



**HEALTH
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Removing Barriers to Receiving Care at Home:

A Perspective from the Cape Breton Region,
Focusing on Hospital to Home

Completed by Health Association Nova Scotia in collaboration with the Cape Breton District
Health Authority and the Nova Scotia Department of Health and Wellness

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Executive Summary

Due to demographic changes and system drivers such as the increase of chronic disease, health services are attempting to shift focus from acute to home and community based care. Current gaps in these primary and continuing care services are leading to a variety of issues, including alternate level of care (ALC) placements in hospitals.

The intent of this project was to identify barriers that limit or preclude individuals from receiving home support in the Cape Breton District Health Authority (CBDHA), specifically focusing on factors that contribute to delays in the process of accessing home care services from the hospital, and identifying solutions that would enable care at home. Recognizing there may be small regional differences, general applicability of the higher-level recommendations is anticipated.

Based on a review of the literature and available data, consultations with key informants in the continuing care system, and interviews with individuals on the long-term care waitlist and their caregivers, the following barriers were identified:

A Facility- Focused Philosophy

Although the home can be a cost-effective and preferred place for service provision, the prevailing philosophy in practice is that frail seniors are most appropriately cared for in a long-term care environment. Programs like My Home First, a recent initiative in CBDHA, are attempting to expand practice and thinking, allowing individuals who would normally be in an ALC bed to wait for a long-term care placement at home, by way of enhanced home care services. Such programs are an excellent first step. Beyond programming, to truly make a shift towards home and community care, “home first” needs be adopted not only as a program, but as a district-wide philosophy that would drive program development, care planning, and the goals of health care services.

Emergency Room Assessment and Discharge Planning Processes

The Cape Breton Regional Hospital has taken steps to incorporate rapid, multidisciplinary assessments for the frail elderly in the emergency room (i.e., the Rapid Assessment Team). This is a positive change, and it is recommended that a multi-disciplinary team be involved in the assessment of, and discharge planning decisions for, elderly hospital patients. Such a team should be headed by a clinical lead that is knowledgeable in available home and community supports. Processes should be standardized so that home/community care is always considered as a first option and the ultimate goal. This includes an assessment for home care as a mandatory first step in accessing continuing care services, and a standardized screening or inquisition process in the ER that would proactively start a patient-provider discussion about home and community options.

Discharge planning should begin at the time of admission and resources should be such that discharge from the hospital to the home can occur seven days a week.

Gaps in Provider to Provider Communication

Seamless transition and integration are key elements of a successful discharge process; however provider-to-provider communication mechanisms are lacking. The District and home care agencies should work together to develop communication guidelines and protocol, with the goal of ensuring that all pertinent information is collected and disseminated in advance of a projected discharge date.

A Misunderstanding of What Home Care is and Does Amongst Health Professionals

There is a lack of awareness of what continuing care is and offers amongst acute care professionals. Hospital physicians are a key area to target in terms of education, given their significant role in determining current and future places of care. Champions, or peer leaders, in all pertinent health professions, would help support education / awareness and implement shifts in philosophy and practice.

Home and Community Care Options

There is ample opportunity for public home and community care options to expand. Caregivers identified that an increase in service authorization hours would be the enhancement of greatest benefit. The current hours- and task- based system precludes the use of simple and practical solutions (e.g., allowances for transportation or snow removal). Some programs supporting the use of simple solutions do exist, although they may only be of real benefit to those of very low-income. They can also be difficult to navigate given their siloed nature. More flexible programming and service authorization models have proven successful elsewhere, built somewhat as “one-stop shopping” models for all things supporting care at home. These programs typically result in successful downward substitutions. Such a model is recommended for implementation in Nova Scotia.

To adequately support the use of practical solutions, enhancing services such as adult day programs and accessible transportation would assist in allowing clients to remain at home.

Home-based paraprofessional service delivery, particularly physical and occupational therapy, would also be necessary to allow people to functionally remain at home. An improved home-based delivery model for these supports should be examined. Services for mental health should similarly extend further into the home and community, particularly through greater support for home care workers and caregivers. This could be done through enhanced training and education for both of these groups, through greater access to challenging behavior resource consultants, and through a mobile psychogeriatric team approach to home/community mental health services.

Access to, and Integration of, Primary Care Services

Primary care provision in the community also must be accessible to deter unnecessary acute and long-term care placements. This would necessitate greater recruitment and

retention efforts for primary care providers, and the utilization of newer models of primary care, for example, those using nurse practitioners and paramedics. The general approach to managing cases in the community must be examined. A system level case management approach is recommended, requiring genuine collaboration not only between the acute and continuing care systems, but with primary care providers as well. Policies and procedures should change to ensure these partnerships are in place, both prior to discharge and on an on-going basis.

Insufficient Supports for Informal Caregivers

Research indicates that there is no significant difference between the clinical profile of those residing in ALC beds and those awaiting LTC placement in the community. Our consultations very clearly indicated that the primary determinant of whether or not home care is an option for an individual is the availability of an informal caregiver. The pressures on caregivers can become unsustainable physically, mentally, and financially. We must question whether we can fundamentally change the system to one that is home-focused given our heavy reliance on informal caregiving. As it stands, caregivers must be supported. As an initial step, enhanced respite options are recommended. An overall caregiver strategy should be developed.

The Cost of Living at Home

Cost is a barrier to remaining at home for many individuals. The cost of care itself may be not prohibitive, but service expenses in combination with others such as incontinence and skin integrity products, snow removal, lawn and house maintenance, and home adaptations can be exorbitant for some. It is recommended that income testing policies be examined for possible increases in income thresholds, and that the examination of necessary expenses become a more prominent piece of the income testing process.

The Assessment Process in the Community

Current process dictates that referrals for continuing care services are made for either home care or long-term care. Assessments for home care should be the first step in receiving continuing care services. This could potentially postpone future long-term care placements, or could provide much-needed help to individuals and their caregivers while they await a facility placement. High-risk or vulnerable individuals could also be pre-emptively identified for home care services at the primary health care provider level, by incorporating a simple screening process into the regular check-up procedure of the elderly.

Information in, and Expectations of, the Public

A wide variety of supports are often overlooked by the public due to a lack of awareness of their existence or a lack of knowledge of how to access them. There is also a great deal of misinformation about what home care is and does in the public. Awareness and knowledge are key elements to a successful home support system. Public relations and educational campaigns regarding home and community options are recommended.

The Current Long-Term Care Waitlist Policy

The Nova Scotia single-entry access policy to long-term care is based, with the exception of certain situations, on the chronological order of the classification date. This is problematic in that those waiting with the greatest level of need may not be in a long-term care bed first. When a high-needs individual with low supports waits in the community, their likelihood of ending up in the hospital is higher. Current policy should be changed from one based on chronological order to one based on need.

Ineffective Data Collection and Evaluation


There is little information available to inform cost-benefit and outcome analyses of various programs and services. Enhanced and targeted data collection, including that which is qualitative in nature, along with systemic knowledge transfer mechanisms, would provide a more comprehensive picture of who has what care needs where, thus better informing service planning.

1. Purpose

Throughout Nova Scotia, hospital beds are being occupied by individuals who are not in need of acute care services. This occurs for a variety of reasons, including insufficient long-term care (LTC) resources, complex needs, and inadequate levels of informal, community, and primary care supports. Regardless of the reason, it is generally agreed that medically stable individuals should be cared for outside of the hospital whenever possible.

The overall intent of this report was to examine how elderly individuals end up in alternate levels of acute care (ALC), and how it can be better ensured that people have access to the right care in the right place in the most efficient manner.

Specifically, the objectives were to examine factors that contribute to delays in the process of accessing home care services from the hospital, to identify barriers that limit or preclude individuals from receiving supports at home, and to identify solutions for making home care a more viable option.



“An opportunity, and in fact, a duty, exists to transform our health care system to meet the needs of this increasingly aged population who will live longer, in states of both health and illness”

- Walker, 2011

2. Methodology

For the purposes of project manageability, the scope of this work was limited to the Cape Breton District Health Authority (CBDHA), chosen due to the region’s particularly long wait-list for long-term care. Recognizing potential regional differences, general applicability of the higher-level recommendations is anticipated. The project was also limited to an examination of the frail elderly population, in, or on route to, an ALC placement.

Both qualitative and quantitative data were used to inform the identification of challenges and recommendations for improving the road from hospital to home, or avoiding a hospital placement altogether. Literature reviews, database searches, interviews, focus groups, and raw data from the Government of Nova Scotia provided evidence. More particularly, MDS-RAI and SEAScape information was examined, as was home care service delivery hours and utilization rates within CBDHA. Grey literature was used to investigate solutions to home care barriers in other jurisdictions. Qualitative information was collected from a variety of stakeholders in the district through a committee of health authority, home care provider, and government representatives.¹ Interviews were conducted with 26 individuals (or their caregivers) on the long-term care waitlist in the Cape Breton region, some who were receiving public home care

¹ For a list of committee members, see Appendix B

services, others using private options, and still others with only informal support. A physician from the Regional Hospital was also interviewed.

3. Limitations

This report was written without in-depth qualitative data on the clinical diagnostic profile of ALC patients in the Cape Breton Region. We were also unable to interview a more representative group of ALC patients regarding their experiences leading to that placement.

4. Background and Context

A Paradigm Shift

The health profile of the western world is changing due to factors such as the aging of the baby boom generation, outmigration, and lower birth rates. Seventeen percent of the population of Nova Scotia is senior - the highest proportion in the country, and that proportion that is expected to rise to 25% by 2026 (Statistics Canada, 2012; Province of Nova Scotia, 2005). The Cape Breton Regional Health Authority is comprised of 14% of the total provincial population, although nearly 20% Nova Scotia's seniors reside in the area (Department of Health and Wellness, 2012; Cape Breton District Health Authority, 2008).

Knowledge, pharmaceutical and technological advances, and lifestyle changes are keeping people alive longer. Whereas infectious disease was once society's most prominent health concern, chronic disease is now the biggest driver of health system use (Canadian Institute for Health Information, 2011). The Cape Breton population in particular has chronic disease concerns, as many health indicators pertaining to this region indicate higher than average disease levels and undesirable health outcomes (Statistics Canada, 2011, 2012; CBDHA, 2008). The paradigm shift from infectious to chronic disease is catalyzing slow modifications in the health system, with decision-makers attempting to redirect focus from acute services to care along the continuum. Few jurisdictions, however, have fully committed to this change (Goldsmith, 1990; Ross, 2010; Walker, 2011).

Within the continuing care field, emphasis is heavily placed on long-term care, as it is, for a variety of reasons, often considered the best and safest option for the frail elderly and individuals with complex needs. Keeping up with the demand for long-term care has proven challenging. The Government of Nova Scotia has constructed over 800 new long-term care beds since 2006, yet still faces an ever-increasing wait-list that is now reaching over 2200 people (Province of Nova Scotia, 2011; Nova Scotia Department of

Health and Wellness Continuing Care Branch, 2012). Tackling supply seemingly does little to ease the demand (Nova Scotia Department of Health and Wellness, 2010).

It has also been suggested that only a small proportion of the elderly have care needs so intense that residential care is the only safe option (Williams, et. al., 2009). The inability to perform the light instrumental activities of daily living, such as housework, transportation, meal preparation, medication management, and grocery shopping, is the typical catalyst for a long-term care placement (Williams, et. al., 2009).

ALC Beds in Nova Scotia and CBDHA

Individuals who occupy hospital beds who do not require the level of service provided in that setting can be said to be “alternate level of care” (Ontario Ministry of Health and Long-Term Care, 2008). This is a designation given by a physician or delegate. Depending on the hospital, these patients may be housed in specific beds, transitional care units (TCUs), or in regular acute care beds.

About 3% of hospitalizations in the province are categorized as ALC. Fourteen percent of Nova Scotia’s ALC patients die while still in hospital – the highest proportion of ALC deaths in the country (Canadian Institute for Health Information, 2009). CBDHA has five facilities with ALC beds or admissions, similarly accounting for 3% of the acute care population in the jurisdiction (Canadian Institute for Health Information, 2009; Canadian Institute for Health Information, 2011). The District has longer lengths of ALC stay at 61.3 days than both the province as a whole (54.4 days) and nation-wide (21.7 days) (Canadian Institute for Health Information, 2009). Just over 60% of ALC patients in Cape Breton are discharged to LTC facilities (Nova Scotia average is 46%). About one quarter of ALC patients in the District are discharged home, approximately half of which go home with public home care services.

Table 1: ALC Cases and Lengths of Stay

Location	ALC Cases (total)	% ALC Cases of all Hospitalizations	Avg Length of Stay (# days)
CBDHA	306	3.0	61.3
Nova Scotia	2,190	2.8	54.4
Canada	87,893	4.0	21.7


Canadian Institute for Health Information (2011). Alternate levels of care profile. *Discharge Abstract Database*. Accessed May 18, 2012.

Table 2: ALC patients by discharge disposition (%) October 1, 2010 to September 30, 2011

Location	Transfer to other acute location	Discharge to long-term care	Discharge home with support services	Discharge home without support services	Died
CBDHA	2	61	13	11	12
NS total	14	46	10	11	14

Data from the Nova Scotia Department of Health and Wellness and the Cape Breton District Health Authority.

Generally speaking, ALC patients are likely to have chronic, comorbid conditions and a high level of care need (Canadian Institute for Health Information, 2009; The Change Foundation, 2011). Most ALC cases are the frail elderly, individuals with cognitive or behavioral problems, or are neurology or stroke patients. Others have been admitted for palliative, convalescent care, or physical therapy (Canadian Institute for Health Information, 2009; Walker, 2011). Our committee indicated that the patient profile of CBDHA ALC patients generally mirror this picture, with these individuals experiencing frailty, heart conditions, neuropathy, diabetes, physical, mental and cognitive impairments, or other chronic and high level care needs. Almost 97% of ALC patients in the District have moderate to severe difficulty in performing the instrumental activities of daily living, and nearly half have a diagnosis of Alzheimer’s or dementia (Cape Breton District Health Authority, 2012).



There is no significant clinical difference between patients who remain in hospital for a long-term care placement and those who are sent home, indicating that other factors, besides those medical in nature, are at play.

Interestingly, research tells us that there is no significant clinical difference between patients who remain in the hospital for a LTC placement, and those who are sent home (Canadian Institute for Health Information, 2009; The Change Foundation, 2011). This clearly indicates that other factors, besides those which are medical in nature, are at play. Many, if not most, ALC patients await long-term care placement because they cannot perform basic self-care, and/or they have an insufficient level of informal support at home.

Eighty percent of ALC admissions in Nova Scotia originate in the emergency room (Janet Ivory, DHW, personal communication, December 17, 2012). Anywhere from 45-75% of emergency room (ER) cases in Nova Scotia’s regional hospitals are considered minor in nature, and this percentage grows higher in smaller rural hospitals, primarily due to insufficient access to primary and community care. (Ross, 2010). Many areas of Cape Breton are identified as lacking in primary and community service options, while at the same time the region has more emergency departments per capita than elsewhere in the province (which is partially attributable to geography, but also due to culture and public opinion) (Ross, 2010). Thus, hospitals often become the default entry point into the system and the go-to spot for even the most basic of services.

ALC placements pose significant challenges to the provincial health care system as they can obstruct the provision of services to those who need acute care. Unnecessary hospital stays can also play a factor in the deconditioning of ALC patients themselves. The magnitude of the ALC problem is indicative of a health system failure to provide the services needed by this population – a gap which results in inappropriate resource

utilization and poorer health outcomes. As such, an opportunity lies in closely examining exactly why these individuals remain in hospital, and conscientiously shifting focus to address the barriers that inappropriately keep individuals from living functionally and safely at home.

5. Barriers and Solutions

A Facility- Focused Philosophy

The home can be an appropriate and cost-effective place to provide care for chronic conditions (The Change Foundation, 2011; Williams, et. al., 2009; North East Local Health Integration Network, 2011). More importantly, the home is typically where people want to be. When appropriate resources are in place, care at home can result in better health outcomes, slowed deterioration, and can occasionally improve circumstances to the point where the trajectory to long-term care can be slowed or stopped (Shepperd, 2008; The Change Foundation, 2011; CBDHA, 2012).

Mirroring a similarly named initiative in Ontario, CBDHA recently implemented My Home First programming to provide enhanced home care services to would-be ALC patients. Under this program, medically stable inpatients in the transition unit of the Cape Breton Regional Hospital are provided enhanced home care hours and supports, in order to await long-term care placement in their own residence. Eligibility guidelines for the program are relatively restrictive. Participants must have a family doctor, be able to, or have a plan to, manage their own care, and must remain on the long-term care waitlist to partake (CBDHA, 2012). The program has proven valuable in Ontario, and is intended to be expanded not only within Cape Breton, but elsewhere throughout Nova Scotia (Knowles, 2012).

While the underlying principal of the My Home First initiative is that people should be in their own homes whenever it is safely possible, our consultations indicated that the prevailing philosophy in practice is that frail seniors are most appropriately cared for in the long-term care environment. Depending on the point of entry to the system and the individuals making the decision (i.e., physicians, care coordinators, individuals / families), frail seniors and other vulnerable populations can be put on the long-term care trajectory without due consideration of home care. Many decision-makers favor least-risk care decisions, which can often lead to service provision in an institutional setting.

The District should consider instating “home first” not only as a program, but as a district-wide philosophy. Such a philosophy would require a change in culture and a new definition of what success “looks like” for all health related programs, accompanied by a related shift in resources. Walker (2011) recommended a similar “assess and restore” philosophy for Ontario, under which all services and programs would be designed to get an individual safely home. Williams et. al., (2009) described a “balance of care” model

used in the United Kingdom, where success was not measured by a person's return to full functionality (a generally unrealistic goal for the elderly), but by care and adaptations that allowed a person to be functional in the home environment. Denmark, touted for its emphasis on home care, has intentionally not built a new nursing home since 1987, favouring instead investment in formal care delivery in the home (Schulz, 2010). These are all examples of changes in philosophy leading to changes in practice.

Under a "home first" philosophy in the Cape Breton region, the approach to care at the acute level would shift to one that is focused on restoration. The philosophy would see ALC beds transform from holding units to places of rehabilitation, with the goal of progressing a patient to the point where he or she could participate in an expanded home care program. To operationalize this ideology, additional and targeted programming and staffing, particularly in the physiotherapy and occupational therapy sectors, would be necessary (Walker, 2011). Care programs would be designed to mitigate deconditioning and to restore a person to the point of being functional at home.

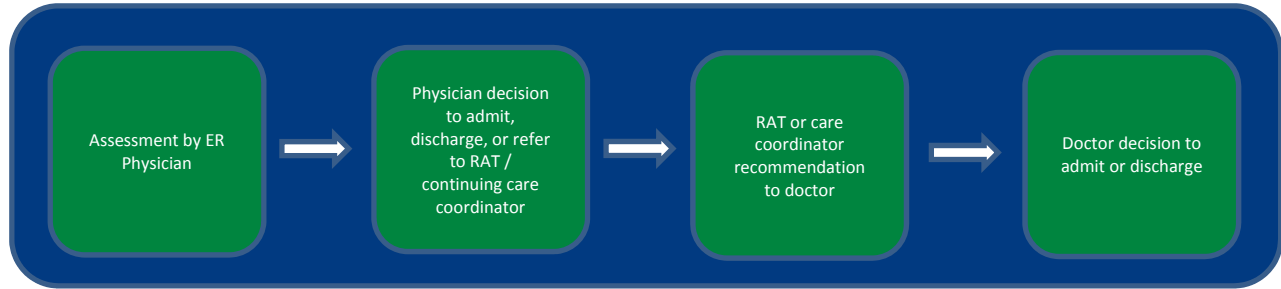
The following recommendations are made to mitigate the barrier of a facility-focused philosophy:

- The District should adopt "home first" not only as a program, but as a philosophy, making safe and effective care at home the primary goal.
- The philosophy driving care for ALC patients should be changed from one based on transition to one based on restoration. Services and supports on these units and for these patients should be enhanced accordingly (e.g., physiotherapy and occupational therapy).
- Based on the success of programs like My Home First in other areas, CBDHA should reconsider its My Home First eligibility guidelines, extending them to include more ALC patients and beyond (for instance, current LTC residents) who could potentially benefit from the program.
- Under new extended guidelines, all ALC patients should be immediately reassessed for their ability to receive care at home.
- The District, government, and home care agencies should work together to ensure that agencies are appropriately positioned and supported to care for clients in extended home care programs.

The Emergency Room Assessment Process

Based on a new "home first" philosophy, new processes need to exist. It is understood through conversations with our committee that different hospitals use different processes to assess patients presenting in the ER. For the purposes of this paper, we will use the Cape Breton Regional Hospital as an example of current practice (Figure 1).

Figure 1: Continuing Care Assessment Process in the Cape Breton Regional Hospital Emergency Department



The emergency department at the Cape Breton Regional has a Rapid Assessment Team (RAT), consisting of a social worker, physiotherapist, and occupational therapist. The team can be called on by an attending physician to evaluate a medically stable, senior-aged patient for the ability to be safely discharged (CBDHA, 2011). The Regional is the only hospital in the District to have a RAT, and, as it has only been recently introduced, its value has yet to be quantitatively evaluated. Local staff do anecdotally indicate that the team helps to make better and quicker care decisions. The RAT makes recommendations to the ER physician, who is the final decision-maker in how and where an individual will be cared for. When the RAT is unavailable, a referral for a home care assessment can be made to a social worker, physiotherapist, or care coordinator.

The RAT currently works in the emergency department weekday mornings only. The team spends weekday afternoons doing home visits. Ross (2010) indicates that emergency admission rates are relatively predictable on a day-to-day basis, and as such, the District should ensure that the RAT is available to the ED during peak hours of the day and week, if these differ from the current RAT schedule.

We understood through our consultations that a standardized process for the assessment of a medically stable senior in the ER does exist, although, in practice it is not always followed. Continuing care assessment referrals are made at the discretion of the ER physician, who may or may not have a full grasp of possible helpful home and / or community supports. Additionally, in hospital as in the community, continuing care assessment requests are specific to either home or long-term care, again at the discretion of the referrer. Although we heard through our consultations that home care options are often discussed between potential clients and care coordinators at the point of the long-term care assessment, home care is not a mandatory first step in the assessment process. There appears to be an element of subjectivity in a referral, the result of which may be the trajectory towards a nursing home placement without due consideration of home-based services.

Ideally under a “home first” philosophy, all seniors presenting in the ER who are not in a “life or limb” situation would receive a multidisciplinary team assessment for possible home supports. However, given the resources this would require, a possible starting

point could be to consider implementing a standardized screening approach for seniors who present in the emergency room. Triage presents an opportunity for such a screening process, which may be as simple as asking an individual if he or she currently receives home care, along with a few key questions that could indicate if home support would be beneficial.

Based on the barrier of the current ER assessment process, the following recommendations are made:


- In the Cape Breton Regional Hospital, ensure the RAT is available during peak ER hours. Extend these hours as possible.
- Make an assessment for home care the mandatory first step to accessing continuing care services.
- Using an agreed-upon tool or set of questions, standardize the screening process of seniors presenting in the emergency department to proactively indicate potential home/community care beneficiaries.
- Indicate if a person is currently receiving home care services on the emergency room chart. Ensure home care agencies are notified when this is the case for an individual presenting in the ER.

The Discharge Planning Process

Not unlike the assessment process, our consultations also indicated that the discharge planning process can be haphazard and confusing, resulting in last-minute scrambles to assemble information when a patient is ready to leave the hospital.

Discharge planning should begin at the time of admission. This philosophy is used elsewhere with great success (Walker, 2011; Ross, 2010; National Health Services' Institute for Innovation and Improvement, 2006). Data can generally indicate how many days a patient with a particular profile will require in hospital. For example, the average length of ALC bed stay in the Cape Breton District is 61.3 days, with a range of 20 to 90.7 days depending on the acute care location (Canadian Institute for Health Information, 2011). Under a new model based on a "home first" philosophy, discharge dates may become more predictable and shorter, given anticipated expansions in home and community supports. Regardless of the end destination, defining the discharge date in advance allows all stakeholders (the individual, family, and service providers) to understand their accountabilities and have appropriate measures (e.g., supports, paperwork, etc.) completed in advance for a smooth transition. As such, it is recommended that a process be developed that outlines target dates and accountabilities for all necessary steps in the discharge process, so that pertinent

information is collected and supports are in place in advance. This process should be in place regardless of the admission unit or end destination.²



“Whereas physicians possess the skill sets to address the acute care needs of their patients ... case managers possess the skill sets to determine the appropriate discharge destination”
- Walker, 2011

Decision-making around discharges should also be made by a multidisciplinary team, including the patient, family/caregivers, social worker, physiotherapist, occupational therapist, and a physician. It should also involve primary care providers in the community. In addition to evidence showing the positive effects of team-based work and a multidisciplinary approach (see Borrill et. al., no date), practice in other jurisdictions has indicated the success of models whereby care planning is led by a designated team lead or case manager, who takes input from various clinical professionals and matches needs to appropriate care environments using an in-depth knowledge of available resources (Nova Scotia Department of Health and Wellness Continuing Care Branch, 2011; Walker, 2011). As Walker (2011) puts

it, “whereas physicians possess the skill sets to address the acute care needs of their patients ... case managers possess the skill sets to determine the appropriate discharge destination”.

Discharge could be occurring seven days a week (National Health Services, 2006). The practice at CBDHA hospitals leads one to believe that the task of discharge coordination is undefined or that it is for only clinical leads to accomplish. All front-line staff should be aware of their responsibilities in the discharge process and should be poised to fulfill this role. Of course, for discharge to occur all days, home care agencies would have to be supported and prepared to accept clients. As part of the new emphasis on an advanced-planning discharge process, it is felt that the necessary arrangements could be made.

Based on the barrier of the current hospital discharge planning process, the following recommendations are made:

- Continue to advance a standardized and mandatory discharge process, including placing heavy emphasis on starting the process at the time of admission.

² The Cape Breton District Health Authority completed some significant work in early 2013 to streamline the discharge process. A discharge planning booklet for patients and a checklist for service providers was developed and implemented in order to ensure accountabilities, and to pre-emptively collect and disseminate necessary information.

- Make decision-making and discharge planning a multidisciplinary team effort, led by a designated team lead knowledgeable in available and helpful home and community resources.
- Develop guidelines outlining the information and supports necessary for a discharge, with proactive timelines for preparation and accomplishment. Outline who is responsible for each item (including patients / families, front-line staff, doctors, care coordinators, etc.), and when it must be complete.
- Ensure the right people and practices are in place to allow for discharge to occur seven days a week.

Gaps in Provider to Provider Communication

Seamless transition and integration are key elements of a successful discharge process (Canadian Life and Health Insurance Association, 2012; Côté and Fox, 2007; Wilson, 2007). If a decision is made for a person to receive supports in the home, communication and collaboration between acute and community systems is pivotal. Integration through new service agreements between the District Health Authorities and continuing care organizations is on-going, and the two normally siloed systems are drawing closer together. However, systemic communication mechanisms remain lacking, particularly as they relate to discharge communication, and thus the transition process is slowed. New protocol for advanced planning discharge, along with tools such as the newly developed provincial discharge/transfer tool, may start to improve communication; however, neither is sufficiently comprehensive to facilitate best-possible communication between health care providers. The District, in partnership with home care agencies, should develop a set of guidelines that would ensure all of the pertinent information above and beyond what is currently collected and disseminated (including a patient/client's likes/dislikes, financial information, etc.), is ready and communicated well in advance of a projected discharge date.

- Develop guidelines and protocol regarding proactive communication of necessary information, outlining responsibilities and accountabilities for acute care, home care organizations, family members and other key stakeholders.

A Misunderstanding of What Home Care is and Does amongst Health Professionals

We heard through our consultations that there is a lack of awareness of what continuing care is amongst acute care professionals, which can be concerning given these individuals can be responsible for making care trajectory decisions. Hospital physicians would be a key area to target in terms of education regarding what home care is and does, given their significant role in determining current and future places of care. It is important that they are aware of, and well-versed in, home and community options for the most appropriate, yet least intensive interventions. That being said, should the District adopt the recommended multidisciplinary decision-making model, all implicated health professionals would need to be aware of available supports.

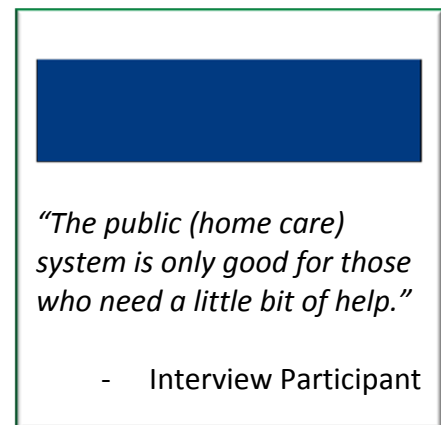
Health professional champions, or peer leaders, would be key in advancing awareness amongst front-line staff and implementing shifts in practice. Research has shown the effectiveness of using champions to change behavior in the health field (e.g. Slaunwhite et. al., 2009; Holland et. al., 2010; Rogers et. al., 2009). All pertinent groups of health professionals (nursing, physiotherapy, etc.) would need a peer leader identified to help foster front-line buy-in to the new philosophies and processes.

Based on the knowledge gap regarding what home care is and does, we recommend the following:

- Develop a strategy for better informing acute care health professionals on the “home first” philosophy, and the availability and appropriate use of all continuing care services.
- Identify peer leaders in each pertinent health profession to champion “home first” philosophies and procedural change (e.g., District Medical Director of Continuing Care, nursing peer leader).

Home and Community Care Options

Just over 3% of seniors in CBDHA receive home care (Nova Scotia Department of Health and Wellness, 2012). Most of these recipients have lower-level care needs and receive only a few service hours per week (Nova Scotia Department of Health and Wellness, 2012). The majority of Cape Breton home care clients (62.9%) are aged 75 or over when referred, over 70% have moderate to severe difficulty in performing the instrumental activities of daily living, and just over 15% have a form of dementia (Cape Breton District Health Authority, 2012). The largest proportion of direct home support service hours go towards nutritional care (43.7%), followed by personal care (27.6%), light housekeeping (20.3%) and respite (16.3%) (Nova Scotia Department of Health and Wellness, 2012). We cannot definitively say why there are such low hours of care being requested and authorized in the public system, but based on information from our interviews, it is possible to say that lack of awareness may be an issue, and that some of those with more constant care needs are benefitting from a 24/7 caregiver and / or private hire. As one interviewee put it “the public system is only good for those who need a little bit of help”.



These low numbers of public hours and the high proportion of light duties being authorized indicates an opportunity for growth. If emphasis is going to be placed on having people “home first”, the right services and supports must be available for safe and effective care outside of the hospital. By expanding home care options for both those in hospital and those in the community, the number of ALC bed days could be

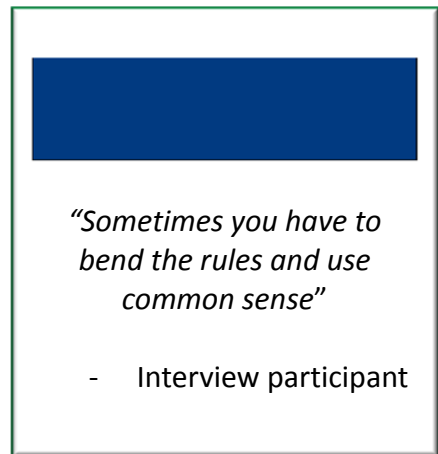
reduced directly (by allowing current ALC patients to go home) and indirectly (by mitigating or postponing future hospitalizations and long-term care placements from the community).

Through the literature and our consultations, we discovered a variety of aspects of service that could be targeted for expansion to make home care a more viable option.

Increased Service Authorization Hours

By and large, the one thing our interviewees said would help keep individuals at home would be more home care hours. Many of those waiting on the long-term care waitlist need “round the clock” care. These care needs may not be intensive from a clinical point of view, but support is necessary on a constant basis due to immobility or cognitive decline. Such a 24-hour watch will typically fall to caregivers, who are at a significant risk of burnout. Private hiring may come into play when it is financially accessible, although it is done so at significant cost. The predominant enhancements to the public home care system suggested by our interviewees were longer sessions (i.e., overnight and weekend respite), an increased frequency in shorter visits (i.e., check-ins), or, in some cases, affordable in-home 24/7 care.

- Where warranted, consider increasing the number of service authorization hours, including longer (e.g., for respite) and more frequent shorter visits (for check-ins), based on the needs of the individual and the availability of a caregiver.³
- Ensure that home care agencies are prepared and appropriately supported to provide increased services and authorization hours.



A Different Approach to Flexible Service Authorization

Regardless of the point of entry into the continuing care system, flexibility in service authorization allows for better client-centred care (Williams, et. al., 2009). As one interviewee put it, the health system “tries to fit everyone into these little boxes”. An hours- and task- based system with strict guidelines on what services can be provided or subsidized can circumvent simple and practical solutions. Service authorization should be based on specific needs, and cannot simply focus on issues clinical or task-based in nature. Rather, they should focus on whatever keeps a person at home. This could range from overnight respite to allowances for transportation and snow removal (two major issues identified in our interviews). The province has recently made strides to address care needs with an enhanced level of flexibility through the development of a new instrumental activities of

³ Since beginning this project, the province has made improvements in line with this recommendation, enhancing the maximum number of service authorization hours from 40 to 100-150 hours per month.

daily living (IADLs) program, which will see DHAs receive funding for IADL concerns in their jurisdiction. Other programs exist to support individuals to live at home, for example, the Department of Health and Wellness' Supportive Care Program, which offers low-income residents with cognitive impairment \$500/month to purchase home supports, and the Department of Community Services' Home Adaptations for Seniors' Independence program, which provides up to \$3,500 in forgivable loans to low-income seniors for home adaptations.

One significant observation can be made. These services and programs are siloed in nature. This division makes them difficult to navigate, or even be aware, of from a consumer perspective. Flexible programs, modeled somewhat as "one-stop shopping" centres for all things related to home care, have proven effective in other jurisdictions. For example, the United States' PACE (Program of All Inclusive Care for the Elderly) project and Quebec's *systeme de services intégré pour personnes agees en perte d'autonomie* (SIPA) provides multidisciplinary teams with prefixed budgets to serve individuals' needs without prescriptive guidelines. These all-encompassing programs typically result in needs-based, tailored, "downward substitutions" (Williams, et. al., 2009). The model makes the interaction with the health system a more pleasant one, and ensures the most appropriate supports are being put in place to serve an individual's unique situation. An all-encompassing program would make care planning easier for a multi-disciplinary team or clinical lead, as the most pertinent supports would be available for authorization or recommendation to clients and patients.

Based on the need for all-encompassing, individualized, collaborative programming:

- Ensure that service authorization guidelines provide an adequate amount of flexibility so that care coordinators / case managers can authorize safe, effective, common sense downward substitutions when they are a viable part of a care plan. Consider the feasibility of using an all-encompassing, prefixed budget model like the PACE or SIPA program, effectively housing all home support options under one roof.

Bring Therapy to the Home

To help people become or remain functional in the home, it would be necessary to enhance home-based physical and occupational therapy (Walker, 2011; Ross, 2010). Some patients remain in the hospital simply to receive paramedical services, based on their cost in the community or a lack of transportation to appointments. Home visits would make it easier for clients to have their therapy, and would allow the treatments to focus on functionality in the home environment. To make the best use of resources in an efficient manner, physiotherapist and occupational therapist assistants could provide in-home sessions, under the direction of the appropriate paraprofessional.

- Create a plan for physical and occupational therapy home visitations, including the potential use of paraprofessional assistants for therapeutic visits.

Provide Support for Those with Mental Health Concerns

The number of individuals on the long-term care wait list with dementias and other cognitive impairments indicate there would be benefit in increasing mental health supports and treatments in the home and community. Mental health issues can lead to a variety of concerns that typically result in a facility placement, including aggressive behavior, wandering, and forgetfulness. While it is noted that more severe cognitive conditions may require a facility placement at this point and time, there are some home care enhancements that could be made what would facilitate home-based care.

Home support workers require more comprehensive mental health training, and staff should be receiving increased education on identifying and managing mental health issues. Training could, and should, also be made available to informal caregivers, as they are the individuals who spend the majority of time with the client.

Both home care workers and caregivers could be more sufficiently supported by the Challenging Behavior Program and challenging behavior consultants. Workers and caregivers would also benefit from a psychogeriatric team approach to therapy in the home. Under such an approach, an interdisciplinary team of professionals, knowledgeable in caring for a psychogeriatric population, could provide outreach, ambulatory care clinics, geriatric rehabilitation, and emergency management services. Similar programs have been successfully established in areas like Toronto, where the goal is to “provide a seamless continuum of care to treat acute illness and return a frail senior to the highest possible level of independent functioning” (Regional Geriatric Program of Toronto, 2011).

Finally, the District and home care agencies should develop or strengthen relationships with mental health organizations and networks providing support for seniors and their caregivers. An example would be the Alzheimer’s Society of Nova Scotia. Our consultations indicated that there are resources and supports available from such groups, although accessibility may not be adequately far reaching. Those in rural areas may not be able to travel or find respite time to attend peer-help groups or education sessions. Health service providers and the government can partner with organizations to identify and implement more effective ways to provide support.

- Provide enriched mental health training to home care workers.
- Make similar training and education available to caregivers.
- Provide more support to the home care sector via the Challenging Behavior Program and challenging behavior consultants.
- Explore the feasibility of using a psychogeriatric team approach to care in the home.
- Explore the feasibility of partnering with relevant mental health related organizations to provide and enhance appropriate and accessible supports for individuals and their caregivers.

Utilize and Expand Adult Day Programs

Adult day programs are seen by many as a valuable tool in keeping seniors at home. For caregivers, these programs provide peace of mind and respite from the daily demands of caregiving. Some of our interviewees found trying to balance family, work, and caregiving extremely stressful and overwhelming. Adult day programs can help to ease some of this stress by providing an alternative staying home or hiring private care during the day. They can also reduce social isolation and loneliness for the elderly, both of which were concerns of the caregivers we spoke to.

A scan of adult day programs across Cape Breton indicated different usage patterns across the region depending on the location. Some programs are functioning at capacity and others are being underutilised. There is no evidence definitively indicating why this may be the case, although our consultations suggested that lack of transportation and awareness, along with financial accessibility, may be contributing factors. District providers may wish to examine caregiver and patient/client profiles in low-uptake areas to see if the program is better suited elsewhere, or if it is issues like transportation, awareness, or cost, that are barriers.

- Ensure adult day programs are present in areas where they would be of greatest benefit.
- Where there is a low up-take of an adult day program in a high-needs area, investigate the predominant reasons for the low up-take and develop plans to mitigate these barriers.
- Ensure that the public and health professionals are aware of the existence and benefits of adult day programs.
- Using the recommendation of flexible service guidelines and a “one-stop shopping” home care program model, make adult day programming part of possible service recommendations by care coordinators.
- Ensure that the cost of participating in adult day programs is affordable.

Invest in affordable, reliable transportation for seniors

Transportation can be an enormous barrier to accessing services and performing the IADLs, particularly in rural regions. In the case of one of our interviewees, Emergency Health Services was the only accessible and safe option for a loved one’s transportation. This is obviously costly and an ineffective use of emergency services, but speaks to the potential enormity of the transportation issue.

There are excellent examples of successful, inexpensive and flexible rural transportation programs in the province, for example, Straight Area Transit in the Port Hawkesbury area. The District may wish to partner with local municipalities to mirror the organization’s model, or to develop a different, locally-based system. If and when such transportation options exist, its benefits should become part of a multi-disciplinary team’s and care coordinator’s inventory of home / community support options. Using a new service authorization guideline model with flexible budgeting, monetary allowances for affordable transportation could be offered.

- Work with municipalities and other relevant local partners to enhance reliable, inexpensive transportation options throughout the district.
- Ensure case managers / care coordinators are aware of local transportation options in their region. Ensure that the consideration of transportation support is included in care and discharge plans.
- Use flexible service authorization guidelines and a “one-stop shopping” home care program model to provide allowances for affordable transportation where it is deemed a significant barrier.

Access to, and Integration of, Primary Care Services

At the root of exacerbated chronic illness and repeated visits to the emergency room is a lack of primary care provision in the community.


There are a variety of ways to increase access to primary care. The recruitment and retention of family doctors who are willing to take on frail elderly populations is one obvious measure. Nurse practitioners are becoming an increasingly popular alternative for primary care delivery. There is a great deal of interesting work being done using paramedics for chronic care treatment and monitoring (Travers, 2014; Ross, 2010). The District should continue its work in attempting to meet the primary care needs of its population and considering implementing or enhancing these services using newer models of care as appropriate.

In addition to new primary care resources and models, the general approach to case management must be examined. A system-level case management approach in the community would require strong collaboration between acute, primary, and continuing care systems. British Columbia recently developed such an approach through its Home Is Best™ program (Canadian Home Care Association, 2012). Similar to My Home First, yet strategically emphasizing the primary care component, case management under Home Is Best™ is done via a health care team, including a family physician. Primary care nurses are engaged to monitor uncomplicated conditions. Applying a similar model in the Cape Breton region could be investigated. Policies and procedures could change to ensure the engagement and partnership of primary care resources before a discharge to the community, and on an on-going basis. These partnerships could be further solidified after establishing new primary care models and involving new practitioners (e.g., nurse practitioners, paramedics).

- Enhance primary care access through the recruitment and retention of family practitioners, as well as through the utilization of newer models of primary care provision, for example, those using nurse practitioners and paramedics.
- Examine the approach to case management in the community, including how primary care is engaged. Develop an approach that uses appropriate collaboration between acute, continuing, and primary care providers.

Insufficient Supports for Informal Caregivers

Our consultations very clearly indicated that the primary determinant of whether or not home care is an option is the availability of an informal caregiver. Informal caregiving plays a vital role in the Canadian health system. Seventy-five to 85% of care provided in the community is done by an informal caregiver at an average of 22 hours a week (Nova Scotia Respite Working Group, 2000; Posse, et. al., 2008). There are implications for opting for a system so heavily reliant on informal caregiving; implications which are becoming increasingly significant due to an aging population, longer life spans, progressively complicated care demands, smaller families, and an out-migration of family members (The Change Foundation, 2011; Nova Scotia Community Counts, 2012; Nova Scotia Respite Working Group, 2000). In the Cape Breton District, 37% of individuals on the long-term care waitlist, and almost one-quarter of persons receiving publically funded home care, require 25+ hours of informal care a week. We spoke to many people who were far beyond this point, requiring 24 hour care provided either by a stay-at-home caregiver or private hire. The pressures on caregivers can become unsustainable physically, mentally, and financially. Some younger caregivers give up their own family and personal lives to care for a mother or father. Some caregivers are sick, frail, and old themselves. Fifteen percent of informal caregivers to home care recipients, and 30% of caregivers to long-term care waitlist referrals, experience caregiver distress (Cape Breton District Health Authority, 2012). When the ability to cope is exceeded, a typical result is a visit to an emergency room (Canadian Institute for Health Information, 2010, Ross, 2010; Walker 2011).



The primary determinant of whether or not home care is an option is the availability of an informal caregiver.

There are a variety of supports currently available to caregivers. A recent announcement saw the provincial government increase funding to Caregivers Nova Scotia for community-based peer groups, telephone assistance, and other services (Government of Nova Scotia, 2012). In October 2012, the Government raised the low-income threshold of its \$400/month caregiver benefit from \$18,785 to \$22,003, which was estimated to assist an additional 100 citizens (Government of Nova Scotia, 2012). However, this threshold remains quite low. As one interviewee put it “you basically have to be on social assistance to get any help”. Other eligibility criteria for the benefit are of concern, for example, an individual’s MAPle score (an indicator of cognitive function) must be at least moderately high for the caregiver to be considered, leaving many in the moderate, yet still demanding, range, ineligible for financial assistance.

To fundamentally change the system to one that is home focused, a philosophical question must be posed – will we continue to rely on informal caregiving, or will we formally support individuals and their families to the full extent needed for them to stay home? If we are to continue to rely on caregivers, they must be adequately supported.

- Develop a Caregiver Strategy to support caregivers. Include in this strategy enhanced elements of financial and social assistance.

Enhance Respite Options

Both our interviews and the grey literature indicated that enhanced respite options would be of great benefit to caregivers and would make a significant difference in the ability to cope (Canadian Life and Health Insurance Association, 2012). Respite care in Nova Scotia has been deemed costly and fragmented, and there remains a lack of awareness around existing options (Nova Scotia Respite Working Group, 2000). To ensure these placements are well utilized, a strategy to increase the knowledge of their existence, both for the general public and for relevant health professionals, should be implemented. A review of the criteria for access may also be warranted. Respite could become a more integral part of a discharge plan from the hospital, for example, respite days could be pre-emptively booked in advance of a discharge.

Facility-based respite does not have to be the only option. Under a “home first” philosophy, expansions to home-based respite could be made. Our consultations indicated that overnight or weekend stays would be extremely beneficial. Ross (2010) specifically recommends up to 24 hour respite breaks.

- Ensure respite options and benefits are part of a continuing care education and awareness plan for health professionals and the public.
- Ensure that a proactive respite plan is part of a discharge care plan.
- Allow for 24 hour at-home respite breaks as part of a discharge and care plan where it would be beneficial.

The Cost of Living at Home

While it may be true that most people receiving public home care are receiving it free of charge, it must be noted that cost is still deemed a significant barrier for some individuals. Monetary benefits and subsidies typically only go to those who are of very low income. Our consultations indicated that for many it is not the cost of care itself, but its expense in combination with others such as incontinence and skin integrity products, snow removal, lawn and house maintenance, and home adaptations, to name a few. The cost of living at home and receiving care can be very burdensome and a significant barrier. Income testing for subsidies has a low threshold, and the process does not adequately take expenses into consideration.

- Examine the income-testing process. Consider raising the threshold for subsidies.

- Consider including the examination of expenses as a more prominent piece of the income testing process.

The Assessment Process in the Community

As previously discussed in the section on assessments in the ER, continuing care referrals are made for either home care or long-term care. Nearly 37% of people on the long-term care waitlist in CBDHA do not receive publically funded home care services, a fact not likely attributable to being in receipt of private care, as the majority are of low income (Cape Breton District Health Authority, 2012; Dill, 2012). Similar to our recommendation regarding assessment in hospital, assessments for home care should be the first step to receiving continuing care services. As an immediate first action, all individuals on the long-term care waitlist who have not been assessed for home care services should be. This may mitigate some future ER visits by proactively having supports in place.

We also heard the need to pre-emptively identify individuals who are at high risk for “softer” (i.e., non-medical) hospital admissions to try to ward off future ALC placements. Dr. John Ross stated in his 2010 report, and Walker (2011) agrees, that if high-user groups are targeted, hospitalizations will decrease and costs will be reduced. Proactive assessments are used in Denmark, a country we have already noted for its formal focus on home care, where everyone over the age of 75 is entitled to two proactive home care assessments a year (Schulz, 2010). A similar, yet perhaps less intensive, early intervention model for the frail and vulnerable elderly could be explored. Similar to our previous recommendation regarding screening at the point of triage in the hospital, a similar tool or set of questions could be incorporated into a process for primary care practitioners. Used as part of a regular check-up, these proactive discussions could identify individuals or families at high-risk for hospital visitation or caregiver burnout, and trigger a more pre-emptive referral to a care coordinator.

- Assess all individuals seeking a long-term care placement for home care support as a first step in receiving continuing care services.
- Implement a process, along with the required tool(s) or protocol, to permit the early identification (and related referral to a care coordinator) of individuals at risk for deterioration. This should become a normal part of a regular primary care examination for the elderly.

Information in, and Expectations of, the Public

While there are limitations to available home and community services, a wide variety of supports do exist that are often overlooked by the public due to a lack of awareness of their existence or how to access them. Misinformation could also be a problem, for example, some people believe that home and community services are fully funded, or alternatively, that they are solely based on out-of-pocket pay. Our consultations indicated that a lot of information about home and community supports is learned

through the community “grapevine”, at the point of the long-term care assessment, or through the hospital social worker. Public awareness is a key element to a successful home support system (Nova Scotia Department of Health and Wellness Continuing Care Branch, 2011; Côté and Fox, 2007). Public relations and educational campaigns regarding the possibilities and limitations of home and community options would be helpful in raising awareness. As part of such a campaign, community health centres and primary care provider clinics could be targeted as mechanisms for information distribution. This would not only target key locations for the intended audience, but it could also help bolster awareness amongst health care professionals, important due to their typically more in-depth relationship with patients and their ability to influence decision-making.

- Develop a public awareness campaign about local home and community support options, including information on how to access them.
- As part of this campaign, target primary and secondary care clinics, and their health professionals, as a mechanism for information distribution.

The Current Long-Term Care Waitlist Policy

The Nova Scotia single-entry access policy to long-term care is based, with the exception of certain situations (e.g., adult protection cases, deferrals, variance, etc.), on the chronological order of classification date. This is problematic in that those waiting either in hospital or in community with the greatest level of need may not be reaching a long-term care bed first. When a high-needs individual with low social supports is waiting in the community, their likelihood of ending up in the hospital due to a medical or situational crisis is higher, thus potentially increasing the likelihood of an ALC placement. As such, it is recommended that the waitlist policy be changed to one that is based on the priority of medical and social need.

- Base the provincial single-entry access policy on need as opposed to chronological order.

Ineffective Data Collection and Evaluation

The spending of the Department of Health and Wellness accounts for approximately 40% of the provincial budget (Nova Scotia Department of Health, 2004). Reams of data are collected in the health sector each year, yet the information stemming from this collection is poor, particularly as it relates to cost-benefit and outcome analyses (Ross, 2010). Enhanced and targeted data collection, systemized methods for collecting qualitative information, and systemic communication mechanisms among pertinent stakeholders would provide a more comprehensive picture of who has what care needs where, and would serve to better inform proactive service planning. It would also give an indication of what interventions are the most beneficial, from both an outcomes and cost-effectiveness perspective.

- Examine ALC and continuing care service data and information collection methods. Enhance information collection in a targeted fashion to better enable service planning from an outcomes and cost-effectiveness perspective.

6. Conclusion

Care at home is often the preferred option. Health systems are in the early phases of a shift away from acute and institutionalized services toward more home and community based care. These changes do require a critical examination of a few major assumptions, chiefly, that Nova Scotians are prepared to take on more responsibility for care at home, that housing and employment circumstances are supportive of such a shift, and that care at home will not only be more cost-effective, but will be equally, if not more, successful from an outcomes point of view (Coyte, 2000). The system has to be ready to sustain such a shift. District Health Authorities and home care agencies must be appropriately resourced, staffed, and supported to make these changes work. The recommendations outlined in this paper are by no means an easy undertaking. The “deinstitutionalization” of the health care system does need to be done thoughtfully and cautiously, but with the right supports in place, changes in philosophies and practices can make home care a viable option for many of our frail seniors.

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Appendix A: List of Barriers and Recommendations

A Facility- Focused Philosophy

- The District should adopt “home first” not only as a program, but as a philosophy, making safe and effective care at home the primary goal.
- The philosophy driving care for ALC patients should be changed from one based on transition to one based on restoration. Services and supports on these units and for these patients should be enhanced accordingly (e.g., physiotherapy and occupational therapy).
- Based on the success of programs like My Home First in other areas, CBDHA should reconsider its My Home First eligibility guidelines, extending them to include more ALC patients and beyond (for instance, current LTC residents) who could potentially benefit from the program.
- Under new extended guidelines, all ALC patients should be immediately reassessed for their ability to receive care at home.
- The District, government, and home care agencies should work together to ensure that agencies are appropriately positioned and supported to care for clients in extended home care programs.

The Emergency Room Assessment Process

- In the Cape Breton Regional Hospital, ensure the RAT is available during peak ER hours. Extend these hours as possible.
- Make an assessment for home care the mandatory first step to accessing continuing care services.
- Using an agreed-upon tool or set of questions, standardize the screening process of seniors presenting in the emergency department to proactively indicate potential home/community care beneficiaries.
- Indicate if a person is currently receiving home care services on the emergency room chart. Ensure home care agencies are notified when this is the case for an individual presenting in the ER.

The Discharge Planning Process

- Continue to advance a standardized and mandatory discharge process, including placing heavy emphasis on starting the process at the time of admission.
- Make decision-making and discharge planning a multidisciplinary team effort, led by a designated team lead knowledgeable in available and helpful home and community resources.
- Develop guidelines outlining the information and supports necessary for a discharge, with proactive timelines for preparation and accomplishment. Outline who is responsible for each item (including patients / families, front-line staff, doctors, care coordinators, etc.), and when it must be complete.
- Ensure the right people and practices are in place to allow for discharge to occur seven days a week.

Gaps in Provider to Provider Communication

- Develop guidelines and protocol regarding proactive communication of necessary information, outlining responsibilities and accountabilities for acute care, home care organizations, family members and other key stakeholders.

A Misunderstanding of What Home Care is and Does amongst Health Professionals

- Develop a strategy for better informing acute care health professionals on the “home first” philosophy, and the availability and appropriate use of all continuing care services.
- Identify peer leaders in each pertinent health profession to champion “home first” philosophies and procedural change (e.g., District Medical Director of Continuing Care, nursing peer leader).

Home and Community Care Options

- Where warranted, consider increasing the number of service authorization hours, including longer (e.g., for respite) and more frequent shorter visits (for check-ins), based on the needs of the individual and the availability of a caregiver.
- Ensure that home care agencies are prepared and appropriately supported to provide increased services and authorization hours.
- Ensure that service authorization guidelines provide an adequate amount of flexibility so that care coordinators / case managers can authorize safe, effective, common sense downward substitutions when they are a viable part of a care plan.

Consider the feasibility of using an all-encompassing, prefixed budget model like the PACE or SIPA program, effectively housing all home support options under one roof.

- Create a plan for physical and occupational therapy home visitations, including the potential use of paraprofessional assistants for therapeutic visits.
- Provide enriched mental health training to home care workers.
- Make similar training and education available to caregivers.
- Provide more support to the home care sector via the Challenging Behavior Program and challenging behavior consultants.
- Explore the feasibility of using a psychogeriatric team approach to care in the home.
- Explore the feasibility of partnering with relevant mental health related organizations to provide and enhance appropriate and accessible supports for individuals and their caregivers.
- Ensure adult day programs are present in areas where they would be of greatest benefit.
- Where there is a low up-take of an adult day program in a high-needs area, investigate the predominant reasons for the low up-take and develop plans to mitigate these barriers.
- Ensure that the public and health professionals are aware of the existence and benefits of adult day programs.
- Using the recommendation of flexible service guidelines and a “one-stop shopping” home care program model, make adult day programming part of possible service recommendations by care coordinators.
- Ensure that the cost of participating in adult day programs is affordable.
- Work with municipalities and other relevant local partners to enhance reliable, inexpensive transportation options throughout the district.
- Ensure case managers / care coordinators are aware of local transportation options in their region. Ensure that the consideration of transportation support is included in care and discharge plans.

- Use flexible service authorization guidelines and a “one-stop shopping” home care program model to provide allowances for affordable transportation where it is deemed a significant barrier.

Access to, and Integration of, Primary Care Services

- Enhance primary care access through the recruitment and retention of family practitioners, as well as through the utilization of newer models of primary care provision, for example, those using nurse practitioners and paramedics.
- Examine the approach to case management in the community, including how primary care is engaged. Develop an approach that uses appropriate collaboration between acute, continuing, and primary care providers.

Insufficient Supports for Informal Caregivers

- Develop a Caregiver Strategy to support caregivers. Include in this strategy enhanced elements of financial and social assistance.
- Ensure respite options and benefits are part of a continuing care education and awareness plan for health professionals and the public.
- Ensure that a proactive respite plan is part of a discharge care plan.
- Allow for 24 hour at-home respite breaks as part of a discharge and care plan where it would be beneficial.

The Cost of Living at Home

- Examine the income-testing process. Consider raising the threshold for subsidies.
- Consider including the examination of expenses as a more prominent piece of the income testing process.

The Assessment Process in the Community

- Assess all individuals seeking a long-term care placement for home care support as a first step in receiving continuing care services.
- Implement a process, along with the required tool(s) or protocol, to permit the early identification (and related referral to a care coordinator) of individuals at risk for deterioration. This should become a normal part of a regular primary care examination for the elderly.

Information in, and Expectations of, the Public

- Develop a public awareness campaign about local home and community support options, including information on how to access them.
- As part of this campaign, target primary and secondary care clinics, and their health professionals, as a mechanism for information distribution.

The Current Waitlist Policy

- Base the provincial single-entry access policy on need as opposed to chronological order.

Ineffective Data Collection and Evaluation

- Examine ALC and continuing care service data and information collection methods. Enhance information collection in a targeted fashion to better enable service planning from an outcomes and cost-effectiveness perspective.

Appendix B
Access to Home Care from Hospital:
Barriers and Potential Solutions
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