewan Health and the RHAs should explore the feasibility, in addition to adult day care, of having other central locations to which clients could travel to receive services, as appropriate.

Recommendation 8: Preventive and maintenance home care services should be accorded a higher priority and be provided through a coordination/facilitation/community development function, for clients who can receive a clear benefit from such services.

Recommendation 9: Saskatchewan Health and the RHAs should consider enhancing, and/or developing, group homes and adult foster care as supplements to existing residential care services.

Recommendation 10: Saskatchewan Health and RHAs should work collaboratively to review the enhancement of existing home care services, and the addition of new services, in regard to the Home Care Program.

Recommendation 11: RHAs should consider making a part-time physician and a part-time pharmacist available as a resource to home care.

Recommendation 12: Saskatchewan Health and the three northern RHAs should consider options for change, and/or for collaboration with Health Canada, to reduce or eliminate the differences between the federal and provincial home care programs in these RHAs.

Recommendation 13: Saskatchewan Health and the RHAs should consider the desirability of developing a revised user fee structure for home care services.

Recommendation 14: Saskatchewan Health and other appropriate bodies should work together to review existing health human resource issues and develop creative solutions to issues which impact service delivery, and the recruitment and retention of home care workers in the north.

Recommendation 15: Saskatchewan Health should ensure that there is a clear understanding of the benefits and limitations of its information infrastructure and that these benefits and limitations are well documented so that all concerned parties can have a clear understanding of what the information infrastructure can and cannot do.

Recommendation 16: Saskatchewan Health should consider enhancing its analytical capacity, and that of the RHAs, in order to derive the maximum potential benefit from its investments in information systems infrastructure.

Recommendation 17: Saskatchewan Health and the RHAs should work together to refine accountability requirements and accountability-related reporting.

Recommendation 18: Saskatchewan Health should consider the benefits of further investments in home care.

Recommendation 19: Given the complexity of any major change process, there should be ample time, and a strong collaborative Saskatchewan Health/RHA process, to review and consider the recommendations in this report, and to move forward with any desired changes.

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To read the complete Home Care Program Review, visit the Saskatchewan Health website:

<http://www.health.gov.sk.ca>