Saskatchewan Health, Community Care Branch

Home Care Program Review

Final Report

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 as 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.

ACKNOWLEDGEMENTS

We would like to most sincerely acknowledge, and thank, all of the people who took the time to assist us on this project. This includes the staff, managers and executives of Saskatchewan Health, officials in the Regional Health Authorities, and officials in Ministries of Health and Regional Health Authorities across Canada.

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1. INTRODUCTION

1.1 Overview of the Saskatchewan Home Care Program

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.

Home care is an integral part of the continuum of care that includes both community and institutional services necessary to ensure the best possible quality of life for people with varying degrees of short and long term illness or disability and support needs. The objectives of the home care program are to help people who need acute, palliative and supportive care to remain independent at home, and to supplement, but not replace, home support by family and community.

The Saskatchewan Home Care Program includes a process for assessing individual needs and coordinating care to meet them, plus a range of services provided in the home to meet acute, palliative and long term care needs such as homemaking, meals, personal care, respite and skilled nursing services.

1.2 Overview of the Home Care Program Review Project

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 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.

The major activities of the project included an environmental scan and assessment of the current vision, goals and services, as well as analysis and recommendations relating to a vision for home care that will meet the needs of Saskatchewan's population now and into the future, addressing issues of:

- Required mix of types of care (e.g., acute, palliative, supportive) to provide appropriate substitution for hospital care and institutional supportive care, and to provide quality of life to Saskatchewan residents.

- Required mix of types of service (e.g., case management, nursing, therapies, personal care, homemaking, meals, etc.) to provide appropriate care in the home.
- Existing fee structure for home care.
- Required home care capacity.
- Methods for providing care in rural and remote communities.

This document constitutes the Final Report for the Saskatchewan Home Care Review Project.

2. METHODS

2.1 Introduction

There were several different components to this project. This chapter provides a brief overview of the methods used for each project activity.

2.2 Document Review

An initial aspect of the project was to review existing documentation about the Saskatchewan Home Care Program, such as policy manuals, accountability requirements documents, descriptions of the program, and so on. Documents for this review were obtained from officials in the Community Care Branch of Saskatchewan Health. Additional documentation about home care programs at the RHA level was also obtained from officials in RHAs as part of the interview process (see below).

2.3 Literature Review

The literature review for this project built on previous work conducted by Hollander Analytical Services Ltd. related to models of care delivery and the cost-effectiveness of home care. A new literature search was conducted for this project on the topic of the cost-effectiveness of home care. This search was designed to update earlier work conducted by Hollander Analytical Services and focused on the time period 1995 to 2005. A second, new search was also conducted for this project on the cost-effectiveness of palliative care. It also focused on the 1995-2005 time period.

The following databases were searched for appropriate citations for the period 1995 to 2005 in regard to the cost-effectiveness of home care and palliative care:

1. EBM Reviews - Cochrane Database of Systematic Reviews
2. CINAHL - Cumulative Index to Nursing & Allied Health Literature
3. EMBASE
4. Ovid MEDLINE(R)
5. PsycINFO

Table 2-1 presents an overview of the research terms used for all of the literature searches (existing and new searches) used for this project. It should also be noted that, with regard to the cost-effectiveness of home care and palliative care, we looked primarily at the broader categories for each of the topic areas. Thus, this was not a search of all possible sub-components of home care *per se*. Nevertheless, some citations were found on specialty areas (e.g., telehome care, home IV therapy). Such citations are also included in this literature review.

Table 2-1: Search Categories for the Literature Review

Component	MeSH term	Keyword
Cost Component	Cost-benefit analysis/	Cost-Effective$ Cost-Minim$
Home Care	Home care services/ Home nursing/ Homemaker services/	Community long term care Home health care Home support Meal program$ Community Physiotherapy Community Occupational therapy
Assisted Living/ Housing	Housing for the elderly/ Group homes/	Supportive housing Congregate housing Assisted living
Palliative Care	Palliative Care/ Terminal Care/ Hospice Care/	Care for Dying End of Life

An extensive literature review on the above topics was completed and provided to Saskatchewan Health as a separate document. This document contains a summary of the separate, larger literature review in Chapter 3.

2.4 Demographic Projections

In order to obtain an overview of the implications for home care of changes in the structure of the Saskatchewan population to 2021, an analysis of demographic data, and projections was conducted for this study. This data was obtained from Saskatchewan Health. The projections are based on materials developed by Saskatchewan and differ somewhat from the projections developed by Statistics Canada. The demographic data, and projections, were also used for developing estimates of projected future utilization for Saskatchewan as a whole, and age standardized projections for each of the RHAs.

2.5 Review of Relevant Quantitative Data

Detailed data for this project were obtained from Saskatchewan Health. There were several levels of data requests. The first level was to obtain demographic data and is described above in Section 2.4 Anonymized data were also obtained on the home care and long term residential care programs. These data went through a series of checks and edits to ensure that the data used in the analysis would be as clean as possible. As is usual with such administrative data sets, some editing was required, for example, to take out duplicates and people who had been registered, but had not received any services.

2.6 Review of the Saskatchewan Home Care Program

An important part of this project was to obtain data on perceptions about the home care program from the people involved in program management and service delivery. In addition, there was a desire to obtain information about how home care programs are organized, funded

and delivered across other jurisdictions in Canada. Thus, interview schedules were developed for these groups. We originally thought that separate interview schedules would need to be developed for Saskatchewan Health and RHA officials. However, given the commonality of the information required, it was decided to use one interview schedule for both sets of officials (with some prompts to distinguish between provincial and regional officials, as appropriate). A separate interview schedule was developed for provincial and regional officials in other jurisdictions. Finally, it should be noted that given the similar traditions across Western Canada in regard to home care and continuing care, a relatively greater emphasis was placed on obtaining data from the other western provinces. The interview questions used for this project are presented in Appendix A. The findings of the interviews are presented in Chapters 6, 7 and 8 of this report.

Table 2-2 presents the number of people originally designated to be interviewed and the actual number of people interviewed for each of the three groups of interviewees. The original lists of potential interviewees for Saskatchewan Health and the RHAs was provided by Saskatchewan Health. It should also be noted that at least one representative was interviewed from each RHA across Saskatchewan.

Table 2-2: Record of Interviewees for this Project

	Officials from Saskatchewan Health	Group	
		Officials from Regional Health Authorities[1]	Officials from Other Jurisdictions
Original number to be interviewed	10	33	20
Actual number interviewed	10	31	13

[1] For some RHAs we were asked to interview additional people not on the original list of designated interviewees.

3. OVERVIEW OF THE LITERATURE ON INTEGRATED MODELS OF CARE DELIVERY

3.1 Introduction

As noted above, an extensive literature review was prepared for this project. There were two parts to the literature review. The first part focused on models of integrated care delivery, of which home care is an important component. How home care is delivered and what services are provided is, in large part, related to the broader context of health care delivery in which home care functions. There is growing evidence that an integrated model of care delivery allows for greater efficiencies because it is easier to make trade-offs and substitutions of less costly services for more costly services, while maintaining at least an equivalent quality of care, in integrated models. This is because such models typically have one administrative structure and one funding envelope. Thus, those responsible for the program can make administrative and resource allocation decisions, on a broader systems basis, to increase the efficiency and effectiveness of care delivery, and to enhance the quality of care. These kinds of decisions are much harder to make in more fragmented systems with separate, and often competing, administrative and/or funding structures.

If one is willing to grant that the "system may be the solution," one also needs evidence regarding whether or not, and to what extent, home care services can function as cost-effective alternatives for institutional services, while providing at least an equal quality of care.

The following section of this chapter provides an overview of six leading models of integrated care delivery while the subsequent section addresses the extent to which home care can be a cost-effective alternative to institutional care. It also addresses of the issue of the cost-effectiveness of palliative care.

3.2 Major International Models of Continuing Care Service Delivery Systems

3.2.1 Introduction

There are a wide variety of integrated continuing care (home care, home support, long term residential care and case management) service delivery systems in Canada and internationally. The six models described below typically have a number of publications describing and/or evaluating the model of care. We have excluded models that, while potentially interesting, only have one or two documents describing the model, and models which may have more documentation but are quite similar to the model selected for review in this chapter.

3.2.2 International Models

3.2.2.1 Social Health Maintenance Organizations (S/HMOs)

Social Health Maintenance Organizations (S/HMOs) were developed as an extension of the Health Maintenance Organizations (HMOs) in the United States which have typically provided integrated hospital and medical care services. HMOs were expanded, in the S/HMO

concept, to include a broader range of health and social services for the elderly, and persons with disabilities. S/HMOs combined a full array of acute and primary care services with case management and access to chronic care services for those with disabilities up to a given amount per year. S/HMOs were designed to be available to the full range of the elderly population, not just those eligible for long term care facility placement and to deliver a full range of acute and long term care services to a cross section of the elderly population within a prepaid capitated budget. Thus, the S/HMO model is similar to RHAs in Canada, except that they also include physician services and drugs.

3.2.2.2 Program of All-Inclusive Care for the Elderly (PACE)

The objective of PACE programs is to provide coordinated preventive, primary, acute and long term care services so participants can continue living in the community. PACE programs are run by non-profit organizations. Services may be provided in the home, a PACE centre, or an inpatient facility. Key program components are: multidisciplinary teams, PACE centres, capitated funding, and transportation.

The multidisciplinary teams include primary care physicians, nurse practitioners, nurses, social workers, occupational and physical therapists, recreation therapists, dieticians, health workers, and transportation workers. The entire team functions as the case manager, assessing participant needs, formulating care plans, allocating resources, delivering services, monitoring the effectiveness of the care plans, and adjusting care plans.

PACE centres include an adult day health centre and a medical clinic. A centre typically serves from 120 to 150 enrollees with 60 to 80 staff. Centres are open 5 to 7 days a week. All PACE sites have at least one centre that operates on weekends. At a minimum, PACE centres include the following services: primary care, social services, restorative therapies, personal care and supportive services, nutritional counselling, recreational therapy, and meals.

3.2.2.3 The Arizona Long Term Care System (ALTCS)

The Arizona Long Term Care System (ALTCS) targets elderly, physically disabled, and developmentally disabled individuals considered to be at risk for institutionalization by state assessors. The program offers a variety of home and community based services in an effort to substitute home and community care for institutional care and thereby lower long term care costs. Approximately 50% of the elderly and physically disabled, and almost all of the developmentally disabled, are served in the community.

ALTCS capitates program contractors to provide a full range of acute and long term care services to eligible beneficiaries at risk of institutionalization. Services for entitled enrollees are paid on a fee-for-service basis and are generally provided by the same contractors. All covered services are integrated into a single delivery package which is coordinated and managed by the program contractors. The services include: home and community based services (including transportation); alternative residential settings; nursing facilities; intermediate care facilities for the developmentally disabled; hospice; acute care services; behavioural health; and case management services. In general, ALTCS members are not restricted in the amount or range of

home and community based services they can receive. Home and community based settings for elderly and physically disabled individuals include: the member's home; adult foster care; assisted living home; assisted living centres; behavioural health facilities; hospice; group homes for traumatic brain injured individuals; and residential settings for developmentally disabled individuals (as appropriate).

In addition to home and community based services, ALTCS provides institutional care in an approved nursing facility, hospice or intermediate care facility, as appropriate. As well, ALTCS members receive the same acute care services as individuals enrolled in the acute health care program. These services include: outpatient health services; hospital; pharmacy and durable medical equipment; laboratory and x-ray; specialty care; home health; and family planning. Services for elderly and/or physically disabled members are delivered through a network of program contractors located throughout the state.

3.3 Canadian Models of Integrated Service Delivery Systems

3.3.1 The Comprehensive Home Option of Integrated Care for the Elderly (CHOICE)

The Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) program was the first Canadian replication of PACE (Program of All-inclusive Care for the Elderly). The program was started in 1996 and is funded by the Capital Health Authority, in Edmonton Alberta.

The CHOICE program is intended to provide a full continuum of care to older individuals with multiple and/or complex health needs who are frequent users of acute care services and/or who would otherwise require admission to a long term care facility (i.e., high care needs clients). The program is specifically designed to help frail seniors remain in the community for as long as possible within the bounds of medical, social, and economic feasibility.

Each client's care is managed through a multi-disciplinary case management approach. All potential clients attend the CHOICE day health centre at the relevant site for five days prior to a final decision being made regarding their admission to the program. Clients are admitted to the program based on their needs, the wishes of the clients and their families, and the current resources available to the care team. The program provides all basic services under one umbrella. Individuals in the program have access to a day health centre, home care services, respite and treatment beds, and 24 hour emergency services.

Within the same building, the day health centre provides: medical monitoring and treatment by physicians and nurses; medications (which are dispensed by program pharmacists); foot care; dental and eye screening; physical, occupational and recreational therapy; personal care (such as assistance with dressing and bathing, and foot and nail care); health and wellness education; and meals and snacks. Specialized services not routinely available on site (such as dental work) are accessed through consulting or referral arrangements. Home care services may include: personal care; adaptation of the home environment; homemaking; and meals. Transportation services, primarily involving wheelchair accessible vans, are available to take participants to and from the day health centre and other appointments.

A limited number of beds are available for clients whose sub-acute needs can be managed outside an acute care hospital and within the resources of the program. These beds are available for individuals who require planned or emergency respite, or close medical monitoring or extensive rehabilitation for a short period of time, as well as those who are awaiting placement in a long term care facility. Clients are able to contact program staff 24 hours a day, 7 days a week. Telecare, a telephone support service, is available for some clients.

3.3.2 Système de services intégrés pour personnes âgées en perte d'autonomie (SIPA)

SIPA (Système de services intégrés pour personnes âgées en perte d'autonomie) was developed as part of a joint University of Montreal-McGill University collaboration focusing on the organization, delivery, and financing of integrated services for seniors. SIPA was developed to meet the full range of complex needs of frail older individuals and like CHOICE is based on the PACE model of care. The primary objective of SIPA is to optimally respond to the needs of frail older adults living in the community in order to maintain and promote their independence. SIPA also aims to optimize the utilization of community, hospital, and institutional resources.

SIPA is a community-based model which integrates and coordinates all health and social services required by frail older adults. It functions as a single-entry system, and a comprehensive range of services is offered through the program, including both community and institutional services. One SIPA centre is responsible for the entire population of older adults in a given region. The SIPA team maintains clinical responsibility for services, regardless of where the client is referred from (including long term care facilities).

There are several key elements that define the clinical model. SIPA uses intensive case management which allows clients to build long term, trusting relationships with their case managers. Case managers, who are normally social workers or nurses, work as part of multidisciplinary teams. Multidisciplinary teams generally include social workers, nurses, physicians, homecare workers, physiotherapists, and occupational therapists. They may also include nutritionists and pharmacists. All individual service plans are developed collaboratively and all cases are discussed by the team. A 24 hours a day, 7 days a week on-call service provides immediate and around-the-clock access to SIPA.

Funding for the conceptualization, demonstration, and evaluation of the model was received from several sources including the Quebec Ministry of Health and Social Services, Health Canada's Health Transition Fund, and the Canadian Health Services Research Foundation (CHSRF). SIPA is, however, no longer operational as it did not receive ongoing funding after the demonstration period.

3.3.3 The Western Canadian Continuing Care Model: The Example of British Columbia

The Canadian model of continuing care evolved in Western Canada from the mid-1970s to the early 1990s. The continuing care model was originally developed in Manitoba in the mid-1970s. The model was adopted in the other western provinces, and in some parts of Atlantic Canada, in the 1980s and early 1990s. A leading example of this model would be the British

Columbia continuing care model which existed in the late 1980s and early 1990s. This model contained most of the features of the models in other jurisdictions and had some additional, desirable features.

The Continuing Care Division (during 1983-1994) was a decentralized professional organization with its central office in Victoria providing overall administration, policy direction and control. All programs were delivered at the community level through 16 provincial Health Units, four Municipal Health Departments and one Regional District. Continuing Care Managers were based in each of these 21 health jurisdictions. These officials were responsible for the coordination and administration of the Division's programs in the local community.

In the Continuing Care Division, services were delivered from three programs: the Long Term Care Program (home support and residential long term care); the Community Home Care Nursing Program; and the Community Rehabilitation Program. The latter two programs were jointly referred to as the Direct Care, or Clinical Services, Programs (at different points in time). Long term care assessment and case management, home nursing services, and rehabilitation services were provided directly by provincial or municipal government employees. All other services were provided through the purchase of service from not-for-profit, or for-profit, service provider agencies external to the Ministry of Health.

The Long Term Care Program and the two Clinical Services Programs were complementary and offered clients coordinated services. The components of referral, assessment, determination of eligibility, development of a service plan, reassessment of need, and client discharge from the system were similar for all three programs. Referrals to all three programs could be made by any relevant party such as a health professional, family member, friend or other such person.

3.4. Comparisons of the Six International and Canadian Models of Care

The six models presented above are all integrated models of care delivery for the elderly. They all have single entry, a comprehensive assessment, ongoing case management and a single administrative structure. The American Models (S/HMOs, PACE and the Arizona model) all have a single funding envelope through a program of capitation for all component services. The BC model also had a single funding envelope for all continuing care services through a budget process, while CHOICE and SIPA did not. The BC model was the only model of the six reviewed which had one standard care level classification system for all clients served, irregardless of the site of care. Tables 3-1 and 3-2 provide a comparison of the six models across a number of relevant dimensions.

Table 3-1: Comparison of the Key Characteristics of the Six Programs

	Type of Context	Type of Client	Functions of Home Care Addressed	Key Aspects of Model	Integration Into The Broader System of Health Care
S/HMO	Primarily Metropolitan and Urban Sites	Elderly population with and without functional deficits	• Acute Care Substitution • Long Term Residential Care Substitution • Maintenance and Preventive Function	Capitation funding to provide home and community care, residential care, acute care, and primary care	Well integrated as primary care and acute care services are part of S/HMOs
PACE	Multiple Metropolitan and Urban Sites	55 years of age or older and be certified as eligible for long term care facility placement	• Acute Care Substitution • Long Term Residential Care Substitution • Maintenance and Preventive Function	Capitation funding to provide home and community care and primary care, and to purchase long term residential care and acute care	Separate programs but integrated through purchase of service arrangements for primary care, acute care and long term residential care
ALTCS (Arizona Model)	State-wide Program, Urban and Rural	Elderly population, and physically and developmentally disabled who are at risk of institutionalization	• Acute Care Substitution • Long Term Residential Care Substitution • Maintenance and Preventive Function	Capitation funding for integrated program of primary care, acute care, home care, and residential long term care	Well integrated and is part of the Arizona Health Care Cost Containment System
CHOICE	Metropolitan	Frail Elderly Client	• Acute Care Substitution • Long Term Residential Care Substitution • Maintenance and Preventive Function	Intensive and expanded adult day service	Fully integrated into region
SIPA	Metropolitan	Frail Elderly Client	• Acute Care Substitution • Long Term Residential Care Substitution • Maintenance and Preventive Function	Home care and intensive case management	Partially integrated but no longer funded
BC Continuing Care System	Province-wide	Elderly Clients and Adults with Disabilities	• Acute Care Substitution • Long Term Residential Care Substitution • Maintenance and Preventive Function	Province-wide integrated model incorporating home care, home support, case management, residential care and some acute care.	Part of broader Provincial system of care

Table 3-2: Comparisons of the Outcomes and Costs of the Six Programs

	Quality of the Service	Impact on Health Services	Cost-Effectiveness
S/HMO	• S/HMO clients had same levels of satisfaction with access, quality, interpersonal relations and cost-benefit as HMO clients but levels were higher for persons who remained in the S/HMO than for those who left.	• Many people use benefit as a home care, hospital replacement service. Only 50% of people who were eligible for residential care remained eligible for such care one year later indicating that people can get better over time.	There were problems with the evaluation and, thus it is not clear whether or not S/HMOs are cost-effective.
PACE	• PACE findings were variable across sites but, in general, PACE had a positive effect on frequent attendance at social activities and was related to short-term improvements in quality of life, satisfaction with care, and functional status.	• PACE is associated with decreased home nursing visits, admissions to hospital, inpatient hospital days and nursing home days. It has also demonstrated reductions in the use of prescription drugs.	Studies have concluded that PACE programs result in an overall savings of 14% to 39% compared to fee-for-service models.
ALTCS (Arizona Model)	• The availability of services has continued to improve throughout the state. Surveys indicate fairly high levels of satisfaction with services.	• ALTCS clients had fewer inpatient admissions and fewer inpatient days but used more ambulatory services than fee-for-service models.	Total costs were, on average, 16% lower for the ALTCS than for a comparable but more traditional Medicaid program.
CHOICE	• Clients and caregivers reported high satisfaction with care.	• Reductions in the use of hospital beds, drugs, ambulatory care visits and ambulance services. • Increase in use of physician services.	Savings of $14.13 per person per day on CHOICE compared to before CHOICE, but cost of CHOICE not factored in.
SIPA	• Clients and caregivers reported higher satisfaction with care. • Rapid response in emergencies appreciated.	• Length of stay in emergency departments shorter, but number of visits the same as control group. • Greater use of community services by SIPA.	Per client costs slightly higher in SIPA but there may be a lagged effect on cost savings and the evaluation is continuing.
BC Continuing Care System	• Fairly high satisfaction with care and quality of life.	• Long term reductions in the utilization ratio of residential care services • Reductions in the use of hospital services.	Home care found to be a cost-effective alternative to residential care services.

3.5 A Best Practices Model for the Organization and Management of an Integrated Continuing/Community Care Service Delivery System

Given the interest in integrated care delivery systems for persons with ongoing care needs, Hollander Analytical Services Ltd. conducted a major project for Health Canada in the early 2000s (Hollander & Prince, 2002). The project was designed to analyze the strengths and weaknesses of care delivery systems across Canada for four populations of persons with ongoing, or long term, care needs (i.e., the elderly, persons with disabilities, chronic mental health clients and children with special needs). In addition to conducting the research, the project leaders, based on the literature, other existing models, and the findings of the study they conducted, developed a best practices framework for organizing continuing care service delivery systems. This framework incorporates most of the key aspects of the leading models of continuing care. The best practices are organized as a framework which can be adopted to create more specific care delivery models for particular populations groups or jurisdictions. Thus, it is a flexible framework which can be adapted to meet local needs, and one which the authors believe should increase the efficiency and effectiveness of service delivery.

There are a number of philosophical and policy prerequisites which constitute the first component of the framework. Unless policy makers, program administrators, and care providers understand, and agree with, these prerequisites, it is unlikely that the framework will actually be adopted.

The second component of the framework is a set of best practices for organizing service delivery systems. The first five best practices relate to administrative best practices and the second five relate to best practices for service delivery. The third component addresses issues of coordination and linkage. Figure 3-1 provides a schematic overview of the proposed best practices framework for organizing systems of continuing/community care services.

Continuing/community care combines the best aspects from both integrated health systems (vertical integration) and primary care/primary health care (a broad base of home and community services) and incorporates them into one system. That is why this approach is referred to as “the third way” (i.e., it combines the best aspects of two different, and competing, models of care delivery). The system has components of primary care, secondary care and tertiary/quaternary care which are linked both horizontally and vertically through case management. Figure 3-2 presents a schematic of the structure of a generic continuing/community care system which could apply to populations with ongoing care requirements.

Figure 3-3 shows a simplified schematic of how clients would flow through the system of continuing/community care. Clients can refer themselves to the system or be referred by family members, professionals or other concerned persons. The referral is made to the local single point of entry organization. There is typically a telephone screen to provide information, ask about care needs and ask about eligibility. If it appears that the client is a potential candidate for care, the client is assessed using a system level assessment tool (preferably with a built-in classification system).

Figure 3-1: A Best Practices Framework for Organizing Systems of Continuing/Community Care Services

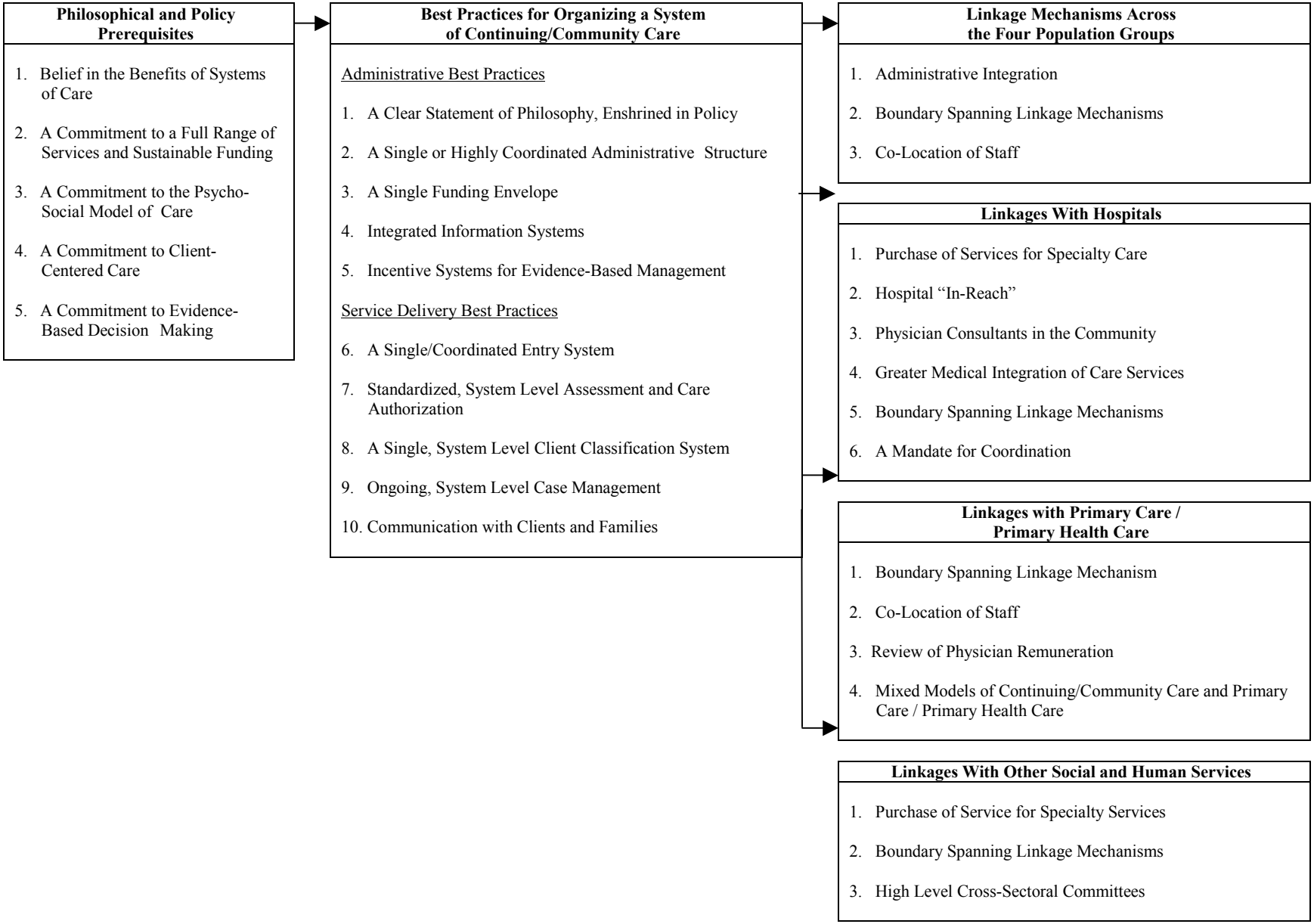


Figure 3-2: A Schematic of the Structure of the Continuing/Community Care Service Delivery System

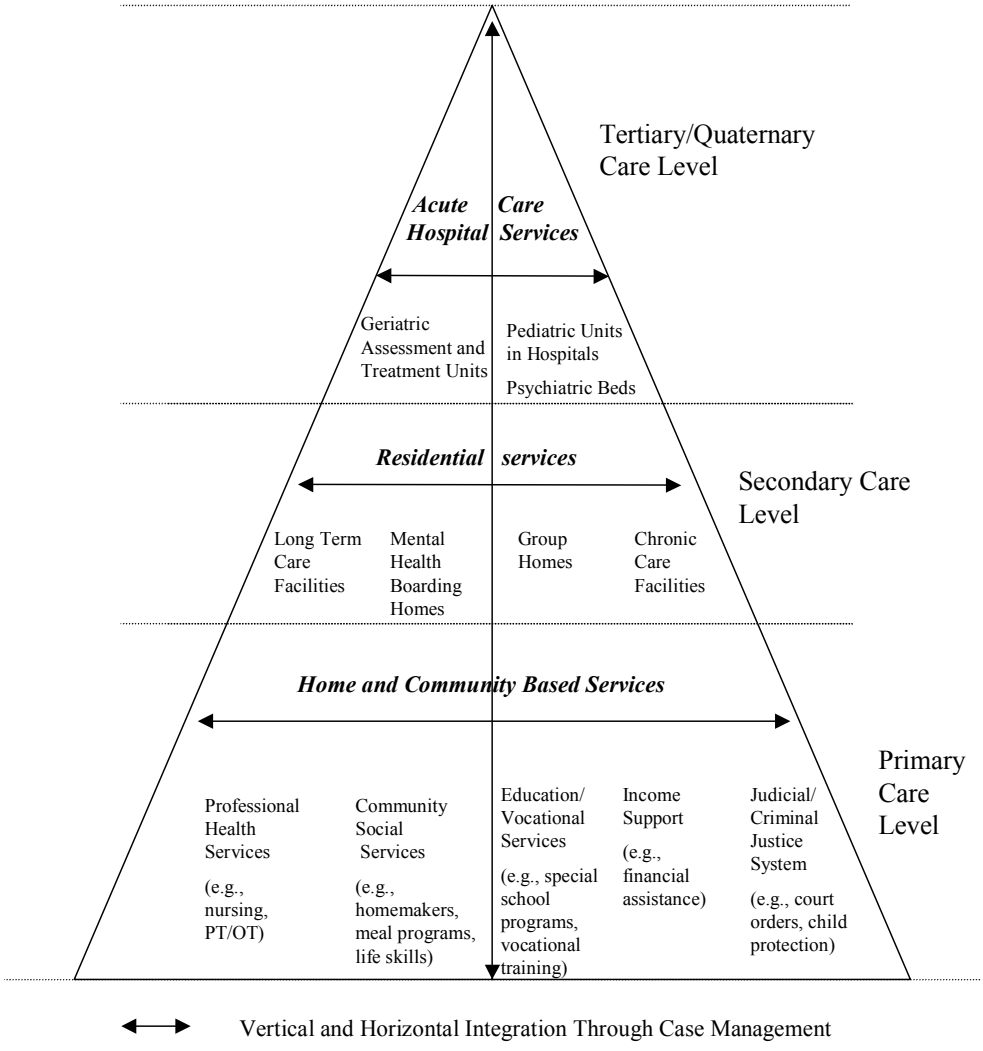
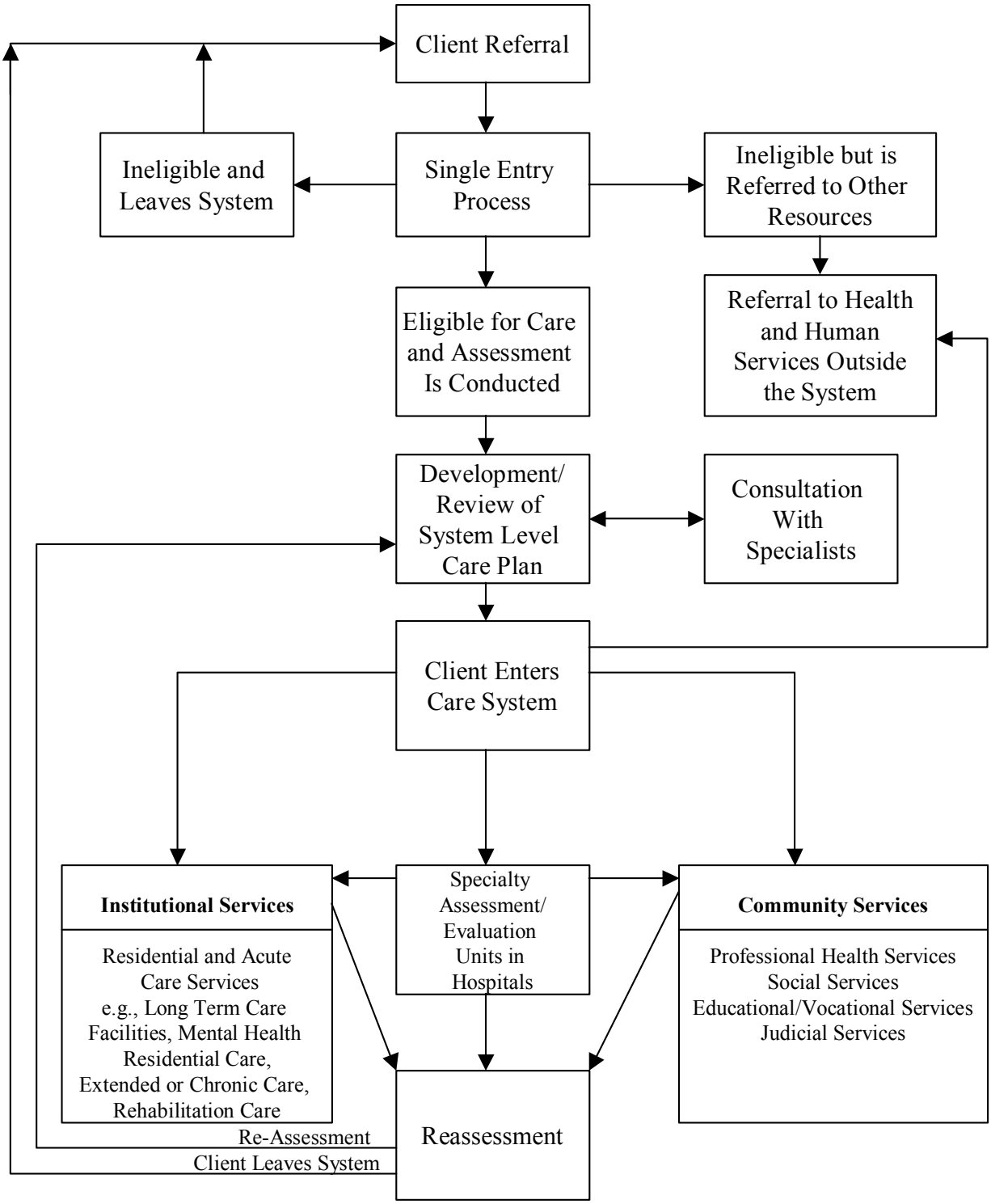


Figure 3-3: A Schematic of Client Flow Through the System of Care



Based on the assessment, on discussions with the client and his or her family, and on discussions with the family physician and/or other specialist(s), a care plan is developed. The client then enters the care system. If the client has complex problems he or she may be seen in a hospital-based specialty service such as a geriatric assessment and treatment unit, or a psychiatric evaluation unit. Once assessed in the specialty unit clients may be admitted to a hospital based service such as a psychiatric ward or an extended care/chronic care ward in the hospital, or may be referred to a residential facility or to care in the community. Clients may also be referred for additional care to health and human services outside the system of care. Clients would be re-assessed by their system level case managers on a regular basis and their care plan would be revised, as necessary. Clients may also leave the system but can be referred back to it at any time.

3.6 Discussion and Conclusions

This literature review on models of care delivery points to some key findings. There is a great deal of commonality in the key structure and process elements of the six models discussed above. These elements are also consistent with the best practices noted in the conceptual model discussed in Section 3.5. All of the models 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 some form of 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, and 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. As discussed in the following chapter, there is also now empirical evidence regarding the cost-effectiveness of these types of integrated care delivery systems.

4. OVERVIEW OF THE LITERATURE ON THE COST-EFFECTIVENESS OF HOME CARE

4.1 Introduction

4.1.1 The Functions of Home Care

There are generally considered to be three main functions of home care. The first function is to prevent or delay further deterioration and to maintain the client at her/his optimal level of care for as long as possible. Thus, this "preventive and maintenance" function of home care focuses on preventing or delaying admission to a long term care facility, or to a hospital. The second function of home care is to act as a substitute for residential long term care. This function of home care deals with clients who have higher level care needs and, in the absence of home care, would be admitted to a long term care facility. Thus, home care acts as a substitute for residential long term care for people who are deemed to be eligible for placement in a long term care facility. The third function of home care is to act as a substitute for hospital care. In this approach, people are discharged from hospitals at the end of the acute care phase of their illness. Instead of spending the convalescent part of their illness in the hospital they convalesce at home with the assistance of professional health care providers such as nurses and/or physiotherapists, and home support workers, as required. Home care may also be used to prevent admissions, or re-admissions, to hospital.

4.1.2 An overview of Economic Analysis

There is a growing literature on the techniques of economic analysis in health care. Economic analysis primarily deals with two aspects: the inputs and outputs, or costs and consequences, of activities; and, choices between alternatives. Thus, economic analysis can be defined as: "the comparative analysis of alternative courses of action in terms of both their costs and consequences". Drummond, Stoddart and Torrance (1987), have developed a typology for the different types of economic analysis based on the dimensions of inputs and outputs, and choices about alternatives. This schematic is presented in Figure 4-1. The primary area of interest for cost-effectiveness studies is box 4 in Figure 4-1, full economic evaluation, particularly cost-minimization and cost-effectiveness analysis.

Finally, it is important to note that cost-effectiveness analysis is not only about costs. Equal weight is given to the outcomes or consequences of the services in question. This includes outcomes such as satisfaction with care, and the quality of life of the client, from the perspectives of clients and informal caregivers.

Figure 4-1: Types of Economic Evaluation

Is there a comparison of two or more alternatives?	Are both costs (inputs) and consequences (outputs) of the alternatives examined?		
	NO		YES
	Examines only consequences	Examines only costs	
NO	1A PARTIAL EVALUATION Outcome description	1B Cost Description	2 PARTIAL EVALUATION Cost-outcome description
YES	3A PARTIAL EVALUATION Efficacy or effectiveness evaluation	3B Cost Analysis	**4 FULL ECONOMIC EVALUATION** **Cost-minimization analysis** **Cost-effectiveness analysis** **Cost-utility analysis** **Cost-benefit analysis**

(Source: Adapted from Drummond et al., 1987, p. 8)

The types of evaluations noted in the above schematic are as follows:

- **Outcome Description**: A description of the program or service provided.
- **Cost Description**: A description of the cost components of the service provided.
- **Cost-Outcome Description**: A description of both the costs and outcomes of a single service.
- **Efficacy or Effectiveness Evaluation**: An analysis in which only the consequences of the alternatives are compared.
- **Cost Analysis**: An analysis in which only the costs of the alternatives are compared.
- **Cost-Minimization Analysis**: An analysis in which the costs of the alternatives are compared and the consequences of service are deemed to be equivalent, for example, a search for the lowest cost alternative.
- **Cost-Effectiveness Analysis**: An analysis in which the costs and consequences of programs are measured in comparable, appropriate, natural physical units, for example, costs are related to a single effect which may differ in magnitude across alternatives.
- **Cost-Utility Analysis**: An analysis in which the costs and consequences of programs are measured in time units adjusted by health utility weights, for example, costs are related to one or more effects, which are not necessarily common to each alternative, by a standardized utility measure such as quality-adjusted life years.
- **Cost-Benefit Analysis**: An analysis in which the costs and consequences of programs are both valued in monetary terms, for example, costs are related to one or more effects, which are not necessarily common to each alternative, by the standardized measure of money.

4.2 The Maintenance and Preventive Function of Home Care

4.2.1 Introduction

In reviewing the materials obtained, it was ascertained that there were very few studies on the maintenance and preventive function of home care *per se*. Studies in the international literature typically focus on certain types of preventive programs, rather than on the broader preventive functions of home care.

The only studies found which focused more broadly on the maintenance and preventive function of home care were Canadian studies. Thus, these are the studies presented in this section. There were also a number of studies related to specific prevention strategies, primarily to reduce hospital utilization. These preventive studies are discussed in section 4.4.3 on the cost-effectiveness of home care compared to hospital care.

4.2.2 Findings That Home Care is Not Cost-Effective

Patterson and Chambers (1995) note that while there is some evidence for the effectiveness of general preventive measures, and screening and early detection of subclinical disease (i.e., primary and secondary prevention), the evidence on initiatives to minimize existing disability (i.e., tertiary prevention) seems to indicate that it is not cost-effective in regard to improving the functional status of older people. Contandriopoulos, Tessier and Larouche (1986) in a study conducted in Lachute, Québec, looked at two different cohorts, one before a home care service was introduced and one after it was introduced. The authors used multiple regression to study the impacts of socio-demographic, economic and health status variables, and the presence or absence of home care, as independent variables. The utilization of hospital inpatient services, emergency and outpatient hospital services, physician services, and home care services, were used as dependent variables. While the authors only present findings for the use of hospital services they note that the results were similar for all of the services. In both the global and specific impact analyses the presence of home care services was not found to be a significant variable in regard to the use of hospitals or other services. The two variables which were significant were age and the number of tests or examinations the client had received.

Another Canadian study was conducted in Saskatchewan (HSURC, 2000) and was a retrospective, observational cohort study which used administrative data. Some 26,490 seniors from across Saskatchewan were in the sample of whom 36% (9,524) received preventive home care (defined as being at level 1 or 2 of a four level classification system) and 9% (2,484) were in seniors housing. This cohort of seniors was studied for eight years. The major findings of the study were that 50% of those receiving preventive home care were more likely to lose their independence or die than those not receiving this service. In addition, costs for clients on preventive home care were three times as high as for clients not receiving this service.

A major shortcoming of this study was that the research team did not have data on the functional status of clients not in home care. As classification systems in Canada for the elderly and people with disabilities rely heavily on functional status (the ability to perform activities of daily living such as bathing and eating) and, in some jurisdictions, the ability to perform

instrumental activities of daily living such as shopping, it would be difficult to make statistical adjustments to truly match clients on home care, and not on home care, without information on the functional status of the people in the study. In order to address the issues of selection bias, several sets of statistical adjustments were made. Even though there is no reason to believe that the adjustments were inappropriate, one has to question the extent to which a series of different types of adjustments, based on a limited administrative data set that lacks information about functional status, can reflect the complex and real world dynamics of the home care system and the characteristics of home care clients. The researchers themselves recognized most of the above noted shortcoming in their study.

4.2.3 Findings That Home Care Is Cost-Effective

In contrast to the above findings, other recent evidence indicates that preventive home care is cost-effective. Hollander (2001a) conducted a study of a natural experiment which occurred in British Columbia in the 1994 to 1995 period in which some health regions cut people from care who were at the lowest level of care need and were only receiving housecleaning services (one component of home support services), and some regions did not make such cuts. He studied the overall costs to the health care system of people who were cut from service in two health regions compared to people who were not cut from service in two similar regions where there were no, or limited, cuts. In the year before the cuts the average annual cost per client for those who were cut from service was $5,052 and the cost per client for the comparison group was $4,535. In the third year after the cuts were made the comparative costs were $11,903 and $7,808, respectively, for a net difference of some $3,500. Thus, on average, the people who were cut from care cost the health care system some $3,500 more in the third year after the cuts than people who were not cut. Total costs over the three year period after the cuts were $28,240 and $20,543, respectively, for those who were cut from care compared to those who were not cut.

In examining the data, it was found that most of the differences in costs were accounted for by increased costs for acute care and long term residential care. Over the three years, there was a net difference in hospital costs of some $2,300 (i.e., an average additional costs of $2,300 for people who were cut from care compared to those who were not cut) and residential long term care service costs of some $3,200. Thus, the findings of the study seem to indicate that even basic home support services can have a significant impact on the cost-effectiveness of our health care system.

4.3 Home Care as a Substitute for Residential Care

4.3.1 Findings That Home Care is Not Cost-Effective

A considerable amount of research has been conducted on studies of home care as a substitute for residential services in the United States. Much of the literature is based on two series of federally funded studies: 14 community care demonstration projects which were funded in the late 1970s and the early 1980s, and an additional 10 projects which were funded between 1982 and 1985.

Given the nature of the American continuing care system in the 1980s, it was considered that the appropriate way to study whether or not home care was a cost-effective alternative to residential care was to introduce case management (often with an enhanced home care program) into a community and then randomly assign eligible clients to existing community services or to enhanced services. Researchers then determined whether or not the enhanced services led to greater quality of life and client satisfaction, decreased morbidity and mortality, increased functional status, and reduced admissions to long term care facilities and hospitals.

Generally, researchers found that the experimental group had greater satisfaction and quality of life and somewhat reduced costs relative to the control group (Mathematica Policy Research Inc., 1986, April). However, when the costs of the enhanced home care program were added into the equation, the overall costs were generally greater for the experimental group than for the control group (Berkeley Planning Associates, May 1985; Mathematica Policy Research Inc., 1986, May).

Weissert (1985) has argued that it is difficult to make home and community based services cost-effective because: community care is an add-on to other services and is not a substitute for residential care; community care does not reduce institutionalization rates; only short long term care facility stays can be avoided by community based care; screening and assessment costs are high; overhead costs can be relatively high particularly when community services are small; and improvements in health status are limited.

Weissert, Cready and Pawelak (1988) expanded on this analysis in a study that looked at over 700 citations published since 1960 with regard to the relative costs of community and home based services versus residential long term care services. Of the 700 documents, 150 were selected for review and the 27 most rigorous and generalizable studies were chosen for detailed analysis. They concluded that their analysis indicated that home and community based long term care services usually raised overall health care service use and costs. They also noted that small savings for institutional care were often offset by the costs of the new home and community service.

Given the findings of studies such as those reviewed above American, and other, researchers concluded that home care was not a cost-effective alternative to residential care because it did not decrease the rate of admission to long term care facilities and, therefore, that home care constitutes an add-on cost.

4.3.2 Findings that Home Care Is Cost-Effective

The research reviewed above suggests that home care is not cost-effective compared to residential care. However, the research generally does not compare the costs of community and home based services versus the costs of long term residential care directly. Rather, the studies tend to compare costs associated with the introduction of a new home care service to existing community services. Several more recent studies have shown that when the costs of community based services are compared directly with the costs of long term care services, home care has the potential to be a cost-effective substitute for facility care.

Weissert, Lesnick, Musliner, and Foley (1997), in an American study, showed that home care can be cost-effective. In a study examining the Arizona Long Term Care System, which was the first capitated, long term care Medicaid program in the United States, Weissert and his colleagues noted that the cost of an integrated care program with case management and home care was less costly than a regular American care delivery systems, due to reductions in admission rates to facility care. The investigators suggested that savings probably came from several sources, including the use of a payment methodology that encouraged program contractors to place clients in home and community based services rather than risk losing money by using more facility days than their monthly capitated rate allowed.

There are also other international studies which demonstrate the cost-effectiveness of home care. Stuart and Weinrich (2001) conducted a broad systems level analysis of the costs of continuing care services in Denmark by comparing the cost trends in Denmark and the United States. Denmark has for many years had an integrated system of care delivery for the elderly and persons with disabilities which puts a priority on home care, and includes a home support component. The authors found that, over the twelve year period after this integrated system was put into place, Danish long term care expenditures leveled off, while expenditures in the United States continued to increase over the same time period. More specifically, they found that for the period 1985 to 1997 per capita expenditures on continuing care services per persons 65 years of age or older increased by 8% in Denmark and 67% in the United States. For persons 80 years of age or older costs actually decreased by 12% in Denmark while they increased 68% in the United States. It appears that the savings in Denmark were the result of reducing nursing home beds by 30%. In the United States, over the same period of time (1985 to 1997), there was a 12% increase in nursing home beds. Thus, an increasing proportion of people were cared for at home.

With regard to findings from Canada, Hollander (2001b) in a study of the cost-effectiveness of long term home care found that over time, and for all levels of care needs, home care, on average, was significantly less costly than care in a long term care facility. For example, average annual health care costs to government for people with moderate care needs (Intermediate care 1 or IC1) in the mid-to-late 1990s, in British Columbia, was $9,624 for persons on home care and $25,742 for people in institutions. For people at the highest, or chronic, level of care (Extended Care) the corresponding costs were $34,859 and $44,233. Similar cost differences are seen if one adopts a broader societal perspective which incorporates out-of-pocket expenses and the care time of informal caregivers into the analysis (Hollander, Chappell, Havens, McWilliam and Miller, 2002; Chappell, Havens, Hollander, Miller and McWilliam, 2004). Finally, in a Veterans Affairs Canada study Pedlar and Walker (2004) report on an At Home Pilot study which offered Overseas Veterans who previously were only eligible for residential care, a home care option. The veterans preferred this option resulting in significant reductions in waiting lists for facility care.

It should be noted that the savings from substituting home care services for residential services are not only theoretical. Actual savings were achieved in British Columbia by holding down future construction of long term care facilities and making investments in home care. Utilization of home and community care services in fiscal 1984/85 was 92 person years per 1,000 population 65 years of age and older and was 71.7 person years, or beds, for residential care for a total of 163.7. The overall utilization rate was also 163.7 for the 1994/95 fiscal year,

but the utilization rate for residential services (long term care and chronic, or extended care, services) was reduced to 50.7 and the utilization rate of home care increased to 113. Thus, over a 10 year period, due to a pro-active policy of substituting home care services for residential services, the utilization of some 21 person years per 1000 population 65 years or older was shifted from residential care to home care for persons with ongoing care needs.

With regard to assisted living arrangements (which are often supported by home care services), Nyman (1994) conducted a review of studies of the costs of assisted living arrangements and concluded that, overall, the unit costs of assisted living are lower than the unit costs of residential long term care facilities. Leon and Moyer (1999) conducted an analysis of the comparative costs of assisted living versus nursing homes for patients with Alzheimer's disease. Costs of care were moderately lower in assisted living arrangements compared to nursing homes. Combining all levels of severity, the authors found that the annual costs of assisted living were 13.9% lower than the costs for nursing homes.

4.4 The Cost-Effectiveness of Home Care Compared to Acute Care Hospitals

4.4.1 Introduction

While current Canadian policy related to short term, acute home care appears to be based primarily on an assumption that home care can act as a substitute for hospital services, there are, in fact, two aspects to short term, acute care related, home care. The first is the direct substitution of home care for hospital care by allowing hospital clients to be discharged earlier and cared for in the community by home care. The other aspect relates to the reduction of hospital admissions, or re-admissions, by using targetted home care services.

4.4.2 The Direct Substitution of Home Care for Hospital Care Services

In an Israeli pre-post study, Guber, Morris, Chen and Israeli (2002) compared the costs of people receiving a home care management system for respiratory patients to the costs of providing respiratory care to the same people in hospital before their transfer to home care. The average length of stay in hospital of the people on the home care program was 181 days per patient and the average time on home care itself was 404 days. The comparative average monthly cost for home care patients was one third of the costs they had incurred in the hospital, that is $3,547 and $11,000 respectively.

In a British study, Hollingworth, Todd, Parker, Roberts and Williams (1993), studied the cost-effectiveness of early discharge to a hospital at home for hip fracture patients, compared to regular hospital care. The authors found that the patients in the experimental group spent 9.2 fewer days in hospital, resulting in a comparative cost reduction of £722 per patient. Casiro, et al. (1993) in a Canadian study of early discharge of low birth weight infants found a cost saving of $153,381 for 29 infants in the 1501 to 2000 gram birth weight group. The cost-effectiveness of the early discharge plus home/community support option was greatest for this age group of infants. In a New Zealand review article Anderson, Mhurchu, Brown and Carter (2002) studied the cost-effectiveness of early discharge and home/community rehabilitation for persons who

had suffered strokes. Their meta-analysis indicated that the overall costs for the early intervention group were 15% lower than for the standard care group.

There were three papers which dealt with early discharge plus home/community support for patients with acute chronic obstructive pulmonary disease (COPD). Nicolson, et al (2001) in an Australian study found that, while outcomes were similar, care at home was considerably less than care in hospital ($745 compared to $2,543). However, the sample sizes in this study were quite small. In a British study, Roberts (2001) conducted a randomized clinical trial (RCT) of early discharge plus home/community care in Edinburgh. The findings of the study were that while outcomes were similar, the costs of care were lower for the home/community option than for people who stayed in hospital (£877 versus £1,753). Similar results to those above were also found in an Irish study (Murphy, Bryne and Costello, 2002).

Teng, et al (2003) in a Canadian RCT study on persons who had suffered a stroke, found, for persons requiring rehabilitation, that the initial costs were similar for the early discharge stroke group and the hospital group. However, the standard care (hospital care group) had considerably more readmissions, resulting in comparative costs of $7,784 versus $11,065 for the early supported discharge group compared to the standard care group. Similar results were found in two British studies, Patel, Knapp, Perez, Evans and Kalra (2004) compared hospital versus community care services and found that total care costs were £11,450 for persons cared for in the hospital based stroke unit compared to £6,840 for those who received care at home. Beech, Rudd, Tiling and Wolfe (1999) found, in an RCT conducted in an inner-city London teaching hospital, that, overall, "early discharge to community rehabilitation for stroke victims is cost-effective." Finally, in a British Cochrane Collaboration paper the Early Discharge Supported Trialists (2002) looked at early discharge plus home rehabilitation for stroke patients. They found that the early supported discharge group had significant reductions in hospital lengths of stay.

In contrast to the above findings, Coyte, Young and Croxford (2000) in a Canadian study of joint replacement patients found that patients referred to home care actually stayed longer in hospital, had overall higher costs and had higher readmission rates. However, this study did not randomly assign a group of similar clients to the different groups. Rather, statistical adjustments were made to attempt to ensure that clients in each of the groups studied were comparable.

4.4.3 The Prevention of Hospital Admissions and/or Re-Admissions

4.4.3.1 Community Based Prevention Programs

Mixed results were found by Stuck et al. (1995) in California with regard to a trial of in-home comprehensive geriatric assessment for elderly people living in the community. This was a three-year, randomized, controlled trial of in-home comprehensive geriatric assessment and follow-up for people 75 years of age or older living in the community.

Rich, et al. (1995) conducted a study in St. Louis on the effects of a nurse-oriented, post-discharge multidisciplinary intervention to prevent the readmission to hospital of elderly patients with congestive heart failure, compared to conventional care. In this prospective, randomized trial, it was found that the treatment group had 56.2% fewer readmissions for heart failure and

28.5% fewer admissions for other causes within 90 days of hospital discharge compared to people receiving conventional care. For the treatment group, the overall costs of care was also $460 less per patient than for the control group. In another American study of a senior's health promotion program, Nuñez, Armbruster, Phillips and Gale (2003) found that in a community based, nurse-managed health promotion and chronic disease management program for community-residing older adults, such adults had better health and social functioning, and fewer doctor visits and hospital days per year, than a national comparison group.

In an Australian study, Lim, Lambert and Gray (2003) found that patients receiving post-acute care coordination used fewer hospital days in the six months post discharge than patients receiving usual care and that this resulted in an average net savings of $1,545 per person for the treatment group. There were also two other Australian studies on home care services for people with congestive heart failure. Stewart, Marley & Horowitz (1999) in a randomized study found that a multi-disciplinary home-based intervention, consisting of a home visit by a cardiac nurse resulted in fewer unplanned readmissions and associated days in hospital compared to usual care. There were 100 patients in both the treatment group and the control group. The overall hospital costs for the treatment group, in Australian dollars, was $490,300 compared to $922,600 for the control group. In a more recent study, Stewart and Horowitz (2003) found in their own work, and in a broad literature review, that home based care for chronic heart failure patients is some 30% to 50% less costly than usual care.

4.4.3.2 The Hospital at Home

There seems to be an emerging literature on the cost-effectiveness of models of care described as "hospital at home." These are similar to the model of the Extra-Mural Hospital in New Brunswick. There were three studies from the United Kingdom on this topic. Jester and Hicks (2003) found that hospital at home was more effective and less costly than care in an acute care hospital. The lower costs were attributable to a 0.9 day reduction in the length of stay and the lack of hospital overhead costs. Coast et al. (1998) conducted a cost-minimization analysis of early discharge to a hospital at home compare to standard care in a hospital. They found that, on average, the cost for the hospital at home option was £2,516 compared to £3,292 for standard care in the hospital. They also note that the findings of lower costs for the hospital at home option were fairly robust based on a number of sensitivity analyses which were conducted as part of the study. In contrast to the above findings, Shepperd, Harwood, Gray, Vessey and Morgan (1998) in a cost-minimization RCT found that there was no difference in costs between the hospital at home option compared to inpatient hospital care for elderly patients, and for people who had had hip and knee replacements, and that costs were higher for COPD patients and persons who had had a hysterectomy.

The hospital at home option is also emerging in a range of other jurisdictions. Board, Brennan and Caplan (2000), in an Australian study, used a RCT design to compare costs for people receiving hospital at home services compared to standard care in an acute care hospital. It was found that costs were lower for the hospital at home group ($1,764 compared to $3,614 for the standard care group), without any differences in clinical outcomes, and higher patient satisfaction. In a Spanish study Hernandez et al. (2003) analyzed a hospital at home option as an alternative to hospitalization for COPD patients admitted to a hospital emergency department. Patients were randomized into hospital at home and standard inpatient hospital care groups (i.e.,

people who presented at emergency and were subsequently hospitalized). The authors found that there were no differences in mortality or hospital readmissions, but that there was lower subsequent use of the emergency department and better quality of life. The costs for the hospital at home option were also 62% lower than for standard care.

3.4.3.3 Home Parental Nutrition

In a British study Puntis (1998) in a review of home parenteral nutrition, notes that the costs for home parenteral nutrition has been found to be some 25% to 50% of the costs of providing this care in a hospital. In another British study, using cost-utility analysis, Richards and Irving (1996) found that the average cost per quality adjusted life year (QALY) for home based care was £68,975 compared to £190,000 per QUALY for hospital based care.

3.4.3.4 Home IV Therapy

Harjai et al. (1997) in an American study, compared before and after costs and outcomes of home IV inotropic therapy for patients with advanced heart failure. They found that home IV inotropic therapy reduced hospital utilization, reduced costs by $1,465 per month, and improved patient functioning. Coyte, Dobrow and Broadfield, in a Canadian study (2001), compared the costs of receiving IV therapy in a hospital clinic (using bag and pole) versus initiating treatment in the clinic and returning home to complete treatment using a portable and disposable IV therapy device. The authors used a broad societal perspective in their analysis and found that, considering all costs, the cost was $4,636 for the home based alterative compared to $20,477 for full care in the clinic.

4.4.3.5 Home Ventilation

In an Israeli pre-post study, Guber, Morris, Chen & Israeli (2002) looked at respiratory home care. They found that when patients were moved from care in the hospital to care at home (with high-tech ventilatory support systems) the cost of home care was one-third of the cost of care in the hospital. Tuggy, Plant & Elliott (2003) in a British study looked at home based ventilation treatment for COPD patients. They randomized patients who had frequent repeat admissions into usual care, and a home ventilation option, to determine if the home care option reduced costs by decreasing the number of admissions to hospital. While the sample size for the home care group was fairly small (n=13), they found that home based ventilation did reduce hospital admissions and reduced costs by £8,254 per person per year. Larson, Odegard and Brown (1992), in a Canadian study, conducted a comparative cost analysis of a Respiratory Home Care Program in Alberta for patients on ventilators who were cared for in the hospital (in a long stay unit) and at home. While the sample size was fairly modest, they found that by treating patients at home through the Respiratory Home Care Program, they were able to save some $2.7 million per year as a result of the cost differential of treating 27 patients at home compared to the hospital.

4.4.3.6 Assistive Technologies and Home Modifications

Mann, Ottenbacher, Fruss, Tomita and Granger (1999) conducted a study of the effectiveness of assistive technology and environmental interventions in maintaining independence and reducing home care costs for the frail elderly. After an 18 month intervention

it was found that scores for the Functional Independence Measure (FIM) were reduced for both groups but that there was a significantly greater decline for the control group. The authors note that there was no statistically significant difference for overall costs, even though the average cost per person was $14,173 for the treatment group and $31,610 for the control group. There were two Australian studies on home modification based fall prevention initiatives. Smith and Widiatmoko (1998) used simulation modeling to estimate the costs and outcomes of home based fall prevention initiatives. The simulation indicated that home assessment and modifications could result in reduced morbidity, less hospital utilization and, possibly, improved quality of life. Salkeld et al. (2000) studied a home hazard reduction program (through home modifications). They randomized people who had a history of falls and who were to be discharged from hospital into a group which received the hazard reduction program and a group which did not receive the program. They concluded that the hazard reduction program was cost-effective for older people with a history of falls.

4.4.3.7 Telemedicine

An interesting and, potentially useful model of care, particularly in more rural areas, is telemedicine. In a Cochrane review paper Currell, Urquhart, Wainwright and Lewis (2005) note that they were not able to find rigorous cost-effectiveness studies of telemedicine. They do note, however, that the technology seemed to be reliable and that the studies considered did not show any detrimental effects. Thus, they indicate that current data are inconclusive and further research is required. Dick et al. (2004), in a Canadian study, analyzed pediatric telehome care support after hospitalization. They found that parents had a strong preference for, and satisfaction with, telehome care. They also note that further research is required.

4.4.3.8 Quick Response Teams

Darby (1992), in a Canadian study, found that a Quick Response Team in the Greater Niagara Hospital in Ontario was able to prevent 206 admissions from the Emergency Department to the hospital of frail, elderly adults, out of 237 referrals, over a 12 month period. While Darby does not provide a cost comparison, he does indicate that by being able to send people home, with enhanced services, the Quick Response Team was able to free up the equivalent of 8 to 10 beds for a one year period.

4.5 The Cost-Effectiveness of Palliative Care

A number of writers have reported on the findings of the National Hospice Study in the United States. This study was conducted in the early 1980s and compared the costs of 833 home based patients, 624 hospital-based hospice patients and 297 patients in conventional care with cancer (Bosanquet, 2002). It was found that, on average, home based hospice costs were $4,000 lower than conventional care and that hospital based hospice costs were $1,300 lower than conventional care. However, most of the difference was found in the last month of life and, in fact, the costs for people with long hospice stays (over 3 – 4 months) were higher than the costs of conventional care. There were also differences in what care was provided. Hospice based patients had ten times more home care services than people receiving conventional care who, in turn, were seven times more likely to receive aggressive anti-tumor intervention near death (Robinson and Pham, 1996). The authors also note a study based on a subsequent re-analysis of

the data which noted that the "quality of the death" was better in home and hospital based hospice settings.

In an American study, Aliotta and Andre (1997) provide an overview of the benefits of the integrated models of care delivery which includes palliative care. In another American study Cherin, et al. (2000) evaluated the cost-effectiveness of a community based continuum of care model, using multi-disciplinary staff (hospice trained nurses, social workers and case managers) in California. This model was compared to a traditional home nursing care model for the care of late stage HIV/AIDS patients. While there was a somewhat lower cost for professional services for the Transprofessional Model compared to the Standard Model ($1,543.95 versus $1,675.46 for the care episode), savings were significant once drug costs were included in the analysis ($2,258 versus $3,598 for the care episode).

In contrast to the above studies Salisbury et al. (1999) in a British review paper note that in their review they found that there was little evidence of better quality of life outcomes for coordinated care compared to conventional home care. However, they did not review comparative cost data. Smith (1998) in a review article cites a British study which found that the addition of a nurse coordinator for terminally ill patients reduced costs from £8,814 to £4,414, for a cost savings of 41%. The actual British study (Raferty, et al., 1996) also mentions that in a more refined analysis (restricted to patients who actually died), the ratio of potential cost savings to the costs of service co-ordination was between 4:1 and 8:1.

In a study which was somewhat similar to the American National Hospice Study, Deans (2004) provides an overview of hospice service costs in the United States for their government based health insurance systems. The author notes that, for 2001, the per diem charge for hospital based hospice care was $3,069. The comparable, daily costs for hospice in a long term care facility and at home were $422 and $125, respectively. The author does not provide comparative costs data on the full episode of care.

In a Canadian review article Chochinov and Kristjanson (1998) review a number of articles on the cost-effectiveness of hospice. Among their conclusions they note that the cost savings reported for home based palliative care may be a function of nearness to death, that family related costs for end-of-life care are substantial, and are often not factored into most cost analyses, and that there may be a two tiered system of palliative care in which families with higher incomes may be better able to afford the help required to support home deaths. In an Italian study, Maltoni, Nanni, Naldoni, Serra and Amadori (1998) noted that there are cost savings for home based palliative care in the last three months of life. They conclude that home care hospices are more satisfactory to patients than conventional home care and that the savings from such hospice care are mainly attributable to shorter stays in hospital. In an American study of Alzheimer's patients, Lane, Davis, Cornman, Macera and Sanderson (1998) found that the per day cost of hospital care was six times the cost of hospice/home care. However, they also found that of the people at home only 8% died at home and 51% still died in hospital.

In a British review article Higginson, et al. (2003) found that, while there were few rigorous cost-effectiveness studies, the evidence did seem to indicate that compared to other models, the benefit was strongest for home care. In a British study of the comparative costs of

palliative care in hospitals, hospices and home care Coyle, et al. (1999) found that the average cost of hospital based palliative care was lower than the cost of residential hospice care. In both cases, however, costs were reduced once the patient was admitted to the hospice setting. They also found that the per day costs of hospital and residential hospice care, after admission to hospice, were higher than the per week cost of home based palliative care (£146.82 for hospital hospice per day, £207.23 for residential hospice per day and £121.06 per week for home based care).

4.6 Discussion and Conclusions

A key finding from the literature review on the cost-effectiveness of home care noted above 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 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 specific, well planned and executed preventive initiatives can actually have a positive impact in delaying institutionalization. A corollary of the above is that there are a number of more "medical" preventive interventions or programs which may also be able to bring about greater program efficiencies. Thus, from a program development perspective, it may be useful to increase both the "high tech" and "high touch" aspects of home care, to the extent that such services can increase the overall efficiency of the health care system.

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. Thus, 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.

As always, one must be aware that investments in greater efficiencies can only achieve positive results if there are real and tangible substitutions or trade-offs which can actually occur at the front lines, or if blockages in the efficient flow of services can be relieved (e.g., reductions in waiting lists/waiting times, and/or in Alternative Level Care [ALC] hospital patients). For example, one may be able to, in theory, reduce hospital stays by 20 beds per year, at one-third of the cost of such days, using a new home care service. However, unless one recognizes that such a trade-off has occurred, it may simply appear that there is an add-on cost for the new home care service. Unless the efficiencies gained are recognized: by valuing outcomes such as reduced ALC bed days, or waiting lists, because 20 beds have been "freed up" during the year; or by reducing current bed allocations, and/or future bed growth, actual increases in efficiencies for the overall health care system may not be adequately recognized.

5. TRENDS IN DEMOGRAPHY, SERVICE UTILIZATION AND COSTS

5.1 Introduction

This chapter provides an overview of key findings, based on administrative data provided by Saskatchewan officials, on demographic trends, service utilization and costs. While the focus of this project was on home care services, we also conducted some analyses related to residential care services in order to better estimate the potential for cost-effective substitutions of home care for institutional services.

5.2 Overview of Demographic Changes Over Time

The following materials provide an overview of demographic changes in Saskatchewan over time. More in-depth analyses of age standardized utilization patterns, and projections for home care and residential care clients, are provided in subsequent sections. Three sets of tables and figures are presented below. For each set, the table is presented first, followed by a corresponding figure.

Table 5-1 presents existing and projected population data for Saskatchewan from 1971 to 2021 in terms of the standard, or regular, projection, and for the upper and lower boundary projections (i.e., the most likely highest and lowest estimates).

Table 5-1 indicates that there was a substantial increase in the year over year growth rates (over a series of five year periods) for persons 20 to 64 and 65+ in the 1970s, and a decrease in the growth rates of the population aged 0-19. There was a steady decline in the growth rate of the population 65+ from 1981 to 2006, but there is a projected increase in this growth rate from 2006 to 2021. There appears to be a reduction in the overall population of Saskatchewan from 1971 to 2021. There also has been, and will continue to be, an ongoing negative growth rate for persons 0 to 19 years of age from 1971 to 2021.

Figure 5-1 presents, in effect, the cumulative growth rate from 2001 to 2021, using the "regular" projection series. It can be seen that, while there is a dip in 2006, there will be significant growth in the number of people aged 65+ after 2011, while the working age population will remain reasonably constant from 2001 to 2021. The population aged 0 to 19 will decrease over the 2001 to 2021 period. Thus, based on these projections, it appears that it may indeed be timely to streamline services for seniors so that they can be as efficient and effective as possible to mitigate the coming demand for services.

Another point to note is that while it may still take some time to feel the added pressure on resources from future clients, there may be a current impact on service providers as the baby boomer cohort begins to retire. This may continue to present human resources challenges over the coming years. For example, nurses born in 1946 turn 60 in 2006.

Table 5-2 and Figure 5-2 present the cumulative increase from 2001 to 2021 for each age group of seniors: the young old (65-74), the middle old (75-84) and the old old (85+). Traditionally, service utilization increases with age. Thus, pressures on resources may be

somewhat mitigated 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 goes through to about 2046 when those born in 1961 become 85 years of age.

Dependency ratios are one way of documenting the relative pressures on society for services by "dependent" populations, that is those who are not of working age, compared to persons who are of working age. As can be seen in Table 5-3 and Figure 5-3, there has been a continuing decrease in the dependency ratio for children since 1971, a modest increase in the dependency ratio for seniors, and a modest overall decrease in the total dependency ratio. This means that, over time, there has been a pattern where there are proportionally more working aged persons than "dependent" persons. Thus, in terms of the overall tax base there are, on a proportional basis, relatively more taxpayers to pay for health, education and social services now than in 1971. The overall dependency ratio will increase somewhat (that is, there will be a higher proportion of dependent persons) from 2011 to 2021, but the ratio in 2021 will still be lower than it was in 1996.

What does all this mean? It means that given the overall tax base, there should continue to be sufficient tax revenues to support the health, education and social service needs of young people and seniors, as long as there is no significant cost, or average per client utilization (by levels of care), escalation, in the services provided to these populations. In addition, there may be an increasing proportion of seniors who will have pension benefits, which are taxable, over time. These factors could increase the relative tax base. Finally, to the extent that resources can be decreased for younger people, in proportion to their decrease in numbers, over time, these resources could be re-allocated to seniors whose numbers are increasing.

In conclusion, while it may well be that, taken in isolation, there may be future demands for resources for home care services, due to the aging of the population, it appears that on an overall basis it should be possible to respond to these cost pressures. As long as cost escalation in unit costs, and the amount of service provided per person, can be contained, it appears that the pressures of "apocalyptic demography" can be mitigated, at least until about 2021.

Table 5-1: Population and Percentage Change: 1971-2021

REGULAR PROJECTIONS 2006-2021

	POPULATION					YEAR OVER YEAR % CHANGE					%CHANGE FROM 2001				
Year	0-19	20-64	65+	75+	85+	0-19	20-64	65+	75+	85+	0-19	20-64	65+	75+	85+
1971	389,323.00	456,086.00	94,226.00	40,747.00	9,182.00										
1976	358,368.00	487,707.00	103,388.00	41,945.00	10,746.00	-7.95	6.93	9.72	2.94	17.03					
1981	339,282.00	534,741.00	116,723.00	46,463.00	11,781.00	-5.33	9.64	12.90	10.77	9.63					
1986	332,220.00	579,597.00	129,541.00	53,496.00	12,619.00	-2.08	8.39	10.98	15.14	7.11					
1991	316,291.00	554,440.00	139,795.00	62,582.00	14,717.00	-4.79	-4.34	7.92	16.98	16.63					
1996	312,003.00	567,808.00	147,740.00	70,983.00	18,292.00	-1.36	2.41	5.68	13.42	24.29					
2001	295,385.00	581,371.00	148,032.00	75,346.00	21,462.00	-5.33	2.39	0.20	6.15	17.33					
2006	275,738.45	601,681.66	146,950.15	77,097.70	23,889.34	-6.65	3.49	-0.73	2.32	11.31	-6.65	3.49	-0.73	2.32	11.31
2011	260,693.92	615,113.58	148,741.64	75,557.21	25,029.35	-5.46	2.23	1.22	-2.00	4.77	-11.74	5.80	0.48	0.28	16.62
2016	254,010.41	609,831.58	161,481.81	73,788.38	24,986.24	-2.56	-0.86	8.57	-2.34	-0.17	-14.01	4.90	9.09	-2.07	16.42
2021	253,845.56	587,338.67	182,640.28	75,432.53	23,989.77	-0.06	-3.69	13.10	2.23	-3.99	-14.06	1.03	23.38	0.11	11.78
LOWER BOUND PROJECTIONS 2006-2021															
Year	0-19	20-64	65+	75+	85+	0-19	20-64	65+	75+	85+	0-19	20-64	65+	75+	85+
2006	257,373.04	565,660.47	140,703.33	72,843.78	21,660.30	-12.87	-2.70	-4.95	-3.32	0.92	-12.87	-2.70	-4.95	-3.32	0.92
2011	223,394.80	541,463.36	137,331.31	68,251.35	21,230.47	-13.20	-4.28	-2.40	-6.30	-1.98	-24.37	-6.86	-7.23	-9.42	-1.08
2016	196,435.08	498,717.63	144,500.78	64,230.87	20,163.45	-12.07	-7.89	5.22	-5.89	-5.03	-33.50	-14.22	-2.39	-14.75	-6.05
2021	175,297.29	440,492.34	158,261.83	63,649.56	18,577.77	-10.76	-11.68	9.52	-0.91	-7.86	-40.65	-24.23	6.91	-15.52	-13.44
UPPER BOUND PROJECTIONS 2006-2021															
Year	0-19	20-64	65+	75+	85+	0-19	20-64	65+	75+	85+	0-19	20-64	65+	75+	85+
2006	294,103.86	637,702.84	153,196.97	81,351.62	26,118.38	-0.43	9.69	3.49	7.97	21.70	-0.43	9.69	3.49	7.97	21.70
2011	297,993.04	688,763.80	160,151.97	82,863.07	28,828.24	1.32	8.01	4.54	1.86	10.38	0.88	18.47	8.19	9.98	34.32
2016	311,585.73	720,945.53	178,462.84	83,345.89	29,809.03	4.56	4.67	11.43	0.58	3.40	5.48	24.01	20.56	10.62	38.89
2021	332,393.83	734,185.00	207,018.74	87,215.51	29,401.77	6.68	1.84	16.00	4.64	-1.37	12.53	26.29	39.85	15.75	36.99

Figure 5-1: Cumulative Percentage Change From 2001 to 2021

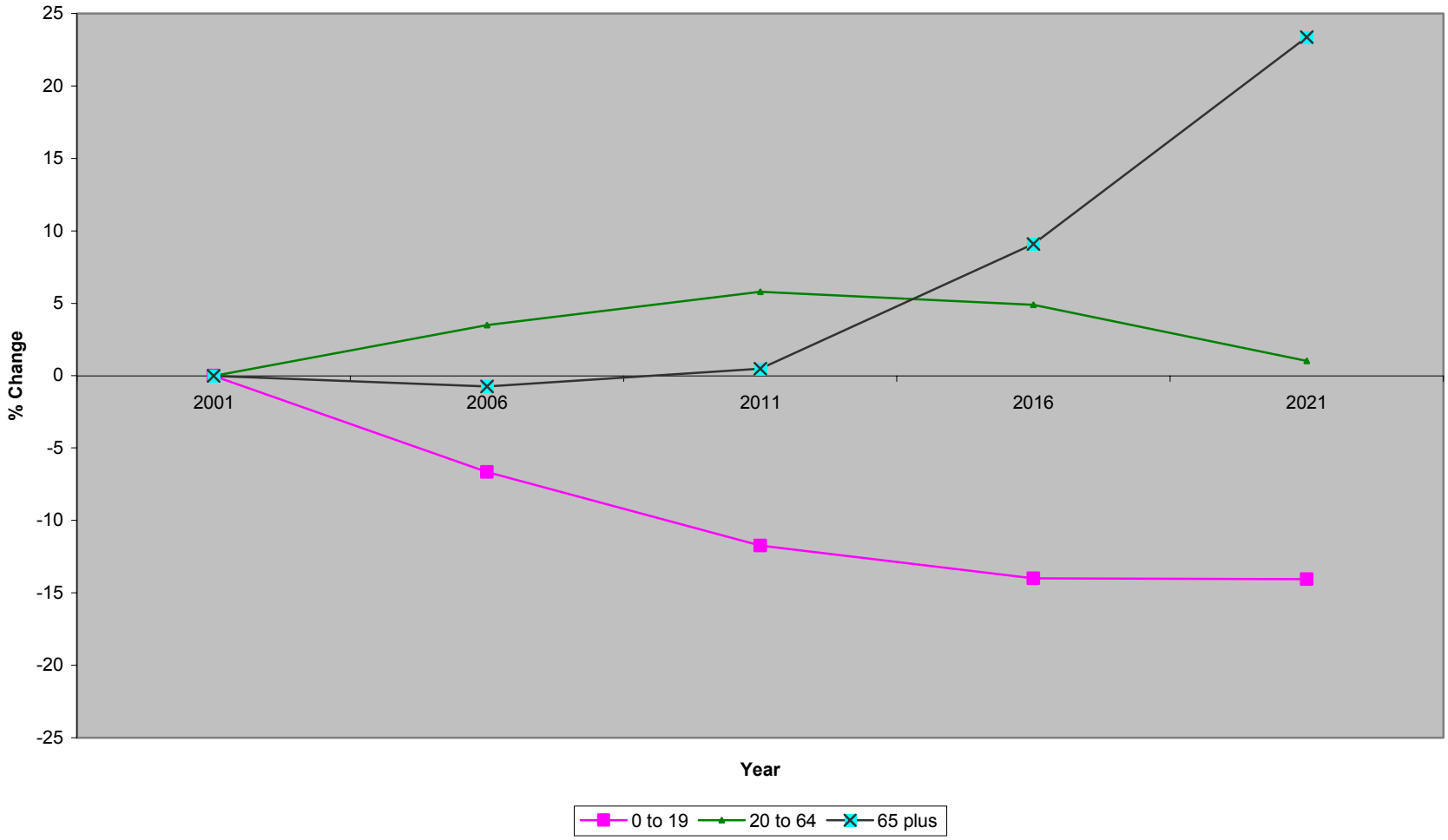


Table 5-2: Percentage Change From 2001 to 2021 for Seniors

REGULAR

	Population			%Change from 2001		
	65-74	75-84	85 Plus	65-74	75-84	85 Plus
2001	72,686.00	53,884.00	21,462.00			
2006	69,852.45	53,208.36	23,889.34	-3.90	-1.25	11.31
2011	73,184.43	50,527.85	25,029.35	0.69	-6.23	16.62
2016	87,693.43	48,802.14	24,986.24	20.65	-9.43	16.42
2021	107,207.75	51,442.76	23,989.77	47.49	-4.53	11.78

LOWER BOUND

	65-74	75-84	85 Plus	65-74	75-84	85 Plus
2001	72,686.00	53,884.00	21,462.00			
2006	67,859.55	51,183.48	21,660.30	-6.64	-5.01	0.92
2011	69,079.96	47,020.88	21,230.47	-4.96	-12.74	-1.08
2016	80,269.92	44,067.42	20,163.45	10.43	-18.22	-6.05
2021	94,612.27	45,071.78	18,577.77	30.17	-16.35	-13.44

UPPER BOUND

	65-74	75-84	85 Plus	65-74	75-84	85 Plus
2001	72,686.00	53,884.00	21,462.00			
2006	71,845.35	55,233.24	26,118.38	-1.16	2.50	21.70
2011	77,288.90	54,034.83	28,828.24	6.33	0.28	34.32
2016	95,116.95	53,536.86	29,809.03	30.86	-0.64	38.89
2021	119,803.23	57,813.74	29,401.77	64.82	7.29	36.99

Figure 5-2: Cumulative Percentage Change From 2001 to 2021 for Age Groups 65-74, 75-84, and 85 Plus for the Regular Projection

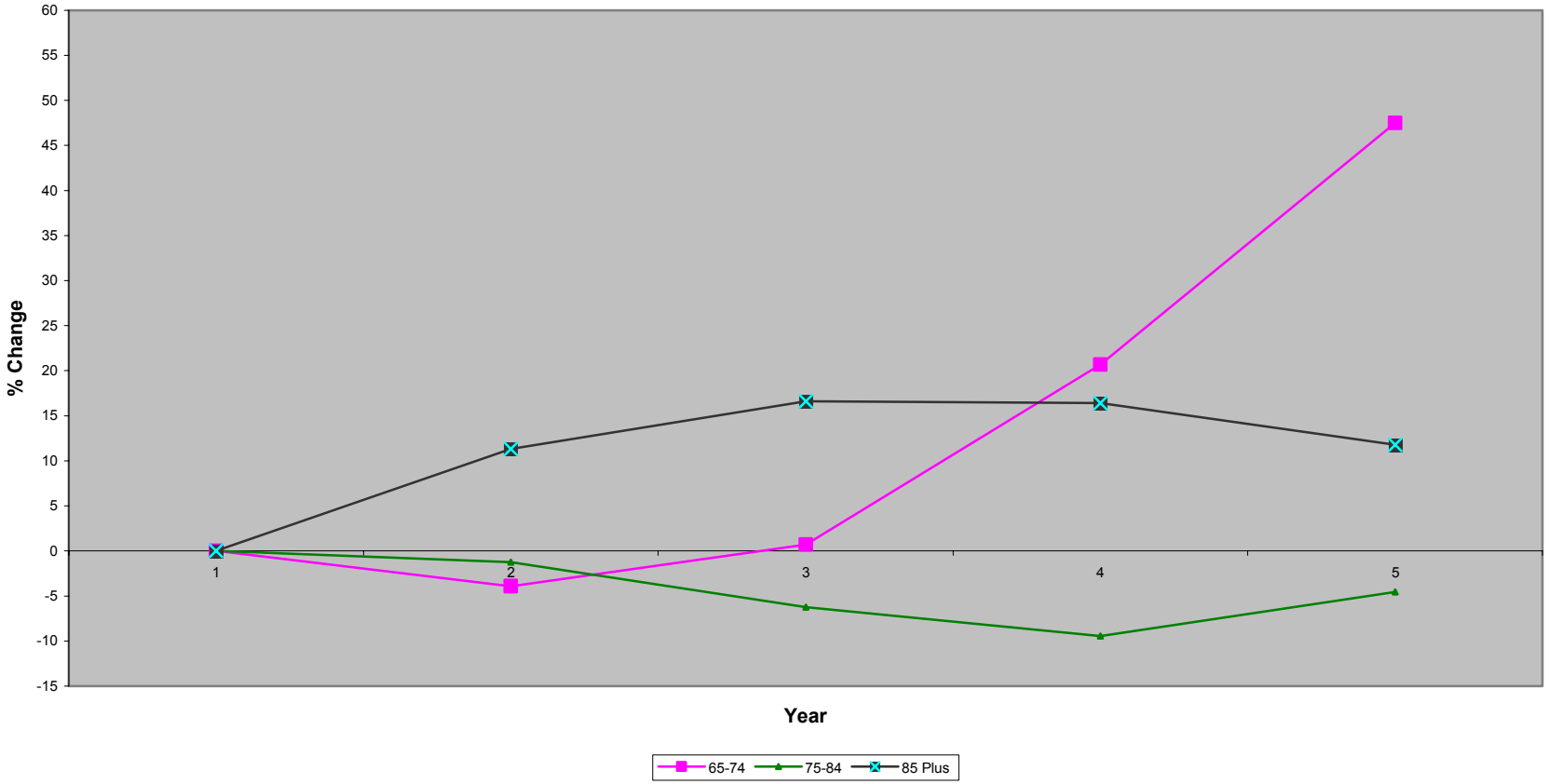
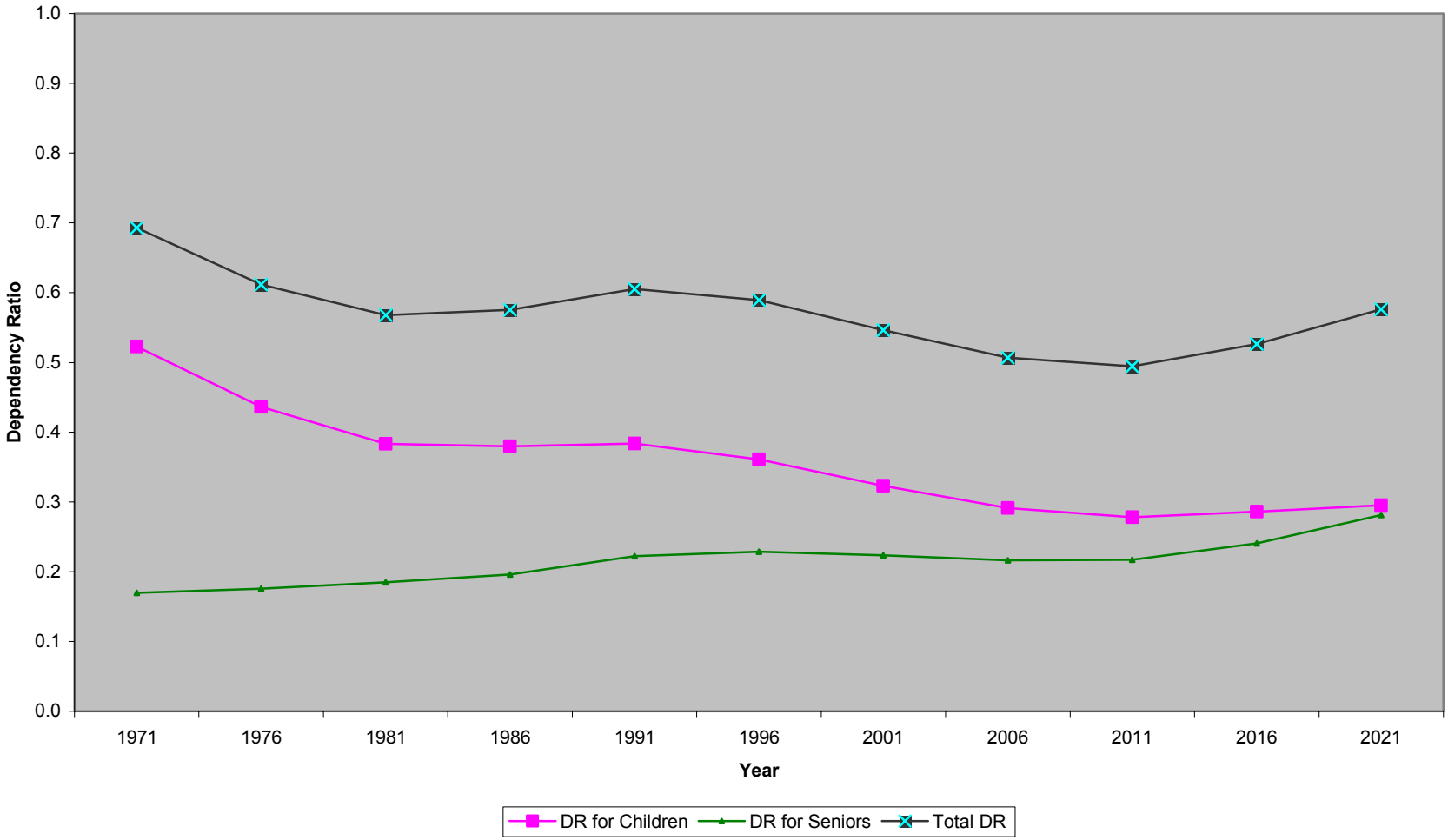


Table 5-3: Dependency Ratios for Children, Seniors, and Totals

	Population				Dependency Ratio		
REGULAR	**0-14**	**15-64**	**65 and Over**	**Total Population**	**For Children**	**For Seniors**	**Total**
1971	290,340.00	332,241.39	94,226.00	716,807.39	0.5231	0.1698	0.6928
1976	257,038.00	331,328.22	103,388.00	691,754.22	0.4364	0.1755	0.6119
1981	242,079.00	351,946.14	116,723.00	710,748.14	0.3831	0.1847	0.5678
1986	250,801.00	387,707.15	129,541.00	768,049.15	0.3794	0.1960	0.5754
1991	241,311.00	402,932.21	139,795.00	784,038.21	0.3834	0.2221	0.6055
1996	233,249.00	429,636.18	147,740.00	810,625.18	0.3608	0.2285	0.5893
2001	214,030.00	441,227.09	148,032.00	803,289.09	0.3230	0.2234	0.5463
2006	197,751.43	454,274.28	146,950.15	798,975.86	0.2910	0.2162	0.5072
2011	190,401.34	468,043.24	148,741.64	807,186.23	0.2778	0.2170	0.4948
2016	192,127.12	471,462.64	161,481.81	825,071.57	0.2860	0.2404	0.5264
2021	191,591.78	463,041.43	182,640.28	837,273.49	0.2949	0.2812	0.5761
LOWER BOUND							
	0-14	**15-64**	**65 and Over**	**Total Population**	**For Children**	**For Seniors**	**Total**
2006	183,157.49	432,095.34	140,703.33	755,956.15	0.2862	0.2199	0.5061
2011	160,086.66	418,350.03	137,331.31	715,768.00	0.2647	0.2271	0.4918
2016	144,772.67	389,908.98	144,500.78	679,182.43	0.2630	0.2625	0.5256
2021	130,108.06	350,176.23	158,261.83	638,546.12	0.2679	0.3259	0.5937
UPPER BOUND							
	0-14	**15-64**	**65 and Over**	**Total Population**	**For Children**	**For Seniors**	**Total**
2006	212,345.38	476,453.21	153,196.97	841,995.56	0.2951	0.2129	0.5081
2011	220,716.02	517,736.46	160,151.97	898,604.45	0.2881	0.2091	0.4972
2016	239,481.56	553,016.30	178,462.84	970,960.71	0.3020	0.2250	0.5270
2021	253,075.49	575,906.65	207,018.74	1,036,000.88	0.3111	0.2545	0.5656

Figure 5-3: Saskatchewan Dependency Ratios For 1971 to 2021 for the Regular Projection



5.3 Overview of Data for Home Care Services

Anonymized, administrative data on home care services were obtained from Saskatchewan Health. It should be noted that an attempt was made for all of the tables in this chapter, and the more detailed set of tables on home and residential care data in Appendix B, to ensure that there are at least five people in each cell in each table. In order to try to approximate this standard it was necessary to aggregate the data from the three northern regions (Mamawetan Churchill River, Keewatin Yathe and Athabasca), and to combine response categories, as appropriate. Nevertheless, in some cells this convention was not upheld but, for most such cases, they appear in an "unknown" category and, thus, it would also be quite difficult to identify individuals in these cells as the data that could be used to identify such persons in missing.

As can be seen from Table 5-4 the bulk of services are provided to clients needing 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. For example, Five Hills and Regina have 40% and 45%, respectively, receiving supportive care and 56% and 50% receiving acute home care. Saskatoon has proportions that are consistent with the provincial average, while a number of RHAs provide supportive care to over 75% of their clients. Given the distributions noted in Table 5-4, we shall focus in this section on acute and supportive care data as the proportion of clients receiving palliative care is quite modest. The full set of data tables for home care services are provided in Appendix B.

Tables 5-5 and 5-6 present data on the socio-demographic characteristics of acute care and supportive care clients. As can be seen in Table 5-5 on acute home care, Five Hills and Regina have higher proportions of adults (aged 19-64) among their clientele (overall, there were very few clients 0-19 years of age in home care). This may be consistent with the relatively greater proportion of acute care clients served by these regions. Overall, there were about an equal proportion of adults (51%) on the Acute Home Care Program, compared to seniors (49%). In contrast to the different age patterns across regions, the gender distribution for acute home care clients was fairly consistent across RHAs, except for the Northern RHAs. Some 80% of acute home care clients lived in a house prior to admission and some 50% lived with a spouse, or a spouse and others, prior to admission.

In contrast to the data on acute home care clients in Table 5-5, Table 5-6 on supportive home care indicates that, overall, there were more females receiving supportive services (66%) than acute services (45% from Table 5-5). There was also a significant difference in the age structure, as some 87% of supportive clients were 65 years of age or older compared to 49% for acute home care. Furthermore, the comparative proportions across RHAs of people in different age groups were more consistent for supportive home care clients than for acute home care clients. Some 60% of supportive home care clients lived in a house prior to admission and 52% lived alone prior to admission.

Table 5-4: Type of Care for Home Care Clients: Fiscal 2003/04

Number and Percentage of Clients		Region											
		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
All	#	28,552	1,875	2,220	1,597	7,158	2,506	6,362	1,824	1,308	2,079	1,780	121
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Palliative	#	1,201	62	88	42	376	99	376	39	43	54	40	.
	%	4.21	3.31	3.96	2.63	5.25	3.95	5.91	2.14	3.29	2.60	2.25	.
Acute	#	9,426	188	1,237	346	3,548	771	1,763	387	242	426	612	7
	%	33.01	10.03	55.72	21.67	49.57	30.77	27.71	21.22	18.50	20.49	34.38	5.79
Supportive	#	17,881	1,624	895	1,207	3,231	1,633	4,192	1,397	1,023	1,596	1,127	114
	%	62.63	86.61	40.32	75.58	45.14	65.16	65.89	76.59	78.21	76.77	63.31	94.21
Unknown	#	44	1	.	2	3	3	31	1	.	3	1	.
	%	0.15	0.05	.	0.13	0.04	0.12	0.49	0.05	.	0.14	0.06	.

Table 5-5: Socio-Demographic Characteristics for Acute Home Care Clients: Fiscal 2003/04

Number and Percentage of Clients		Region											
		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
All	#	9,426	188	1,237	346	3,548	771	1,763	387	242	426	612	7
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Gender													
Male	#	4,198	80	535	148	1,675	324	725	167	122	194	273	2
	%	44.54	42.55	43.25	42.77	47.21	42.02	41.12	43.15	50.41	45.54	44.61	28.57
Female	#	5,228	108	702	198	1,873	447	1,038	220	120	232	339	5
	%	55.46	57.45	56.75	57.23	52.79	57.98	58.88	56.85	49.59	54.46	55.39	71.43
Age Group													
00-54	#	3,603	47	590	50	1,747	169	529	85	52	101	263	1
	%	38.22	25.00	47.70	14.45	49.24	21.92	30.01	21.96	21.49	23.71	42.97	14.29
56-64	#	1,222	24	158	31	513	76	248	42	25	55	67	.
	%	12.96	12.77	12.77	8.96	14.46	9.86	14.07	10.85	10.33	12.91	10.95	.
66-74	#	1,609	26	188	78	562	137	324	78	56	83	93	3
	%	17.07	13.83	15.20	22.54	15.84	17.77	18.38	20.16	23.14	19.48	15.20	42.86
76-84	#	1,932	52	209	106	497	231	424	118	67	122	122	3
	%	20.50	27.66	16.90	30.64	14.01	29.96	24.05	30.49	27.69	28.64	19.93	42.86
85Plus	#	1,060	39	92	81	229	158	238	64	42	65	67	.
	%	11.25	20.74	7.44	23.41	6.45	20.49	13.50	16.54	17.36	15.26	10.95	.
Marital Status													
Single Divorced or Separated	#	2,623	35	318	61	1,164	152	520	66	55	92	185	2
	%	27.83	18.62	25.71	17.63	32.81	19.71	29.50	17.05	22.73	21.60	30.23	28.57

Number and Percentage of Clients		Region											
		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
Married	#	5,022	112	750	174	1,920	390	828	211	129	232	328	2
	%	53.28	59.57	60.63	50.29	54.11	50.58	46.97	54.52	53.31	54.46	53.59	28.57
Widowed	#	1,768	41	168	111	459	228	410	110	58	102	98	3
	%	18.76	21.81	13.58	32.08	12.94	29.57	23.26	28.42	23.97	23.94	16.01	42.86
Unknown	#	13	.	1	.	5	1	5	.	.	.	1	.
	%	0.14	.	0.08	.	0.14	0.13	0.28	.	.	.	0.16	.
Living Arrangements Prior to Admission													
Lives Alone	#	2,805	49	292	118	1,019	266	586	125	86	128	161	1
	%	29.76	26.06	23.61	34.10	28.72	34.50	33.24	32.30	35.54	30.05	26.31	14.29
With Spouse Only	#	3,667	97	508	147	1,401	320	583	160	89	175	228	.
	%	38.90	51.60	41.07	42.49	39.49	41.50	33.07	41.34	36.78	41.08	37.25	.
With Spouse and Others	#	983	11	211	19	329	54	189	38	27	45	66	2
	%	10.43	5.85	17.06	5.49	9.27	7.00	10.72	9.82	11.16	10.56	10.78	28.57
With Other Family Members	#	1,487	25	185	31	655	108	258	40	28	55	121	4
	%	15.78	13.30	14.96	8.96	18.46	14.01	14.63	10.34	11.57	12.91	19.77	57.14
Others/Unknown	#	484	6	41	31	144	23	147	24	12	23	36	.
	%	5.13	3.19	3.31	8.96	4.06	2.98	8.34	6.20	4.96	5.40	5.88	.
Type of Residence On Admission													
House	#	7,609	169	1,013	263	3,137	618	1,119	321	199	354	498	6
	%	80.72	89.89	81.89	76.01	88.42	80.16	63.47	82.95	82.23	83.10	81.37	85.71
Apartment	#	1,411	17	212	59	215	134	545	47	38	60	95	1
	%	14.97	9.04	17.14	17.05	6.06	17.38	30.91	12.14	15.70	14.08	15.52	14.29
Other/ Unknown	#	406	2	12	24	196	19	99	19	5	12	19	.
	%	4.31	1.06	0.97	6.94	5.52	2.46	5.62	4.91	2.07	2.82	3.10	.

Table 5-6: Socio-Demographic Characteristics for Supportive Home Care Clients: Fiscal 2003/204

Number and Percentage of Clients		Region											
		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
All	#	17,881	1,624	895	1,207	3,231	1,633	4,192	1,397	1,023	1,596	1,127	114
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Gender													
Male	#	6,084	503	326	419	1,060	562	1,459	435	377	590	371	32
	%	34.02	30.97	36.42	34.71	32.81	34.42	34.80	31.14	36.85	36.97	32.92	28.07
Female	#	11,797	1,121	569	788	2,171	1,071	2,733	962	646	1,006	756	82
	%	65.98	69.03	63.58	65.29	67.19	65.58	65.20	68.86	63.15	63.03	67.08	71.93
Age Group													
00-54	#	1,302	85	59	71	328	48	386	66	54	118	96	12
	%	7.28	5.23	6.59	5.88	10.15	2.94	9.21	4.72	5.28	7.39	8.52	10.53
56-64	#	988	84	37	62	179	77	259	53	62	98	60	26
	%	5.53	5.17	4.13	5.14	5.54	4.72	6.18	3.79	6.06	6.14	5.32	22.81
66-74	#	2,423	212	94	177	400	187	519	190	113	347	173	37
	%	13.55	13.05	10.50	14.66	12.38	11.45	12.38	13.60	11.05	21.74	15.35	32.46
76-84	#	6,537	649	333	466	1,132	597	1,480	512	375	616	398	30
	%	36.56	39.96	37.21	38.61	35.04	36.56	35.31	36.65	36.66	38.60	35.31	26.32
85Plus	#	6,631	594	372	431	1,192	724	1,548	576	419	417	400	9
	%	37.08	36.58	41.56	35.71	36.89	44.34	36.93	41.23	40.96	26.13	35.49	7.89
Marital Status													
Single Divorced or Separated	#	3,375	230	164	173	760	292	897	169	206	298	179	38
	%	18.87	14.16	18.32	14.33	23.52	17.88	21.40	12.10	20.14	18.67	15.88	33.33

Number and Percentage of Clients		Region											
		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
Married	#	6,478	646	301	505	955	524	1,503	525	386	713	433	46
	%	36.23	39.78	33.63	41.84	29.56	32.09	35.85	37.58	37.73	44.67	38.42	40.35
Widowed	#	8,005	748	429	528	1,515	817	1,773	702	431	585	515	30
	%	44.77	46.06	47.93	43.74	46.89	50.03	42.29	50.25	42.13	36.65	45.70	26.32
Unknown	#	23	.	1	1	1	.	19	1	.	.	.	.
	%	0.13	.	0.11	0.08	0.03	.	0.45	0.07	.	.	.	.
Living Arrangements prior to Admission													
Lives Alone	#	9,228	889	491	601	1,628	939	2,136	786	601	616	579	43
	%	51.61	54.74	54.86	49.79	50.39	57.50	50.95	56.26	58.75	38.60	51.38	37.72
With Spouse Only	#	5,228	536	235	420	762	426	1,197	446	291	599	339	24
	%	29.24	33.00	26.26	34.80	23.58	26.09	28.55	31.93	28.45	37.53	30.08	21.05
With Spouse and/or Others	#	3,425	199	169	186	841	268	859	165	131	381	209	47
	%	19.15	12.25	18.88	15.41	26.03	16.41	20.49	11.81	12.81	23.87	18.54	41.23
Type of Residence On Admission													
House	#	10,766	1,025	440	875	1,681	1,078	2,262	931	606	1,169	718	87
	%	60.21	63.12	49.16	72.49	52.03	66.01	53.96	66.64	59.24	73.25	63.71	76.32
Apartment	#	5,322	546	377	284	686	458	1,599	409	372	264	345	26
	%	29.76	33.62	42.12	23.53	21.23	28.05	38.14	29.28	36.36	16.54	30.61	22.81
Other/ Unknown	#	1,793	53	78	48	864	97	331	57	45	163	64	1
	%	10.03	3.26	8.72	3.98	26.74	5.94	7.90	4.08	4.40	10.21	5.68	0.88

With regard to the more detailed data tables in Appendix B, it was surprising to find that some 73% of palliative care clients received supervisory or limited personal care services and only 11% received extended care (the highest level of care need) or short term nursing services. It may well be that medical interventions are provided by the primary care sector. Nevertheless, it may be worthwhile clarifying what type of home care is provided, and why, for palliative care clients. We fully expect that the service provided is appropriate, but it may be worthwhile to address this unexpected result in the data.

With regard to acute home care some 32% of clients received short term nursing services and 52% received supervisory care. In contrast supportive home care had 8% of clients who received short term nursing services and 40% who received supervisory care. Overall some 77% of supportive home care clients received supervisory or limited personal care services, 12% received intensive nursing or personal care services and 3% received extended care services.

Table 5-7 provides an overview of the average monthly service utilization by types of services, that is, it represents the average monthly service utilization across the 12 months in fiscal 2003/04. As can be seen, relatively few services are provided in regard to home maintenance and repair, physiotherapy and nursing for personal care related services.

Table 5-8 presents projections of Total Weighted Units of service for all home care services from fiscal 2003/04 to 2021. The total weighted units were calculated, by RHA, using a formula provided by Saskatchewan Health to set the cost of each of the different services to be the equivalent of the cost for one meal. For example, the costing ratio for nursing is 9.7, meaning the cost of a nursing visit is equivalent to the cost of 9.7 meals. As can be seen in Table 5-8, the overall increase in resources based on demographic projections is fairly modest (about 10%) from some 8.35 million weighted units in 2003/04 to 9.1 million weighted units in 2021. Thus, cost pressures from demographic factors alone, appear to be modest at about one half of one percent per year, using current utilization ratios and projecting them out to 2021.

Table 5-8 also presents data for projected utilization, in two ways. It uses the population distribution (in five year age groups) of the region and the RHAs weighted units (i.e., creating a ratio of weighted units per population group) and projects it out. Thus, the column "Using Regional Data" refers to future projections, within each RHA, of existing utilization patterns in the respective RHA. In contrast, the "Age Adjusted Rate" calculates the ratios of weighed units per population group for the province as a whole. These ratios are then applied to the actual age groupings in each region to obtain an estimate of the number of weighted units for the RHA, assuming the RHA had the same population distribution as the whole province. This procedure standardizes service utilization to the overall population. Thus, two regions may have the same overall population but one may have more weighted units than the other, however, that RHA may have an older population than average, while the other region may have a younger population. When one compares the two regions, they may well both have similar age standardized weighted units. It would, in fact, be appropriate for the region with relatively more seniors to receive more resources as they have a higher proportion, than the average, of older people who need care services.

Table 5-7: Service Units for an Average Month: Fiscal 2003/2004

Monthly Average	Weighted Service Units	Home Maintenance	Meals	Other Homemaking	Other Nursing	Personal Homemaking	Physiotherapy	Personal Nursing
Province	695,989	145	35,445	32,719	25,847	52,594	855	2,265
Sun Country	48,346	0	3,172	2,566	1,737	3,606	4	90
Five Hills	43,752	0	1,440	3,205	1,173	3,762	0	0
Cypress	36,556	30	2,704	1,871	475	2,137	314	851
Regina Qu Appelle	147,745	0	4,416	5,945	7,074	9,649	537	22
Sunrise	60,866	0	3,352	2,426	2,753	4,356	0	70
Saskatoon	190,778	0	7,677	8,750	7,566	15,795	0	72
Heartland	42,802	0	4,336	3,106	1,329	2,080	0	262
Kelsey Trail	43,427	0	3,815	1,000	1,178	5,348	0	0
Prince Albert Parkland	40,985	13	2,462	1,282	1,671	3,331	0	182
Prairie North	38,166	4	1,909	2,265	860	2,524	0	683
Northern Regions	3,095	98	278	359	29	46	0	31

Table 5-8: Total Service Utilization Projections in Weighted Units: 2003/204

	Weighted Units 2003/04	Projected Service in Weighted Service Units											
		2006			2011			2016			2021		
		Using Regional Rate	Using Age Adjusted Rate	Difference	Using Regional Rate	Using Age Adjusted Rate	Difference	Using Regional Rate	Using Age Adjusted Rate	Difference	Using Regional Rate	Using Age Adjusted Rate	Difference
Province	8,351,865	8,568,146	8,568,146	0	8,786,728	8,786,728	0	8,910,818	8,910,818	0	9,095,341	9,095,341	0
Sun Country	580,154	576,152	546,035	30,117	557,049	529,161	27,889	532,495	506,503	25,992	514,536	487,544	26,991
Five Hills	525,028	526,005	575,689	-49,684	511,064	570,953	-59,889	493,191	549,987	-56,796	483,373	530,138	-46,764
Cypress	438,675	444,146	442,273	1,873	439,068	438,788	280	424,099	423,705	394	406,779	407,587	-807
Regina Qu Appelle	1,772,936	1,828,665	1,918,614	-89,949	1,897,767	2,003,115	-105,348	1,957,162	2,059,552	-102,391	2,020,702	2,122,105	-101,404
Sunrise	730,387	725,870	714,520	11,350	692,433	685,383	7,050	654,510	647,130	7,380	626,137	614,770	11,367
Saskatoon	2,289,342	2,405,961	2,265,082	140,879	2,596,710	2,428,600	168,110	2,759,682	2,583,456	176,226	2,923,219	2,761,283	161,936
Heartland	513,621	523,589	472,333	51,256	511,044	458,983	52,062	478,634	429,028	49,607	447,617	399,412	48,204
Kelsey Trail	521,123	527,327	440,547	86,780	519,066	433,658	85,407	499,888	419,669	80,218	485,420	409,124	76,296
Prince Albert Parkland	491,814	501,044	579,341	-78,297	518,243	597,559	-79,316	537,865	619,289	-81,424	562,128	646,002	-83,874
Prairie North	457,986	467,609	496,128	-28,519	475,590	507,801	-32,212	486,202	521,992	-35,790	513,438	546,970	-33,532
Northern Regions	30,799	32,678	117,584	-84,906	38,160	132,726	-94,566	44,220	150,508	-106,288	52,600	170,404	-117,804

Table 5-9 presents a projection for the province as a whole of service utilization by type of care category.

In terms of costs it is a bit more difficult to estimate costs overall, and by level of care, for home care clients. There are three groups of clients and many clients are in service for only short periods of time. We wanted to see what the relative cost, by level of care, would be for home care clients and compare this with the costs of residential care. In order to have a more valid comparison it was decided to focus on home care clients receiving supportive care, as they are clients, like long term care facility clients, who receive service over an extended period of time. Given that people are admitted and discharged at various points in time and, as a consequence, that there are more people who receive care in a year than there are service "slots," we used a Full Time Equivalent (FTE) Client methodology which we have used in our work in the past. The simplest way to explain this is to use an analogy from residential care. There may be three clients per year who occupy one bed. In our methodology we would categories each client as being one-third of an FTE. A similar approach is used for home care clients where we separate the care episode into segments. For each segment we note the start and end date, the level of care, and the resources utilized. Thus, for example, if there are three Level 2 clients, each in care for one third of a year they would, combined, constitute one FTE client. Their use of resources would be added, to provide an estimate for one year of the resources utilized by the FTE client.

Table 5-10 shows the breakdown of the total number of individuals receiving supportive home care services, the number of FTE clients, and the monthly costs, by level of care, using the respective cost per weighted unit for each RHA. A summary of the cost by level of care is provided in Table 5-11. As can be seen in these tables, the average cost for the province as a whole ranges from $421 per person, per month for Supervisory care to $2,271 for Extended Care. It is also noteworthy that while the costs for Supervisory Care and Limited Personal care are fairly consistent across RHAs, there begins to be increasing variability across RHAs for the higher levels of care.

Overall, there appears to be a fairly consistent allocation of resources across regions. With a relatively few exceptions, the difference between existing resources (measured in weighted service units), and age standardized resource estimates vary from +10% to -10% (see Table 5-8). This is a relatively narrow band of variation and could be accounted for by a variety of factors. For example, Saskatoon uses relatively more home care resources than the average. However, as we shall see below they have fewer residential care beds than the average. This may reflect a strategy to substitute home care services for residential care services.

It may be possible to extract some efficiencies from the existing allocation of resources across RHAs but, given the small margin of variation, efficiencies may be modest. Furthermore, we expect that there may be legitimate differences that could account for some of this variation, for example, more travel time to see clients in rural areas.

Table 5-9: Current and Project Service Units for Saskatchewan: Fiscal 2003/2004

Year	Home Maintenance	Meals	Other Homemaking	Other Nursing	Personal Homemaking	Physiotherapy	Personal Nursing	Total Weighted Service Units
2003	1,742	425,339	392,623	310,163	631,129	10,263	27,181	8,351,865
2006	1,756	439,033	404,143	316,803	649,136	10,378	27,788	8,568,146
2011	1,893	452,815	415,208	324,436	665,686	10,522	28,419	8,786,728
2016	2,110	459,812	420,487	330,598	671,247	10,826	28,957	8,910,818
2021	2,365	468,095	427,529	340,211	679,244	11,438	29,891	9,095,341

Table 5-10: Average Monthly Cost by Care Level for Supportive Care: Fiscal 2003/2004

Average of Months		Individuals with Service	Weighted Service Units	Days in Care	FTE Clients	Weigted Service Units Per FTE	Cost per FTE
Province	**Supervisory**	4,106	151,532	121,735	3,984	38	420.91
	Limited Personal Care	4,095	228,949	121,359	3,972	58	637.63
	Intensive Nursing or Personal Care	1,336	109,293	39,675	1,299	84	931.70
	Extended Care	338	67,358	10,054	329	206	2,271.12
Sun Country	**Supervisory**	533	16,468	15,863	519	32	358.54
	Limited Personal Care	284	13,663	8,465	277	49	558.61
	Intensive Nursing or Personal Care	150	9,256	4,473	146	63	715.76
	Extended Care	16	3,787	479	16	243	2,741.73
Five Hills	**Supervisory**	188	7,731	5,508	180	43	472.26
	Limited Personal Care	224	12,596	6,605	216	58	642.44
	Intensive Nursing or Personal Care	42	5,567	1,250	41	141	1,552.01
	Extended Care	15	7,984	440	14	585	6,446.56
Cypress	**Supervisory**	300	10,561	8,896	291	36	426.64
	Limited Personal Care	302	15,321	8,884	291	53	620.10
	Intensive Nursing or Personal Care	53	4,150	1,549	51	82	959.72
	Extended Care	10	987	306	10	100	1,177.56
Regina Qu Appelle	**Supervisory**	1,046	52,465	30,710	1,005	52	573.58
	Limited Personal Care	604	36,704	17,871	585	63	691.17
	Intensive Nursing or Personal Care	131	13,541	3,835	126	108	1,187.25
	Extended Care	59	15,240	1,751	57	267	2,923.82
Sunrise	**Supervisory**	305	8,475	9,138	299	28	323.45
	Limited Personal Care	410	19,688	12,268	402	49	559.05
	Intensive Nursing or Personal Care	171	11,408	5,069	166	69	783.74
	Extended Care	35	4,903	1,042	34	144	1,643.82

Average of Months		Individuals with Service	Weighted Service Units	Days in Care	FTE Clients	Weigted Service Units Per FTE	Cost per FTE
Saskatoon	**Supervisory**	746	27,027	22,142	725	37	378.75
	Limited Personal Care	1,229	79,879	36,108	1,182	68	686.94
	Intensive Nursing or Personal Care	303	28,214	9,011	295	96	974.74
	Extended Care	79	19,326	2,368	78	250	2,535.74
Heartland	**Supervisory**	296	8,763	8,860	290	30	327.56
	Limited Personal Care	362	13,289	10,830	354	38	407.06
	Intensive Nursing or Personal Care	172	11,779	5,101	167	71	765.23
	Extended Care	29	3,182	860	28	113	1,224.30
Kelsey Trail	**Supervisory**	171	6,522	5,010	164	40	350.16
	Limited Personal Care	299	18,571	8,886	291	64	561.74
	Intensive Nursing or Personal Care	100	9,967	2,974	97	103	902.91
	Extended Care	24	3,329	721	24	141	1,238.07
Prince Albert Parkland	**Supervisory**	338	7,577	10,086	330	25	359.75
	Limited Personal Care	169	9,513	5,016	164	57	805.46
	Intensive Nursing or Personal Care	87	8,033	2,593	85	95	1,352.01
	Extended Care	35	4,234	1,046	34	129	1,825.10
Prairie North	**Supervisory**	184	5,900	5,507	180	33	419.74
	Limited Personal Care	214	9,730	6,406	210	46	595.53
	Intensive Nursing or Personal Care	128	7,374	3,803	124	60	763.10
	Extended Care	37	4,431	1,094	36	128	1,643.96

Table 5-11: Average Monthly Cost by Care Level for Supportive Care: Fiscal 2003/2004

Average of Months PER FTE	PER FTE							
	Supervisory		Limited Personal Care		Intensive Nursing or Personal Care		Extended Care	
	Weighted Service Units	Cost	Weighted Service Units	Cost	Weighted Service Units	Cost	Weighted Service Units	Cost
Province	38	420.91	58	637.63	84	931.70	206	2,271.12
Sun Country	32	358.54	49	558.61	63	715.76	243	2,741.73
Five Hills	43	472.26	58	642.44	141	1,552.01	585	6,446.56
Cypress	36	426.64	53	620.10	82	959.72	100	1,177.56
Regina Qu Appelle	52	573.58	63	691.17	108	1,187.25	267	2,923.82
Sunrise	28	323.45	49	559.05	69	783.74	144	1,643.82
Saskatoon	37	378.75	68	686.94	96	974.74	250	2,535.74
Heartland	30	327.56	38	407.06	71	765.23	113	1,224.30
Kelsey Trail	40	350.16	64	561.74	103	902.91	141	1,238.07
Prince Albert Parkland	25	359.75	57	805.46	95	1,352.01	129	1,825.10
Prairie North	33	419.74	46	595.53	60	763.10	128	1,643.96

5.4 Overview of Data for Residential Care Services

In Saskatchewan, there are a number of residential care services funded by government. Most services are provided in long term residential care facilities called Special Care Homes. Some additional residential beds are also funded in hospitals, health care centres and other settings. There are also residential services which provide rehabilitation services. Residential settings also provide adult day care services for persons living in the community, and temporary and respite residential services. Finally some facilities are licenced by the province while others are not. However, overall, some 94% of beds are located in Special Care Homes. Overall, of all of the full time and temporary clientele who use facility services, 74% are regular long term care clients who use beds on an ongoing basis while 27% of clients use beds on a temporary basis.

Data on rehabilitation beds and adult day care services are provided in Appendix B. This section focuses primarily on long term care facility clients with some reference to temporary clients, as appropriate.

Table 5-12 presents data on the socio-demographic characteristics of long term residential care clients. The data in Table 5-12 are based on admission data for clients who received at least some service in fiscal 2003/04, irrespective of when they were actually admitted. As can be seen, about one third of clients were men and two-thirds were women. In contrast to home care clients, where some 37% of supportive care clients were 85 years of age or older, some 56% of long term residential care clients were in this age group. A high proportion (some 55%) of clients were also widowed. In terms of the residential setting of clients prior to admission 37% had lived in a house and 23% had lived in an apartment. Some 25% of admissions came from another Special Care Home.

Overall, as noted in Table 5-13, there were relatively few Supervisory or Limited Personal Care (Levels 1 and 2) long term residential care clients in facilities. Some one-third of such clients were in the Intensive Personal or Nursing Care (Level 3) category and almost two thirds (65%) were in the Specialized Supportive and Restorative Care category (Level 4). Thus, it appears that most long term residential care clients have relatively heavy care needs.

In terms of the service received by long term residential care clients, prior to admission to facility care, some 26% had received inpatient hospital care, 24% had received home care and 20% had received temporary care. The primary factors which contributed to the facility admission were a gradual loss of functional abilities (49%), accident or illness (23%) and a request for a transfer from another facility. In contrast, for Temporary Care clients, the main contributory factors were an accident or illness (41%), respite care (23%) and a gradual loss of functional abilities (21%). With regard to the specific purposes for which temporary care clients received residential services, some 59% received it for respite care, 18% for convalescence and 11% for rehabilitation.

Table 5-12: Socio-Demographic Characteristics for Long Term Care Residential Clients: Fiscal 2003/2004

Number and Percentage of Clients		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
All	#	11,798	949	742	666	2,638	1,196	2,781	682	636	767	684	57
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Gender													
Male	#	4,065	338	274	208	843	452	944	238	220	289	237	22
	%	34.45	35.62	36.93	31.23	31.96	37.79	33.94	34.90	34.59	37.68	34.65	38.60
Female	#	7,733	611	468	458	1,795	744	1,837	444	416	478	447	35
	%	65.55	64.38	63.07	68.77	68.04	62.21	66.06	65.10	65.41	62.32	65.35	61.40
Age group													
00-54	#	414	17	8	16	129	25	145	8	11	26	21	8
	%	3.51	1.79	1.08	2.40	4.89	2.09	5.21	1.17	1.73	3.39	3.07	14.04
56-64	#	381	36	14	19	102	23	110	7	17	25	27	1
	%	3.23	3.79	1.89	2.85	3.87	1.92	3.96	1.03	2.67	3.26	3.95	1.75
66-74	#	1,041	78	64	68	242	77	260	40	60	77	64	11
	%	8.82	8.22	8.63	10.21	9.17	6.44	9.35	5.87	9.43	10.04	9.36	19.30
76-84	#	3,400	284	239	188	777	317	787	192	194	224	179	19
	%	28.82	29.93	32.21	28.23	29.45	26.51	28.30	28.15	30.50	29.20	26.17	33.33
85Plus	#	6,562	534	417	375	1,388	754	1,479	435	354	415	393	18
	%	55.62	56.27	56.20	56.31	52.62	63.04	53.18	63.78	55.66	54.11	57.46	31.58
Marital Status on Admission													
Single, Divorced or Separated	#	2,239	193	126	110	534	204	593	93	91	145	132	18
	%	18.98	20.34	16.98	16.52	20.24	17.06	21.32	13.64	14.31	18.90	19.30	31.58

Number and Percentage of Clients		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
Married/Common Law	#	2,825	242	210	172	555	291	649	189	171	209	131	6
	%	23.94	25.50	28.30	25.83	21.04	24.33	23.34	27.71	26.89	27.25	19.15	10.53
Widowed	#	6,543	511	403	380	1,458	696	1,478	399	371	402	413	32
	%	55.46	53.85	54.31	57.06	55.27	58.19	53.15	58.50	58.33	52.41	60.38	56.14
Other	#	191	3	3	4	91	5	61	1	3	11	8	1
	%	1.62	0.32	0.40	0.60	3.45	0.42	2.19	0.15	0.47	1.43	1.17	1.75
Type of Residence Prior to Admission													
House	#	4,341	358	241	278	929	503	862	296	287	271	289	27
	%	36.79	37.72	32.48	41.74	35.22	42.06	31.00	43.40	45.13	35.33	42.25	47.37
Apartment	#	2,712	249	150	153	575	214	730	160	172	116	186	7
	%	22.99	26.24	20.22	22.97	21.80	17.89	26.25	23.46	27.04	15.12	27.19	12.28
Special Care Home	#	2,900	201	210	159	663	330	659	159	130	223	150	16
	%	24.58	21.18	28.30	23.87	25.13	27.59	23.70	23.31	20.44	29.07	21.93	28.07
Other/ Unknown	#	1,845	141	141	76	471	149	530	67	47	157	59	7
	%	15.64	14.86	19.00	11.41	17.85	12.46	19.06	9.82	7.39	20.47	8.63	12.28
Total	#	11,798	949	742	666	2,638	1,196	2,781	682	636	767	684	57
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Table 5-13: Distribution of Long Term Care Clients by Level of Care: Fiscal 2003/2004

Number and Percentage of Clients		Province	Sun Country	Five Hills	Cypress	Regina Qu Appelle	Sunrise	Saskatoon	Heartland	Kelsey Trail	Prince Albert Parkland	Prairie North	Northern Regions
Level of Care													
Supervisory / Limited Personal Care	#	211	5	2	13	112	11	36	2	4	7	16	3
	%	1.79	0.53	0.27	1.95	4.25	0.92	1.29	0.29	0.63	0.91	2.34	5.26
Intensive Personal or Nursing Care	#	3,939	431	335	249	859	146	1,094	106	214	320	173	12
	%	33.39	45.42	45.15	37.39	32.56	12.21	39.34	15.54	33.65	41.72	25.29	21.05
Specialized Supportive and Restorative Care	#	7,648	513	405	404	1,667	1,039	1,651	574	418	440	495	42
	%	64.82	54.06	54.58	60.66	63.19	86.87	59.37	84.16	65.72	57.37	72.37	73.68
Total	#	11,798	949	742	666	2,638	1,196	2,781	682	636	767	684	57
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Table 5-14 presents bed utilization data for residential care services, for all clients and for people 75 years of age or older, by RHA. As can be seen, thee was an overall total beds per 1000 population 75 years of age and older ratio of some 116 beds for Saskatchewan as a whole. While there was some variation, most RHAs had fairly similar bed utilization ratios. The Northern Regions, Five Hills and Saskatoon had relatively lower ratios while Sun Country, Sunrise and Prairie North had relatively higher ratios. Again, as with the home care utilization data, the data in Tables 5-14 and 5-15 are presented by noting current, and future, bed usage based on changes in the population mix of each RHA, and by nothing the age adjusted, or standardized, bed estimates.

As can be seen in Table 5-15, projections based on current utilization patterns indicate a bed increase from 2003/04 to 2021 of some 11% (from 8,853 to 9,859). As with home care, resources are allocated reasonably consistently across RHAs. Opportunities for cost reductions from freezing new bed allocations in higher bed use RHAs, or cost-reallocations by freezing funding for high bed use RHAs and reallocating future bed dollars to lower use RHAs, or to home care, appears to be possible but modest. Furthermore, some RHAs like Saskatoon, which, in isolation, appears to be under-bedded, appear to have made strategic program decisions to increase efficiencies by enhancing home care and minimizing residential care. Thus, any efforts to enhance efficiencies, or reduce costs, needs to carefully consider the full system of care rather than just home care or residential care services by themselves.

Table 5-16 presents data on the estimated daily and annual cost of facility care. It provides data on these costs using a base of all facility beds (Amount Per Facility Bed) and on the number of beds, excluding the vacancy factor (Amount Per Bed Used). Table 5-16 also provides data on total costs, including daily user fees or co-payments, and on the estimated cost to government. Given that Saskatchewan does not have case mix funding, it was not possible to calculate per diem costs for residential care, by level of care. As can be seen the average cost to government per bed is some $39,294 per year. The average annual cost for the highest level of care (Extended Care) for home care was $27,362 for fiscal 2003/04.

Table 5-14: Bed Utilization for Residential Care Excluding Rehabilitation

	75 and Over				Total				Ratio
	Population Estimate 2003	Actual Beds Used	Age Adjusted	Difference	Population Estimate 2003	Actual Beds Used	Age Adjusted	Difference	Total Beds / Per 1000 Population 75 and Over
Province	76,221	7,354	7,354	0	1,024,579	8,853	8,853	0	116.1
Sun Country	5,238	621	533	88	54,807	732	621	111	139.8
Five Hills	5,626	477	532	-55	55,497	542	623	-81	96.4
Cypress	4,236	429	405	25	44,552	522	479	44	123.3
Regina Qu Appelle	16,479	1,593	1,542	50	247,104	1,979	1,897	82	120.1
Sunrise	7,110	804	724	79	57,851	906	832	74	127.4
Saskatoon	19,045	1,622	1,842	-220	291,148	2,037	2,247	-210	107.0
Heartland	4,563	471	451	20	44,902	515	523	-8	112.8
Kelsey Trail	4,237	403	412	-9	43,675	472	485	-13	111.4
Prince Albert Parkland	4,986	474	463	12	77,479	578	576	2	115.9
Prarie North	4,110	430	405	26	72,048	523	496	27	127.1
Northern Regions	590	29	46	-17	35,516	47	75	-28	79.4

Table 5-15: Bed Utilization Projections for Residential Care Excluding Rehabilitation: Fiscal 2003/2004

	Beds Used 2003	Projected Bed Requirements											
		2006			2011			2016			2021		
		Using Regional Rate	Using Age Adjusted Rate	Difference	Using Regional Rate	Using Age Adjusted Rate	Difference	Using Regional Rate	Using Age Adjusted Rate	Difference	Using Regional Rate	Using Age Adjusted Rate	Difference
Province	8,853	9,206	9,206	0	9,573	9,573	0	9,715	9,715	0	9,859	9,859	0
Sun Country	732	734	623	111	718	609	109	687	581	106	659	555	104
Five Hills	542	559	644	-84	567	654	-87	550	635	-85	527	605	-78
Cypress	522	536	492	44	547	501	46	536	488	47	516	467	49
Regina Qu Appelle	1,979	2,085	1,999	86	2,218	2,127	91	2,295	2,202	92	2,356	2,264	92
Sunrise	906	922	845	77	905	828	77	854	783	71	805	740	65
Saskatoon	2,037	2,156	2,379	-223	2,344	2,585	-240	2,507	2,760	-253	2,684	2,952	-268
Heartland	515	536	542	-6	541	547	-7	507	517	-10	464	478	-14
Kelsey Trail	472	482	495	-14	483	498	-15	471	484	-12	459	470	-11
Prince Albert Parkland	578	595	593	2	610	608	1	629	629	0	657	658	-1
Prairie North	523	541	514	27	549	526	24	554	532	23	574	548	26
Northern Regions	47	50	80	-30	56	91	-36	63	105	-41	74	122	-48

Table 5-16: Costs For Institutional Beds: Fiscal 2003/2004

				Total, Including Resident Fees				Estimated Government Portion			
	Budget Amount	Facility Beds	Beds Used	Amount Per facility Bed	Amount Per Bed Used	Amount Per Day Per Facility Bed	Amount Per Day Per Bed Used	Amount Per facility Bed	Amount Per Bed Used	Amount Per Day Per Facility Bed	Amount Per Day Per Bed Used
Province	451,382,768	8,973	8,851	50,305	50,996	137.44	139.33	38,761	39,294	105.90	107.36
Sun Country	41,026,007	782	732	52,463	56,036	143.34	153.10	40,424	43,177	110.45	117.97
Five Hills	27,874,749	541	542	51,524	51,403	140.78	140.44	39,701	39,607	108.47	108.22
Cypress	26,139,265	519	522	50,365	50,028	137.61	136.69	38,807	38,547	106.03	105.32
Regina Qu Appelle	90,824,727	1,920	1,979	47,305	45,894	129.25	125.39	36,449	35,362	99.59	96.62
Sunrise	46,183,391	882	906	52,362	50,992	143.07	139.32	40,346	39,290	110.24	107.35
Saskatoon	92,880,788	2,118	2,037	43,853	45,591	119.82	124.57	33,790	35,129	92.32	95.98
Heartland	28,972,540	548	515	52,870	56,270	144.45	153.74	40,737	43,357	111.30	118.46
Kelsey Trail	29,260,164	510	472	57,373	61,980	156.76	169.34	44,207	47,757	120.78	130.48
Prince Albert Parkland	29,232,718	574	578	50,928	50,606	139.15	138.27	39,241	38,993	107.22	106.54
Prairie North	37,334,376	537	523	69,524	71,445	189.96	195.21	53,570	55,050	146.37	150.41
Northern Regions	1,654,044	38	45	89,281	73,438	243.94	200.65	68,793	56,586	187.96	154.61

5.5 Discussion and Conclusions

Continuing care service delivery is quite complex and in order to develop meaningful data one may wish to develop a more sophisticated approach to analysis in order to have the best possible information for making complex decisions.

With regard to the actual data presented above, it does appear that home care may be a cost-effective alternative to residential care, if appropriate substitutions can be made. Some further clarity is required about how comparable the levels of care are between residential services and home care services. Nevertheless, as noted above, the costs for an Extended Care home care client are considerable, and are consistent with other research we have conducted. This cost is still much less than the cost of facility care, even when one uses an average cost which includes both lighter care and heavier care facility clients.

Finally, it is also important to note that the costs of home care services *per se* are only a fraction of the overall health care costs, for home care clients.

6. FINDINGS FROM INTERVIEWS WITH SASKATCHEWAN HEALTH OFFICIALS

6.1 Introduction

Interviews were conducted with officials in Saskatchewan Health in the early summer. In total, some 10 officials were interviewed ranging from senior executives to directors and managers/analysts of different areas related to home care and residential care services. Interviewees were, overall, quite familiar with the Saskatchewan Home Care program.

6.2 Vision and Strategic Direction

There was a general consensus among all ten respondents that the overall vision, and primary goal, of the Home Care Program was to assist people with functional deficits and/or other care needs to stay in their own home, and to maintain their independence, for as long as possible. This philosophy is documented in more detail in the Statement of Philosophy in the revised Policy Manual.

In addition to the above comments, a number of respondents also noted that people should receive care "closer to home," and that the strategic direction of Saskatchewan Health was to also provide services for palliative care clients and for children with special (complex) care needs. It was also noted that home care can act as a substitute for hospital care and residential long term care.

One must also consider the vision, goals and strategic directions in the broader context. In this regard, some respondents noted that they were concerned that there had been an erosion of home care services over time, that funding had not actually kept pace with the vision noted above, and/or that the emphasis on supportive care had eroded over time. Four respondents noted one or more of those points in some manner. Four respondents also noted some concern about the relative power of the acute care sector, compared to home care, and/or that there seemed to be a shift in priorities and resources to emphasize acute care replacement services.

Concern was also expressed that there were particular challenges in meeting the vision in more rural and remote areas, and that there were challenges in providing services to high care needs children (and appropriate supports for the parents of such children). Finally, one respondent noted that there may not be full consensus on the vision, or that not all RHAs may fully understand and/or buy into the vision. The respondent noted that some RHAs are focusing more on acute care substitution as compared to supportive care and that support for the vision of keeping people independent in their homes may have varying degrees of support among the RHAs.

Thus, it appears that the vision, goals and strategic direction of the Saskatchewan Home Care Program are sound and well understood by Ministry officials. However, more work may need to be done to actualize that vision and to fully make that vision a day to day reality across the province. There was also evidence in the comments of the tension, also existing across

Canada, between the relative emphasis on supportive home care versus short term, acute care replacement home care.

The relative policy emphasis of home care was also addressed by asking respondents about their views of the major national home care initiatives noted in the recent Federal/Provincial Health Accords. There was generally good support among Ministry officials for the accords. There was a perceived benefit from the additional funding which would flow to the home care sector. This would allow for enhancements in palliative home care, in acute care substitution home care, and mental health home care. It was noted that while the emphasis on mental health was helpful, more work would be needed to be done in this area. Overall, seven respondents stated that they supported the accord. The rest did not feel they knew enough to comment or had some reservations.

It was also pointed out that the Accord would be helpful in that all care services would be provided free of charge for 14 days, at least for the designated groups. While there was general support for the Accord (sometimes referred to as the First Ministers Meeting [FMM]), some notes of caution were also raised. A few people noted that more work would be needed to develop Mental Health Home Care and/or that the 14 day time frame was too restrictive. A few people expressed concern that there was not an emphasis on prevention and longer term supportive care. One person noted that the area of supportive care had been eroded in Saskatchewan. Another point which was made was that there may be inadequate assessments being performed for short term home care clients as there is not a standard instrument for these types of assessments.

6.3 Service Delivery

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. However, it was noted that improvements could be made to the accountability process. 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 budget allocation in each funding envelope and permission is required from Saskatchewan Health to move money from one envelope to another. It was noted 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 terms of the services provided in the Saskatchewan Home Care Program, respondents were asked to indicate which services are provided, and how accessible the services are, from a

list based on a national study of services delivery systems (Hollander and Prince, 2002) for a range of persons with ongoing care needs, including children with special needs and chronic mental health clients. This is a comprehensive listing of services and it was recognized that it would be highly unlikely for any one jurisdiction to have all of these services. The responses to the questions about current services are provided in Table 6-1.

As can be seen in Table 6-1, there is some variability in the estimates of how accessible each service is. This was, in fact, a difficult question to answer as accessibility may vary across the province. Thus, obtaining a range of responses was to be expected. Nevertheless, it is clear from Table 6-1 that some services are fairly accessible while other services appear to be less accessible. Accessibility was highest for case management, in-home nursing care, personal care and palliative care. The services which appeared to be least accessible were home maintenance and repair, homemaking, rehabilitation and home care for mental health clients. The limited accessibility to the "softer" home care services is consistent with comments noted earlier in this chapter. There was also a general consensus that it was particularly difficult to recruit and retain rehabilitation professionals, particularly in more rural and northern areas.

There were a few services over which there was some mixed opinion. In general it was noted that adult day care services were not part of home care as they are in residential facilities. This may be an area that requires some clarification as the users of adult day care services are home care clients or others living in the community. Adult day care services, while in facilities, are not, in fact, used by residents of these facilities. Another area was Technical Aids Equipment and Supplies. Again, home care clients use these services but, administratively, the services are provided through SAIL. It should also be noted that home care may provide services in supportive, or other forms of congregate, housing, but that housing options are not part of home care. Thus, it appears that there are a reasonable number of services which are accessible, some which are moderately accessible and some which are not readily accessible. In addition, there are services in which home care plays a part but which are not considered to be part of the Home Care Program. It may be useful to consider if a more formalized approach should be taken, perhaps using the case managers, to facilitate the interfaces between such programs and the Home Care Program.

Respondents were also asked if there were other services which may be required. In general, they felt that the list in Table 6-1 was quite comprehensive. However, some suggestions for other services were made. These services were as follows: pre-surgical care, hospital-in-the-home, home monitoring, and social work. It was also noted that there should be enhanced supportive care, respite care, and care for children with special needs, and that case management should be a mandated service.

Overall, the range of services provided through the Home Care Program is relatively comprehensive and consistent with other, similar programs in other jurisdictions.

Table 6-1: Home Care Services

Type of Service	Part of the Home Care Program		If Yes, the extent of access			Number of Respondents	Average Score (1-3 scale, 3= readily accessible
	Yes	No	Readily Accessible	Moderately Accessible	Not readily accessible, or not accessible, or available, in some areas		
Case Management	X		10	0	0	10	3.0
Information/Referral Services	X		9	1	0	10	2.9
Meal Programs	X		9	1	0	10	2.9
Self-Managed Attendant Services	X		6	4	0	10	2.6
In-Home Nursing Care	X		10	0	0	10	3.0
Home/Community Rehabilitation (PT/OT)	X		5	3	2	10	2.3
Home management/home making	X		3	6	1	10	2.2
Personal care	X		10	0	0	10	3.0
Home maintenance and repair	X		0	5	5	10	1.5
Day Care/Day Support		X					
Group Homes/Personal Care Homes		X					
Respite Care	X		6	3	0	9	2.7
Technical Aids, Equipment & Supplies		X					
Supportive Housing		X					
Life & Social Skills Training & Support Groups		X					
Day Hospitals		X					
Community Emergency Services/Crisis Support		X					
Specialty Transportation Services		X					
Adult Foster Care		X					
Palliative Home Care	X		9	0	0	9	3.0
Home care services for children with high/complex care needs	X		4	4	0	8	2.5
Home Care services for mental health clients	X		1	5	2	8	2.1

6.4 Care Coordination

Respondents were asked about care coordination within the Home Care Program, with residential care, and with other parts of the health care system. With regard to care coordination, it was noted by 9 out of 10 respondents that this was done by the case managers. The other respondent answered in regard to the organization within Saskatchewan health and noted that care was coordinated at the provincial level by having one person responsible for all home care services. Other points related to factors which facilitate care coordination were: single entry, good communication among staff, intra-RHA committees, committees with representatives from Saskatchewan Health and the RHAs, and inter-Ministry committees at the provincial level. It was also noted that Regina and Saskatoon have a separate, centralized system level assessment and care planning process, while in other RHAs these functions are carried out by the Case Managers.

With regard to coordination between home care and residential care, case managers assess clients, a risk assessment is conducted, and a placement committee reviews whether or not the client should be provided access to a residential bed. It was noted that there is generally good communication between case managers and facilities. Once admitted into a facility, the case management function is transferred to the facility.

With regard to links to other parts of the health care and social services systems, the case managers again play an active role. There is coordination with discharge planning in hospitals and some links with the school system in regard to children with special needs. It was noted that there are inter-ministry committees, and local committees, which deal with issues of linkage. It was noted, however, by a few respondents that there should be better linkages between home care and primary care and public health.

6.5 Co-Payments and User Fees

In Saskatchewan, for most of the province, all clients pay a fee of $6.36 for the first 10 units of services per month (a unit is a meal, an hour of personal care, etc.). After the first 10 units, fees are assessed based on income, to a maximum of $383 per month. In the three northern RHAs client pay $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.

Respondents noted that there were few complaints about this model of co-payments. There was some sense that it may be appropriate to leave things as they are. However, one respondent noted that if one were to make changes, one should eliminate fees altogether, or introduce a fee structure which would provide more significant revenues. As it is, user fees bring in about $5 million per year but there does not seem to be any good data on how much it actually costs to collect these fees. It may be useful to investigate the cost of collecting the fees, to determine how much net revenue is actually received.

6.6 Perceived Strengths and Weaknesses of the Current System

A wide variety of responses were obtained when respondents were asked to describe the strengths and weaknesses of the current system. The following presents the strengths and weaknesses noted by respondents in bullet form.

Strengths

- A well developed, widely accessible, mandated program across the province providing service based on client needs.
- Strong, mature and knowledgeable home care staff and management at the field level.
- A good palliative care program and a good individualized funding program.
- A program which reaches out to people in the community and is community oriented.
- A program which keeps people out of institutions.
- A comprehensive philosophy and direction.
- A good quality, committed staff.

Weaknesses

- Relatively modest funding (second lowest per capita funding in Canada).
- No real ability to assess outcomes or evaluate programs (a self-assessment protocol is in the policy manual but there has been little uptake of this at the RHA level).
- Hard to meet the needs of rural and remote clients.
- Lack of consistent and useable data.
- Need to enhance services for children with special needs and to better coordinate with mental health.
- Erosion of supportive services.
- Lack of clarity about what constitutes core services.
- Need for more focus on prevention and preventive programs.
- Need for closer links with Primary Care and Public Health.
- A focus on institutions over home care.
- Inconsistent access to core services across RHAs.
- Lack of flexibility due to current collective agreements.
- Challenges of care provision in rural and remote areas and the north.
- Staff recruitment and retention issues.
- Outdated technology.
- Need for more therapy services.

In relation to the question about strengths and weaknesses, respondents were also asked about which factors they believed contributed to the success of the Home Care Program, and which factors limited the success of the Program. In terms of factors which contribute to the success of the program respondents noted that, compared to institutions, there is greater flexibility in the home care program. In addition, it was noted that the program had been in place for a long time and had knowledgeable and committed people working in the program. It was also noted that the Home Care Program is well integrated with other programs, that it had a good reputation and that the RHAs have bought into the model.

In terms of factors which were seen to limit the success of the program it was noted that the relative emphasis on doctors and hospitals compared to home care was a limiting factor. Human resources issues related to recruitment and retention, and the limitations of the collective agreement, were also noted. The amount of resources currently available for home care was seen to be a limiting factor as was a lack of innovation and experimentation. A lack of good data for decision-making, and turf protection, were also noted as limiting factors.

6.7 Major Challenges

Respondents were asked about the major challenges currently faced by the Home Care Program and about challenges which were unique to Saskatchewan. With regard to the latter, almost all respondents noted at least one of the following: a rural, sparsely populated province and numerous remote areas, particularly in the north; a large First Nations population with a different home care program for people living on-reserve; issues related to care delivery in rural areas such as travel time and heavy workloads; a high percentage of seniors; and high public expectations.

The issues of sparse population and their attendant challenges were also noted in response to the general question on major challenges. Other challenges noted were as follows:

- A need for broader, more innovative, thinking about what home care can do.
- A need for better data and information systems and better outcome data.
- Restrictions on the flexible use of staff due to the collective agreement.
- Pressures to get free professional services rather than personal care services which have user fees (this was particularly true for parents with special needs children).
- Need for a community development approach.
- Increasing acuity of clients.
- The dominance of the acute care sector.
- The perception that over time, people (particularly baby boomers) will be more vocal in demanding more and better home care services.

6.8 Special Topics

6.8.1 Introduction

In developing the interview questions we included questions on special topics which we thought may be of interest. It turns out that most of these topic areas have already been discussed in some detail above as they, in fact, appear to reflect important themes related to the Home Care Program. Thus, in order not to be overly repetitive, we provide a synopsis of each of these topic areas below.

6.8.2 Health Human Resources

Health human resources is clearly a major challenge for the Home Care Program, particularly for more rural, remote and northern areas. As noted above, recruitment and retention

are challenges for all classes of workers. There is a particular challenge, all across Saskatchewan, for home/community rehabilitation professionals. Another consequence of having more rural areas is that staff, and particularly professional staff, may spend a great deal of time traveling as it is not possible to hire staff in very small communities. In addition, it is difficult to provide full time employment if the population base is small, and few people would relocate for a part-time and/or casual position.

It was also noted that, due to the collective agreement, task assignments are based on seniority. This often means that a given person will have different people coming to their homes to provide care. This is frustrating for clients and/or family members as they have to re-explain the condition of the client, where things are in the home, and so on, to each new care provider. This issue has been a major bone of contention in other jurisdictions, particularly ones which use third-party private companies to provide care. We were surprised that this was also an issue in a province where care is provided directly by RHA staff. Another restriction which was noted was that it was not readily possible to have one person work in multiple settings, for example, in home care and in facilities. Other points which were mentioned were an aging workforce which is not that comfortable with computer technology, and that once trained, home care aides may find employment in facilities, or other locations of work, rather than in home care.

6.8.3 Data, Analysis and Accountability

There was a general consensus that the current information infrastructure leaves something to be desired. It was noted that MDS-Residential Care, MDS-Home Care and the Procura system will help.

In terms of accountability and key indicators, it was noted that the main indicators currently used relate to service volumes and dollars. There seem to be relatively few indicators related to the actual outcomes of service, a critical factor in any accountability system. Respondents generally noted that there were few measures of outcome and no substantive outcome evaluations. A number of respondents noted that one measure was the number of complaints and that, overall, there were relatively few complaints. At least one respondent, however, also noted that people may be fearful that if they complain they may endanger the services they already receive. There are however, some measures that are being developed in regard to how quickly clients can access services. All of this is not to say that useful information is not being collected and used, or that RHAs are not being monitored. The indicators in the accountability documents are certainly helpful and constitute a good start in this area. In addition, the self-evaluation guide in the policy manual is another positive step, although there appears to have been little uptake to date from the RHAs.

6.8.4 Consistency of Service Delivery

We asked two questions related to this topic. The first was how well client needs were matched to the actual package of services provided, and the other asked about consistency in service delivery *per se*. There was a general consensus among respondents that there was a reasonable, and consistent, matching of client needs to services provided. It was noted that this was more of a challenge for children with special needs.

Another point to note was that there was a perception that, in at least some cases, case managers were constrained in developing their care plans by the amount of resources which were available for care provision.

With regard to the overall consistency of service delivery, it was noted that there was reasonable consistency but that there was variability across RHAs, perhaps as a consequence of different organizational structures, and differences in relative priorities in care delivery. It was also noted that there were differences in consistency between large and small, and rural and urban, RHAs. Another point, which we believe is quite important, was that it was noted that there may be different levels of support for home care by senior executives across RHAs. It was also noted that, in some regions which had amalgamated a set of health districts, there were still intra-regional differences consistent with that of the old health districts and their former ways of providing care.

6.8.5 Issues Related to the Superstructure of Care Delivery

Respondents were asked if there were key gaps or issues related to broader "superstructure" factors such as legislation, policy and the organization of health services. A number of points were raised in regard to this topic. It was noted that there is still a fair amount of variability in regard to the range and scope of home care services, and organizational structures, across regions. It was also noted that policies for children with special needs were being revised. An important issue was that of "core" services. It was noted that there is a need to better define what core services are and, perhaps, to eliminate some services rather than to state that the services are core although very little service is actually provided, for example, home maintenance and repair.

It was also noted that there are no formal regulations and that home care services rely, instead, on provincial policies. In terms of gaps it was noted that not all people receive an assessment, that there is a service gap for young people/adults with disabilities, and that not all regions have an appeal process.

In terms of policy and priorities, some respondents noted that there had been an erosion of softer and supportive services and that these services did not have the same prominence as acute care services. Other comments noted that more emphasis needs to be placed on children with special needs and that new innovations such as telehealth may be good additions to existing care services.

6.8.6 Excellent Programs

Respondents were asked to identify any exemplary and/or noteworthy home care programs. There were relatively few examples provided. The palliative care programs in Saskatoon and Regina were mentioned, as were the transition program in Regina and the linkage between home care and primary care in the Sun Country RHA.

6.9 A Self-Evaluation

We included a form of self-evaluation in the interview questions. We identified a range of topic areas that one would typically address in an evaluation and asked respondents to rate each topic area on a scale from 1 to 10. Table 6-2 presents the results of this self-evaluation.

As can be seen in Table 6-2, scores for most topic areas ranged from 6.8 to 7.6 out of 10. Areas of particular strength appear to be the training and qualifications of core staff, accessibility to services, the appropriateness and effectiveness of the organization and governance structure, client satisfaction with care delivery, the cost-effectiveness of services and impacts on population health. The weakest area was information systems for which the highest score received was 5 out of 10.

A surprise was the low score given to the perceived sustainability of the Home Care Program. Respondents seemed to be saying that while the system is reasonably good currently, they are concerned that it may not be sustainable over time unless changes and improvements are made. When the senior people responsible for the Home Care Program voice concerns over the sustainability of the program, one must listen. Thus, this review may indeed be timely.

6.10 Discussion and Conclusions

We must at the outset say how impressed we were with the candor and critical self-assessments made by respondents. This is an extremely healthy sign. The first step to improving a service delivery system is to understand and recognize both the strengths and weaknesses of the system. The messages delivered were also loud and clear and seemed to cluster into a number of broader themes. We provide our perceptions, comments and advice on these, and other, themes in Chapter 9 of this report.

The key themes which emerged from interviews with Saskatchewan Health officials were as follows:

- 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.
- The overall sustainability of the Home Care Program.

We address these topic areas, and others, in Chapter 9.

Table 6-2: Self Evaluation of the Home Care Program

Topic Area	Number of respondents	Range of scores	Average score
A. Topics Related to Structure:			
1. **The appropriateness and effectiveness of the organization and governance structure of the Home Care Program:** This topic area relates to issues such as: are there clear lines of authority and responsibility, is there a clear recognition of roles and responsibilities, and are people held to account for their performance.	10	5-8	7.0
2. **The appropriateness of the care model:** This topic relates to whether or not the model itself is well documented and designed and to meet the stated purposes, goals, and objectives of the Home Care Program, and is consistent with best practices in the field. The rationale for the model, the key characteristics of the model and the organizational structure of the model are all included in this topic area.	10	5-8	6.9
3. **The quality, appropriateness and effectiveness of current information systems in regard to home care:** Is there an electronic information system, how much of the data collected are actually computerized, is the information system easy to use, and is it an integrated part of operations at the clinical and management levels or is it an add on (e.g., only records financial data and is not actively used in operations), are all issues to be considered for this topic area?	10	3-5	4.3
B. Topics Related to the Processes of Care Delivery			
4. **The appropriateness and effectiveness of care provision:** This topic area relates to an assessment of the extent to which care provision is appropriate, is carried out in a consistent manner, and is carried out in accordance with documented policies and procedures.	10	4-8	6.7
5. **The appropriateness and effectiveness of the continuity of care within the Home Care Program and between the Home Care Program and other health and social services such as primary care and hospital care:** This topic area refers to how well care services, and the process of providing care, are coordinated across the component parts of the continuum. It relates to the continuity of care provision (do clients see the same care provider on a regular basis), information (does information about the client flow with the client as he or she sees different care providers) and the system of care (are the services of different care providers connected in a coherent manner).	10	5-8	6.8
6. **The extent to which care providers are trained and qualified to provide appropriate and effective care services:** This topic area relates to the professional qualifications and competence of the people providing care services.	9	6-9	7.6

Topic Area	Number of respondents	Range of scores	Average score
C. Topic Areas Related to the Outcomes of Care			
7. **The level of accessibility to care services:** This topic area relates to how well, or poorly, clients can access services and/or have their questions answered. It is related to the hours of operation and the ease of access to needed services.	10	4.5-9.5	7.3
8. **Satisfaction with service delivery:** This topic area relates to the level of satisfaction with services as perceived by clients, family members and key stakeholders.	9	5-8	7.0
9. **The quality of service delivery:** This topic area relates to perceptions about the quality of care providers, and the overall quality of care services, as perceived by clients, family members and key stakeholders.	10	3.5[1]-8	6.9
10. **The cost-effectiveness of care services:** This topic area relates to the value for money received by the organization for the funds expended. This does *not* refer only to the cost of services, it relates to both the costs and outcomes of care.	9	3.5[1]-9	7.1
11. **Positive impacts on population health and the overall health care system:** This topic area relates to the impact, if any, of the Home Care Program on the clientele served, the health status of the broader population, and the impacts on other parts of the health care and social services system (e.g., admissions to hospitals and/or long term care facilities).	9	3.5[1]-9	7.2
12. **The sustainability of the current model:** This topic area refers to the extent to which the current model of delivering home care is sufficiently robust so that there is a high probability that it can continue over time.	10	4-7	5.7

[1] One respondent provided a 3.5 score due to the lack of data on this topic. If omitted the scores for items 9-11 would have been 7.2, 7.5 and 7.6

7.0 FINDINGS FROM INTERVIEWS WITH REGIONAL HEALTH AUTHORITY OFFICIALS

7.1 Introduction

Interviews were conducted with some 31 representatives from RHAs, from the Vice-President to the Manager level. Four interviews were conducted with two respondents and two group interviews were conducted with three respondents each. The rest of the interviews were conducted with one respondent. Face-to-face interviews were conducted in five RHAs, including both of the "urban" RHAs (i.e., Regina Qu'Appelle and Saskatoon). In this chapter we report on the results of these interviews. Where we provide counts of what respondents stated, they are based on the completed interview schedule, irrespective of the number of people interviewed. Thus, when we use the term "respondent" in discussing responses to the interview questions we are referring to the number of interview schedules, not the actual number of people.

It should also be noted that the number of respondents varied across RHAs (from 1 to 4 respondents per RHA). Thus, the counts in Tables 7-1 and 7-2, presented later in this chapter, were prepared in the following manner. We first calculated the average score for the RHA, based on the number of completed interview schedules. Thus, the RHA score could be the result of one interview with one person, or four separate interviews with four people, or one interview with a consensus score of the 2 or 3 people interviewed. This was done to ensure an equal weighting of the results across RHAs. The average scores for each RHA were then averaged into three broader groups. We treated the two urban RHAs as one group, the three northern regions as one group, and all the rest of the RHAs as a third group (called Intermediate/Rural). Tables 7-1 and 7-2 present data in accordance with these three groups.

7.2 Vision and Strategic Directions

In the Intermediate/Rural RHAs eight respondents out of 11 (not all respondents answered this question) specifically noted that the vision for the Home Care Program was to keep people at home and living independently, or that the RHA followed the policies and views of Saskatchewan Health. Four out of six respondents in the Northern RHAs also noted this. It was noted by some respondents that more could be done to clarify the provincial vision of home care and to provide more active, provincial involvement on home care issues. Some of the RHAs noted that provincial policies had been on hold for some time and/or that there had been a dilution of the provincial vision as regions developed their own programs. It was also noted that, in the perception of some respondents, there had been a disconnect between the vision and the provision of dollars to actually carry out the vision at the RHA level. Respondents also noted that if there is a shortage of funding then it would be particularly important to set priorities in terms of what services should be delivered and in what amounts.

It was also noted that the home care program had gone from a social/supportive model to more of a medical model to support early discharge from hospitals. In addition, while it is good to have flexibility, to tailor services to local needs, this was leading to inconsistencies across RHAs and difficulty/confusion in regard to client expectations as clients become aware of differences in home care services across RHAs. It was also noted that, particularly in rural areas,

home management was still quite important as there are few support services in smaller rural communities. Respondents in the north noted that there were, in fact, two different Home Care Programs in these RHAs, the one funded by Health Canada for First Nations on reserve and the one funded by Saskatchewan Health, and that there are material differences between these two programs which sometimes lead to confusion and misunderstanding among clients.

Respondents were also asked about their perceptions about the recent federal/provincial Health Accords. There was general support for the Accord (the FMM being the most recent version) as it will provide needed, additional funding for home care. It was, however, only seen as a good first step by some respondents. It was also noted that the Accord would strengthen the links between home care and mental health, and that, in and of itself, the Accord would raise the profile of the home care sector.

A number of RHAs noted that, while the Accord was helpful, there was little focus on prevention or supportive, longer term, home care and that it would be important to maintain this type of care as well. Furthermore, it was also noted that the RHAs already handled acute home care and palliative home care so, aside from not paying user fees for 14 days, it was not clear how the Accord would impact day-to-day operations. Thus, perhaps the biggest impacts would be in the area of home care for mental health clients. The need to provide services for children with special needs was also noted.

7.3 Service Delivery

Saskatchewan Health provides funding to the RHAs, as described in Chapter 6. The actual organizational structures in which home care is embedded do vary across RHAs. In some cases home care is combined with residential care. Sometimes home care and residential care are combined with hospital services. In other settings home care is separated from facility care and comes under Primary Health Care. Irregardless of the broader structure, there is usually a Director or Executive Director of Home Care and Home Care Managers who administer day-to-day operations, generally on a geographic basis. Case Managers, Nurses and Care Aides are usually all employees of the RHA. This differs from many other jurisdictions in Canada where services are provided through purchase of service agreements with for-profit or not-for-profit, third-party, service providers. There is a standardized provincial assessment tool to obtain information about clients and a risk screen instrument that is used when someone is being considered for residential long term care.

In many RHAs Home Care staff are actually located in hospitals and are used to provide discharge planning services. In other RHAs there is a close linkage between home care and hospital discharge. The urban RHAs have a separate centralized assessment process. Table 7-1 presents an overview of the home care services provided across RHAs, and the perceived degree of accessibility of these services for each of the three groupings of RHAs. As with Saskatchewan Health officials, there were some differences of opinion about the role of home care in areas such as adult day care and housing where there are mixed responsibilities.

Table 7-1: Home Care Services

Type of Services	Part of HC		Average Score[1] for Urban RHAs	Average Score[1] for Intermediate/ Rural RHAs	Average Score[1] for Northern RHAs
	Yes	No			
Case Management	X		3	2.9	3
Information/Referral Services	X		3	2.8	3
Meal Programs	X		3	2.8	2.7
Self-Managed Attendant Services	X		3	2.4	Not available
In-Home Nursing Care	X		3	2.8	2.7
Home/Community Rehabilitation (PT/OT)	X		.25	1.8	Not available
Home management/home making	X		3	2.8	3
Personal care	X		3	2.7	2.3
Home maintenance and repair	X		2	1.0	1.7
Day Care/Day Support		X	0	0	0
Group Homes/Personal Care Homes		X	0	0	0
Respite Care	X		3	2.6	2.0
Technical Aids, Equipment & Supplies		X	0	0	0
Supportive Housing		X	0	0	0
Life & Social Skills Training & Support Groups		X	0	0	0
Day Hospitals		X	0	0	0
Community Emergency Services/Crisis Support		X	0	0	0
Specialty Transportation Services		X	0	0	0
Adult Foster Care		X	0	0	0
Palliative Home Care	X		3	2.6	2.0
Home care services for children with high/complex care needs	X		3	1.9	1.3
Home Care services for mental health clients	X		2	1.9	1.3

[1]The scores presented are based on an average score per region, as some regions had more respondents than others. The average regional scores have again been averaged to provide a group score. Scoring is based on a value of 3 for services which are readily accessible to 1 for services which are not readily accessible.

As can be seen in Table 7-1 there seems to be some relationship between the population base of the RHA and the accessibility of home care services. However, in general, it seems that except for the three northern RHAs, all home care services are, at least to some degree, provided in all RHAs. The services with the lowest degree of accessibility seem to be rehabilitation, home maintenance and repairs, self-managed care, and for the non-urban RHAs, home care for children with special needs and mental health clients.

In addition to the services listed, respondents were asked if they thought that there were other services that may be required. The following is a list of the services which were noted:

- Volunteer services;
- Night respite care in facilities or hospitals;
- Post-hospital rehabilitation services;
- Quick Response Teams and Quick Response (emergency) beds for home care clients;
- Home-based respiratory care services;
- Convalescent care;
- Enhanced therapy services;
- Pharmacist services;
- Dieticians;
- Home IV therapy;
- Home ventilation;
- Hospice services;
- 24-hour (live-in) nursing care;
- Socialization programs to reduce isolation; and
- Diabetic foot care and wound care clinics.

7.4 Care Coordination

Respondents were asked about how care was coordinated within home care, between home care and residential care, and between home care and other parts of the health and social services systems. In most jurisdictions case managers conduct the assessment, develop the care plan and authorize services. There is a single point of entry into the home care system through the case manager. Case managers or care coordinators arrange for services. A physician's referral is required for nursing and rehabilitation services. The urban RHAs have a centralized assessment process that focuses on the broader systems of care, not just home care. In most other RHAs case management is part of home care. There are also various intra RHA committees to coordinate activities. Finally, case managers, nurses and care aides may be physically co-located to further enhance care coordination.

With regard to coordination with residential services, the most common pattern is for the case manager to facilitate the placement process by preparing a case write-up, including a "risk screen" form. This material is reviewed by a panel called the Regional Placement Committee, typically made up of a senior home care representative, a facility representative, and others, as appropriate. Once placed, the facility takes over the care of the new resident. Coordination is also facilitated by good working relationships between the case managers and facilities.

With regard to coordination with other parts of the health care system, many RHAs have home care staff physically located in the hospital to work on discharge planning. They may also participate in inter-disciplinary hospital rounds. It was, however, noted that care coordination may be better with community hospitals than with regional hospitals.

Recent changes to physician billing codes have facilitated the interaction between home care and physicians as doctors can now bill for consultations with home care staff about joint clients. Telephone contact of this sort is particularly time-efficient in rural areas, compared to in-person discussions. There are also links with SAIL and the home oxygen program. Case managers also work to coordinate services with Saskatchewan Housing, the police (for safety issues) and social services. Finally, there are also regional inter-sectoral committees that facilitate communication and coordination.

Care coordination in the northern regions has some unique challenges. Not all case managers or care coordinators are professionals, and there is also a higher utilization of Licensed Practical Nurses (LPNs) in these positions. There are also issues of linkage with home care and residential services in Manitoba and with Health Canada-funded First Nations services. It was noted by some respondents that Manitoba has much richer funding for home care and that on-reserve home care clients pay no user fees. These matters complicate care coordination and dealing with clients. In terms of linkages, in some instances home care services in the northern regions are provided by public health nurses as there are no home care nurses. It was also noted that chronic disease management comes under primary health care. This could become an issue in the future as home care also has responsibility for providing care services to such persons if they are on home care. It may become necessary to more fully clarify the relative roles and responsibilities of primary health care and public health nurses, and home care nurses, in areas such as chronic disease management.

7.5 Co-payments and User Fees

The structure of fees has already been discussed in the previous chapter. Thus, we shall focus on comments about the fee structure in this section. Some respondents stated that there is also a small fee for meals for meal programs and in adult day care. It was noted that income testing may not be adequate as some people have low incomes but large assets. It was also noted that fees are low and the time taken up in collecting fees is high. This begs the question of what is the actual net benefit of fees, as noted previously. It was suggested that there should be a fee for meals in addition to the subsidized home care fee and that perhaps there should be a separate flat hourly rate for house-cleaning services. It was also suggested that with the Accord it may be helpful to waive fees for 14 days after hospital discharge, more generally.

There was truly a range of opinions, and values, about fees. Some thought they should be abolished as they are time consuming and costly to administer. Furthermore, it was also noted that existing fees may actually serve as a deterrent to some clients to ask for service, leading to more rapid deterioration and admission to hospital or residential care. It was also noted that some clients feel intimidated by the process of income testing and a flat fee would be better. Others stated that it was good to have fees as people value the service more and that it creates independence. It was also noted that some people may give their money to their children so that

they can avoid fees by qualifying for a subsidy. Finally, some were in favour of raising the current ceiling of $383 per month so that high income clients, who can afford it, would pay more.

7.6 Perceived Strengths and Weaknesses of the Current Systems

Respondents were asked to comment on the relative strengths and weaknesses of the current Home Care Program. Their responses were a mixture of comments on the program in general, and on the program in their respective RHAs, and are presented below.

Strengths

- Dedicated, educated, motivated, committed, experienced and professional staff;
- Good training for Home Health Aides;
- Single entry to a wide range of services;
- Good teamwork and communication;
- The Procura System throughout the region;
- Standardized policies, guidelines and structures for home care services;
- Coordination of day programs and assisted living by home care;
- Short term acute and palliative care programs;
- Timely response to assessment and arranging services;
- Post-operative therapy program;
- Coordination with other professionals and related providers/services;
- The home care philosophy and the focus on clients' independence and community supports;
- Organizational structure with one regional director for all home care services;
- Focus on health promotion and the determinants of health;
- Meetings between Saskatchewan Health and RHAs to standardize home care;
- Ability of staff to speak First Nations languages and a high proportion of aboriginal staff in the north;
- Flexibility to adapt and adjust the program; and
- High levels of satisfaction with home care services.

Weaknesses

- Poor information systems;
- Inadequate emphasis on, and/or resources for, rehabilitation;
- Insufficient focus on prevention;
- Insufficient funding;
- Recruitment and retention issues for all categories of workers;
- Lack of understanding about the Home Care Program;
- Need to provide services on evenings and weekends (24/7 coverage);
- Differences between the Saskatchewan Home Care Program and the Health Canada and Manitoba programs (in the north);
- Challenges to staff in providing services in an uncontrolled, home environment;
- Poor communication with physicians and a perceived lack of support for home care by some physicians;
- Inconsistencies in service provision within and between regions;
- Inability to meet the expectations of Saskatchewan Health and the public;
- Inadequate collaboration of staff across regions;
- Some nurses cannot yet access Procura;
- Not enough teamwork and difficult to get physicians to function as team players;
- Too much time to administer client fees;
- Difficulty of staff to adapt to change;
- Negative competition between the old health district areas;
- Insufficient continuing education;
- Lack of outcome indicators;
- Organization structure (e.g., Director of Home Care also doing other jobs);
- Lack of care services guidelines;
- Lack of care maps for specific clients;
- Travel distance in rural areas;
- Focus on part-time and casual staff; and
- Inconsistency of care providers who go to see clients.

It is interesting to note that a number of topic areas are present on both lists (strengths and weaknesses) noted above. This could be due to regional variation and/or different levels of perceptions across respondents. Nevertheless, the items noted are a rich resource for addressing shortcomings and building on strengths.

Respondents were also asked about which factors they felt contributed to the success of the Home Care Program and which factors limited the success of the program. In terms of contributing factors, the main items were: the quality, knowledge and dedication of the staff; good communication and working relationships among the staff and between staff and other health and social services providers/organizations; and the flexibility to find solutions at the local level. The quality of leadership and the fact that home care staff generally like their work were also mentioned.

In regard to factors that limit the success of the program, the following were noted: the need for more active engagement at the provincial level; difficulties in attracting staff to serve

remote and northern areas; lack of understanding about the program and its limits; unrealistic expectations by government and the public; lack of adequate funding; the current collective agreement; silos between long term care and acute care; difficulty with change for staff; and the lack of good useable data for clinical, planning and administrative purposes.

7.7 Major Challenges

Respondents were asked about what they considered to be the major challenges for the Home Care Program, and about challenges that are unique to Saskatchewan. With regard to the latter, respondents noted the following: how to provide care in remote and isolated communities, decline of family supports as young people move out of rural areas, lack of specialist services in rural and northern areas, recruitment and retention of staff in rural and northern areas, and federal/provincial issues regarding home care provisions in the north.

Most of the above points were also noted in response to the general question on major challenges. Other challenges that were noted are as follows:

- The need to create a unique identity for home care;
- The need to better integrate home care with other parts of the health care system;
- Increasing the long term sustainability of home care;
- Inclusion of a northern benefits package in the collective agreement to attract staff;
- Dealing with technology;
- Chronic illnesses such as diabetes in the north;
- The tendency of acute care to absorb all available resources;
- Lip service to home care but not sufficient resources to do what is expected;
- The need to make home care a bigger player in the health system, particularly in regard to substituting for residential care and acute care;
- The public's and government's focus on acute care over home care and thinking of home care as housekeeping;
- The danger of having a focus on acute home care erode supportive home care;
- Developing multi-tasking with one staff person performing a set of functions which now require a range of people to come into the home;
- Existing collective agreements;
- A strategy to deal with an ever declining proportion of volunteers;
- Information technology implementation;
- Implementation of policies in a timely manner with prior consultation with stakeholders;
- The need for consistent organizational structures and lines of authority across RHAs;
- Inconsistencies in client user fees in comparison with other services;
- Education of politicians, board members, senior executives and managers about home care so it can be better understood;
- The need for more PCHs and a subsidy, as required, for poor people who may otherwise live at risk in their homes because they cannot afford a bed in a PCH; and
- The challenge of "collective funding" for new groups that previously looked after their own (e.g., the Catholic Church).

7.8 Special Topics

7.8.1 Introduction

In developing the interview questions we included questions on special topics which we thought may be of interest. It turns out that most of these topic areas have already been discussed in some detail above as they, in fact, appear to reflect important themes related to the Home Care Program. Thus, in order not to be overly repetitive, we provide a synopsis of each of these topic areas below.

7.8.2 Health Human Resources

Respondents from the RHAs noted a number of points related to health human resources in the home care sector. In addition to the points noted above related to recruitment and retention, particularly in rural and northern areas, the need for more training opportunities and the limitations on flexibility of how staff are used and what they can do in regard to the collective agreements, were mentioned.

Respondents noted human resources challenges in respect to: an aging workforce and how people will be replaced when they leave or retire; the increasing complexity of the case management role; competition with full-time work in facilities; lack of understanding and knowledge about home care by senior executives in RHAs; discrepancies among staff (for example, care aides have a lower mileage allowance than professional staff); declining levels of family support; security of home care staff as they work in people's homes; the use of LPNs instead of RNs and the whole, broader, transfer of function issue; and the lack of incentive allowances for workers in remote and northern RHAs.

7.8.3 Data, Analysis and Accountability

As noted above, there are mixed reviews about Procura, not so much for its capabilities, which are good, but for its implementation and uptake, that is, the human dimensions of working with this technology. There was also optimism about MDS-Home Care. Nevertheless, as things currently stand, there is an overall sense that information technology was not really meeting the needs of the Home Care Program.

With regard to accountability and evaluation, the most common approaches were use of the accountability framework, and other forms of reporting, to be accountable to Saskatchewan Health. In terms of accountability to clients and the public, RHAs typically have open board meetings that can be attended by the public and produce annual reports that are publicly available. Satisfaction surveys, complaint mechanisms and a Quality Assurance Manager were also mentioned as were nursing audits and accreditation at the RHA level.

In terms of key indicators, RHAs use the indicators in the accountability document, look at service data, waiting time data, data from satisfaction surveys and from Procura, response times, and medication errors and other clinical data (much of this is still under development).

Overall, however, it was noted that much more could be done in terms of developing key indicators and evaluating programs.

7.8.4 Consistency of Service Delivery

We asked two questions related to this topic. The first was how well client needs were matched to the actual package of services provided, and the other asked about consistency in service delivery *per se*. There was a general consensus among respondents that there was a reasonable, and consistent, matching of client needs to services provided. It was noted that this was more of a challenge for children with special needs.

It was noted in the urban regions that while there is a generally good match between client needs and the services provided, that there can sometimes be a "disconnect" between their centralized assessment process and service delivery. It was also noted that re-assessment could be conducted in a more timely manner. It was stated, across all RHAs, that there was an effort to re-assess clients every six months or at least annually, and as their care needs change. It was also noted that, while most clients had a good match between assessed need and the services provided, a significant minority may not receive the services they need due to resource constraints. It was also stated that there is sometimes pressure from the community to provide more services.

With regard to the overall consistency of services, within and across RHAs, the general consensus seemed to be that while, overall, there is some degree of consistency (particularly within many RHAs), there is also inconsistency in service delivery, both within and across RHAs. In particular, respondents noted the differences in user fees between the north and the rest of the province and inconsistencies in coverage for specialty services (e.g., home IV may not be available in all remote areas). In addition, some services that are seen as positive from the RHA accreditation process were not in home care (e.g., wellness clinics). There are also different collective agreements, for each former health district in some RHAs, although there are negotiations to have one contract per region by the spring of 2006. There appeared to be less consistency in regions that had incorporated previously separate health districts compared to regions that maintained their former composition.

It was also noted that there are differences across RHAs for some services such as palliative care, that there are inequities in regard to the relative ratios of professional staff across regions and that, in rural areas, most services are provided by care aides. Overall, it was noted that there were differences between large and small regions and urban and rural regions and that a more sophisticated approach is required to resource allocation which takes into account the broader base of existing health and social services across RHAs. The availability, or lack of, such services can be an important factor in the amount of home care that is required.

7.8.5 Issues Related to the Superstructure of Care Delivery

Respondents were asked if, in their view, there were any gaps, issues or concerns in regard to broader "superstructure" issues such as legislation, policies, program organization, and/or the range of services currently provided. Respondents noted that policies may have been

diluted and that there was variability across regions, that they need provincial policies, and that funding did not seem to match what they were asked to do in policy. It was also noted that more consultation about policies between RHAs and Saskatchewan Health would be helpful. With regard to legislation it was noted that home care is not an insured service such as acute care in the Canada Health Act and this sometimes causes confusion in the public's mind.

In term of programs, it was noted that it may be useful to have early discharge, or transition, suites as a step-down or bridging process between acute care and home care. The need for further work in specialty areas such as palliative care, children with special needs and mental health were also noted.

Other factors that were mentioned were: challenges related to the collective agreement; challenges related to information systems; the need to approach client care in a more holistic manner rather than segmenting parts of the program; and differences in resources and fee schedules between the Saskatchewan, Health Canada, and Manitoba, home care programs. Finally, it was noted that there is a need for more direction from Saskatchewan Health in regard to policy and to enhanced integration between home care and long term care.

7.8.6 Excellent Programs

Respondents were asked to note any exemplary or particularly noteworthy programs. While relatively few programs were identified, the following were noted: 24-hour care in some RHAs, pediatric services in Saskatoon (this service was seen to be very family-centred and flexible), CPAC and SWAD centralized assessment approaches in the urban RHAs, transition home care teams, specialty clinics for wound care, foot care and hypertension, cluster care, ambulatory treatment clinics in Regina and Saskatoon, the hip and knee replacement physio-therapy programs in the Cypress RHA, and residential and emergency bed services administered by home care.

7.9 A Self-evaluation

We included a form of self-evaluation in the interview questions. We identified a range of topic areas that one would typically address in an evaluation and asked respondents to rate each topic area on a scale from 1 to 10. Table 7-2 presents the results of this self-evaluation.

As can be seen from Table 7-2, there seems to be a difference in the scores on the self-evaluation with scores for most areas being highest for the Urban RHAs and lowest for the Northern Regions. However, the overall average score is actually quite similar for the Urban and Intermediate/Rural RHAs, both coming in at about 7.3 out of 10. This difference seems to be due, at least in part, to the different scores given for information systems. It should, also, be noted that one of the Northern Regions self-rated themselves fairly highly, while the other two provided lower scores.

Table 7-2: Self Evaluation of the Home Care Program by RHAs

Topic Area	Average Score[1] for Urban RHAs		Average Score[1] for Intermediate/ Rural RHAs		Average Score[1] for Northern Regions	
	Range	Average Score	Range	Average Score	Range	Average Score
1. **The appropriateness and effectiveness of the organization and governance structure of the Home Care Program:** This topic area relates to issues such as: are there clear lines of authority and responsibility, is there a clear recognition of roles and responsibilities, and are people held to account for their performance.	6.5 - 9.0	7.8	5.5 - 8.5	7.4	4.0 - 8.0	6.3
2. **The appropriateness of the care model:** This topic relates to whether or not the model itself is well documented and designed and to meet the stated purposes, goals, and objectives of the Home Care Program, and is consistent with best practices in the field. The rationale for the model, the key characteristics of the model and the organizational structure of the model are all included in this topic area.	7.0 - 8.0	7.3	5.5 - 9.0	7.1	3.0 - 8.5	6.2
3. **The quality, appropriateness and effectiveness of current information systems in regard to home care:** Is there an electronic information system, how much of the data collected are actually computerized, is the information system easy to use, and is it an integrated part of operations at the clinical and management levels or is it an add on (e.g., only records financial data and is not actively used in operations), are all issues to be considered for this topic area?	1.0 - 3.0	2.0	2.5 - 9.0	5.1	3.0 - 6.0	4.2
4. **The appropriateness and effectiveness of care provision:** This topic area relates to an assessment of the extent to which care provision is appropriate, is carried out in a consistent manner, and is carried out in accordance with documented policies and procedures.	7.5 - 9.0	8.3	6.0 - 10.0	7.9	5.5 - 8.2	6.6
5. **The appropriateness and effectiveness of the continuity of care within the Home Care Program and between the Home Care Program and other health and social services such as primary care and hospital care:** This topic area refers to how well care services, and the process of providing care, are coordinated across the component parts of the continuum. It relates to the continuity of care provision (do clients see the same care provider on a regular basis), information (does information about the client flow with the client as he or she sees different care providers) and the system of care (are the services of different care providers connected in a coherent manner).	6.0 - 8.0	7.0	5.0 - 10.0	6.8	4.0 - 8.3	5.4

Topic Area	Average Score[1] for Urban RHAs		Average Score[1] for Intermediate/ Rural RHAs		Average Score[1] for Northern Regions	
	Range	Average Score	Range	Average Score	Range	Average Score
6. **The extent to which care providers are trained and qualified to provide appropriate and effective care services:** This topic area relates to the professional qualifications and competence of the people providing care services.	7.5 - 8.5	8.0	6.5 - 10.0	8.3	4.0 - 8.0	5.7
7. **The level of accessibility to care services:** This topic area relates to how well, or poorly, clients can access services and/or have their questions answered. It is related to the hours of operation and the ease of access to needed services.	6.0 - 8.5	7.0	6.0 - 8.0	7.2	5.0 - 8.0	6.7
8. **Satisfaction with service delivery:** This topic area relates to the level of satisfaction with services as perceived by clients, family members and key stakeholders.	8.0 - 8.5	8.3	7.5 - 9.0	7.9	5-0 – 7.3	6.4
9. **The quality of service delivery:** This topic area relates to perceptions about the quality of care providers, and the overall quality of care services, as perceived by clients, family members and key stakeholders.	8.5 - 9.0	8.8	7.5 - 9.0	7.8	5-0 – 8.3	6.1
10. **The cost-effectiveness of care services:** This topic area relates to the value for money received by the organization for the funds expended. This does *not* refer only to the cost of services, it relates to both the costs and outcomes of care.	8.5 - 8.5	8.5	7.5 - 9.0	7.9	5.0 - 8.0	6.5
11. **Positive impacts on population health and the overall health care system:** This topic area relates to the impact, if any, of the Home Care Program on the clientele served, the health status of the broader population, and the impacts on other parts of the health care and social services system (e.g., admissions to hospitals and/or long term care facilities).	6.5 - 8.5	7.5	6.5 - 9.0	7.2	5.0 - 8.0	6.5
12. **The sustainability of the current model:** This topic area refers to the extent to which the current model of delivering home care is sufficiently robust so that there is a high probability that it can continue over time.	6.5 - 8.5	7.5	5.0 - 10.0	6.9	4.0 - 7.0	5.5

[1]Average scores were developed for each region. These averages were then again averaged to obtain group averages. Scores ranged from 1 to 10, with 10 being the highest, or best, score.

Overall, the highest scores were for the quality of service delivery, the cost-effectiveness of care, client satisfaction, trained workers, and the appropriateness and effectiveness of care provision. Information systems and the sustainability of the Home Care Program received low scores. Sustainability was scored higher by RHA respondents than Saskatchewan Health officials.

7.10 A Vision for the Future

We closed the interview with a question that asked respondents what changes they would make, and why, to the Home Care Program, if they were in authority to make such changes. A wide variety of responses were provided and are noted below:

- The need for a clear vision, strong leadership, adequate funding and support for preventive services;
- Social work, therapy and community development should be part of home care;
- Increase in funding and overall support, for supportive, longer term home care services;
- Narrow the gaps between regions so that services can be provided on a consistent basis;
- Provide more full-time home care positions, with cars and cell phones, to help to recruit and retain staff;
- Program consolidation of a range of services under home care;
- More flexibility in collective agreements;
- Provide emergency response beds and increase the hours of operation;
- Removal of user fees;
- Provision of better transportation services for clients to come to services in larger centres (e.g., lab tests);
- Standardize the assessment instrument and ensure that it can be used to document issues such as risk and determinants of health;
- Remove disciplinary stovepipes;
- Provide subsidies for poor clients to access assisted living and PCHs, if such services are required;
- Charge a flat fee for meal programs and housekeeping;
- Provide 24/7 (live-in) support for some clients, as needed;
- Add pharmacists and nurse practitioners to the home care team;
- Have Saskatchewan Health provide a more consistent implementation of Procura, MDS and other information systems initiatives;
- Facilitate easier access to SAIL;
- Provide a more anonymous process to allow the public to report incidents of poor care;
- Develop local volunteer coordinators instead of, or in addition to, a regional volunteer coordinator;
- Ensure better linkages with hospitals to ensure that there is better coordination regarding client discharges and that home care is ready to receive these clients;
- Provide activity centres in more isolated areas to reduce the isolation of clients;
- Deal with differences in federal and provincial home care services in the north;

- Turn the system upside down so people only go into long term care facilities or hospitals if they cannot be looked after by home care; and
- Focus more on health status issues such as diabetes.

7.11 Discussion and Conclusions

As with the Saskatchewan Health officials, we were also very impressed with the insights, critical self-awareness, and candor, of respondents across the RHAs. Furthermore, we were uniformly impressed with the quality, insight and knowledge of the respondents responsible for the Home Care Programs across RHAs. As noted above, there was a wealth of information, knowledge and insight offered by the respondents to whom we spoke.

It is also important to note that, while there was perhaps more local texture in the information provided, many of the issues noted were the same issues raised by Saskatchewan Health officials. Thus, it appears that this report, to the extent we have been able to accurately reflect the issues, can serve as a useful planning document in that it can constitute a repository of issues which could be addressed to improve the Saskatchewan Home Care Program. It must also be noted that 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. Thus, in addition to the themes raised above, 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 system's 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.

The above issues, and the issues noted in Chapter 6, are discussed in Chapter 9.

8.0 FINDINGS FROM INTERVIEWS WITH REPRESENTATIVES OF HOME CARE PROGRAMS OUTSIDE OF SASKATCHEWAN

8.1 Vancouver Coastal Health, British Columbia

Vancouver Coastal Health has developed a broad based, integrated service delivery system under its Community Care Network. There is excellent integration of home care services with primary health care and hospital services. With regard to links to primary health care, home care clients can receive services in community health centres. Approximately 20% of home care clients are seen in such ambulatory settings. The rest receive more traditional services in their homes. There is also an increasing emphasis on a self-care model of care. The home care program also subsidizes different types of housing and assisted living services. One example of greater efficiency in care delivery is that of cluster care where people live close together and home care and home support is provided on a "cluster" basis. Thus, a number of people can be provided services with one extended visit in which several people in the cluster are seen sequentially.

Adult day care services are also in home care and can be used for chronic disease management and dementia care. Home care also provides funding for persons who can be in different housing alternatives, and who are resident managers in the building. These managers provide a community development approach to looking after residents, can provide checks and monitoring to ensure people are all right, can assist them with paperwork related to their benefits and other matters, and provide other related assistance.

The Community Care Network also has the notion of a virtual campus, or small community, and whatever steps can be taken, are taken, to allow people to operate at their highest level of functioning for as long as possible.

There has been a conscious choice or, "leap of faith" to do whatever it takes to support people living in the community. Thus, there has been a shift in focus from acute hospital care to home and community care. An important resource in this model is a range of housing options supported by home care services. These options also include transitional care settings, campuses of care (real and virtual) to support aging in place, and other forms of assisted living options. The purpose of this enhanced home and community care network is to delay admission to residential care and reduce hospital utilization.

Services are delivered in three separate geographic areas and each area has its own program. Case managers have broad responsibilities for providing assessment and care coordination activities at a broad, systems level. In terms of staffing, some 50% of services are provided through, external, third-party providers. Home support services are income tested and there is no cap so more affluent individuals can pay up to the full cost of care.

The strengths of this model are that there is strong leadership which has given clear direction to focus on keeping people in the community and reducing institutionalization. Also, there is considerable service integration between the Community Care Network and hospitals and primary health care. There also seems to be clear evidence that this approach is having

positive effects. Home care is formally charged with being the vehicle to reduce bed utilization in hospitals. Prior to the restructuring which led to this model some 12% of hospital beds were occupied by Alternate Level of Care (ALC) clients. At present, after this new model was implemented, ALC beds accounted for 6% of beds, or half of the previous percentage of beds. Thus, they have cut ALC beds in half with this model of care.

8.2 Fraser Valley Health Region, British Columbia

Services in the Fraser Valley Region are broken up into three large geographic areas, representing former, smaller RHAs. Fraser Valley also has a broader, integrated model of service delivery in which Chief Operating Officers (COOs) are responsible for the delivery of all health services in their geographic area. The COOs also have responsibility for content areas of the health care system. For example, one COO is responsible for planning and program development for home care. The COOs are referred to as "Executive Sponsors" for the content area for which they are responsible. The vision of home care states that home care clients should have access to high quality community based care to allow them to live independently with a high quality of life. Most home and community care services are considered part of the care delivery system (because each COO looks after all health services), although some services are delivered directly while other services, such as a range of housing options, have shared responsibilities with home care providing the needed care. Mental health teams also provide community services and do post-acute follow-up.

Clients move from home care to residential care in a manner similar to Saskatchewan. There is a close link with primary health care and interdisciplinary teams which include pharmacists. The strengths of the system are seen to be a broad, systems perspective in regard to care delivery and a close integration with the local communities in the region. The weaknesses are common issues relating to needs for more standardization of care delivery, the need for better indicators, not really being able to know what is happening with clients from the information system, and a desire for stronger leadership from the provincial Ministry of Health, particularly in regard to cross-cutting, inter-sectoral issues such as housing, and care for children with special needs. It was noted that COOs in areas other than the one covered by the interviewee who was the Executive Sponsor for home care may still have their major focus on acute care.

8.3 East Central Health Region, Alberta

East Central is a rural RHA which is trying to strengthen home care in their region. Most clients receive long term supportive care but there is also a focus on mental health and palliative care clients. There is an administrative distinction between home and community care and residential care. The vision of care is to support people to live in the community. This RHA has been doing some excellent work in regard to housing options. Priority foci are on palliative care, younger disabled persons, supportive housing options, 24/7 care, acute care rehabilitation, and longer term supportive home care. Case managers function to coordinate care and assist people to be admitted to facilities, through regional placement coordinators. There are good links with primary health care, and social services. The region also works with the provincial Student Health Initiative which provides incentives in regard to disabled students in schools.

The strengths of this system are perceived to be a strong case coordinator model, effective family service providers, and good links with other agencies, housing and acute care. Challenges noted were the need for more expertise in regard to caring for children with special needs, the need to improve relationships with physicians and the need for increased access to pharmacy and social work services.

8.4 Calgary Health Region, Alberta

Calgary is an integrated health region. There are five operating sectors, that is geographic operations with leaders also having a topic portfolios for different areas such as home care. There is also a topic area for rural health. The vision of the program is to assist people to remain independent as long as possible and to get people back home from hospitals as soon as possible. Case managers are staff of the region but most services are provided through third-party providers. Transition coordinators facilitate the transition between home care and hospitals, and facilitate admission to long term care facilities. Home care has physician partnerships in primary health care in regard to chronic disease management. There is an overall resource cap for home care clients.

The strengths of the program are strong links with other health services and the dedicated people working in the care delivery system. Recruitment and retention of staff is a challenge, including in third-party provider agencies.

In terms of ideal, future directions the respondent noted that home and community services should actually take the lead in the whole continuum of care in the community and look after people to minimize institutionalization. The respondent also noted that mental health requires specialized expertise and that home care should not take the lead in the area of mental health home care, as mental health requires specialized expertise.

8.5 Capital Health Region, Edmonton, Alberta

In Capital Health, community care is divided into three main areas, facility living, home living, and supportive living (including personal care homes, assisted living and housing for the mentally ill). Thus, Community Care is an administrative entity which covers residential care, home care and supportive housing. The vision for home care is to respectfully support people to obtain the maximum quality of life. The overall focus is not as much on medical care, as it is on overall quality of life. The care delivery model, as with all of the other models noted above, is a single entry model where care is coordinated through the case manager. Home care facilitates the placement of clients into residential care facilities.

With regard to other linkages, assessment coordinators are located in acute care hospitals. Capital Health also participates in a student health initiative and has good linkages with the Primary Care Networks which are now being established to provide primary health care.

In terms of user fees, clients pay $5 per hour to a maximum of $300 per month for homemaking and $15 per day for day programs. The strength of the programs are 24 hour access, broad inter-disciplinary teams, single entry, flexibility in tailoring care packages to meet

the unique needs of clients, and committed staff. Key challenges included recruitment and retention, existing information systems and the challenge of being able to demonstrate the positive outcomes and effectiveness of the program.

In terms of an ideal vision for the future, it was noted that there could be even stronger integration between home care and residential care, enhanced client self-management options, and expanding the home care mandate to restore the mandate for preventive home care.

8.6 Home Care in Manitoba

Home care is a core program of Manitoba Health and serves as an alternative to institutional care. Regional Health Authorities administer the program and home care staff are RHA employees. Manitoba Health is responsible for provincial policies, standards, funding, accountability and overall monitoring. While there are specific amounts earmarked for home care, it is part of block funding which goes to the RHAs for all RHA services.

The vision for home care is to support clients and families to live in the community for as long as possible and as safely as possible. In addition to the list of services in the interview schedule, it was noted that the following are part of home care in Manitoba: home oxygen, home IV therapy, some nutrition (supplemental nutrition) and home dialysis.

There is an overall case manager to coordinate care but there are also separate resource coordinators for nursing and for personal care and home support. Home care prepares materials which are reviewed by a long term care access panel regarding admission to a long term care facility. The case manager, or care coordinator, is the key linkage point in regard to coordination with other parts of the health on social services systems.

The strengths of the system are considered to be responsiveness, universality, the lack of user fees for services (and the fact that this allows clients to access the system sooner, before their needs get worse), provincial policies to ensure consistency of the program across RHAs, and the flexibility and client and family responsiveness of care plans. The major weakness noted was the existing information system.

8.7 Parkland Regional Health Authority, Northern Manitoba

In the Parkland RHA in northern Manitoba, home care comes under the Vice-President of Community Health who is responsible for all community services including home care, primary health care and public health. There is another Vice-President for facility care and one for finance and support. The region functions under the vision of home care of Manitoba Health. Care is coordinated by the case manager. A panel chaired by the director of home care determines facility admissions. The Parkland RHA uses the Manitoba assessment form but is considering Procura and MDS-Home Care. In terms of other linkages, home care staff coordinate discharges from acute care hospitals.

The strengths of the home care program are seen to be its accessibility and availability. Weaknesses noted were the overall availability of resources, differential pay scales between

home care and residential/hospital care for the same category of worker, the proportion of casual or on-call home care staff, travel time and distance issues in northern Manitoba, lack of nurses in isolated areas, and transfer of function issues.

8.8 Home Care in Ontario

The Province of Ontario has put forward a plan for a regional model of health care planning and delivery. Although the legislative process has not yet been completed, the plan is to create 14 Local Health Integration Networks (LHINs) in Ontario. The LHINs are intended to take on local health system planning and community engagement; provide funding to a wide range of health service providers including home care; and be responsible for local health system integration.

Ontario conducted pilot projects for home care in the 1950s and started to fund such programs in the late 1950s. The emphasis was on acute home care but the sector subsequently came to incorporate long term, or chronic, home care, and other forms of home care.

In 1996, the government implemented Community Care Access Centres (CCACs) to coordinate the delivery of home care services and perform the functions of case management including assessment, eligibility determination, the authorization (and purchase) of home care services from external, third-party providers and coordination of those services. CCACs also provide an information and referral service, school services, and facilitate placement into long term care homes. In 2001 the Community Care Access Corporations Act was passed to provide a legislative base for CCAC activities. There are currently 42 CCACs across Ontario that are statutory corporations, i.e., they are agencies of the government but the staff are not government employees. These statutory corporations have appointed boards of directors and are approved agencies under the Ontario Long-Term Care Act, 1994. As part of the LHIN implementation process, the plan is to align 14 CCACs with the 14 regional LHIN boundaries.

There are no user fees for home care services. The CCACs coordinate home care services with hospital, community and primary health care services. While there is not a formal vision statement *per se*, the purpose of home care services is to maintain people in their home environment and to avoid institutional care. Home care clients are also eligible for the Ontario Drug Benefit. Ontario uses the MDS-Home Care assessment instrument to assess adult clients who require long term home care service and is developing a common intake assessment tool to identify the needs of acute clients.

The strengths of the home care program are a comprehensive range of services, no user fees, and common automated information systems. The program is flexible and has important specialty services such as home IV, palliative/end-of-life care, telehomecare, medication management, quick response teams, home dialysis, and has initiated the role of nurse practitioners in home care to work on chronic disease management.

The weaknesses of the system are considered to be that the program is complex and it needs to better market its services.

In terms of making changes to make the system ideal, it was noted that better data about results and outcomes would be desirable, as would a greater focus on the long term or chronic home care population, and more empowerment for clients.

8.9 Home Care in Nova Scotia

Nova Scotia has moved to a regional care delivery model for some health services such as acute care but the delivery of home care services remains a provincial responsibility. Care coordination and case management is done by provincial staff but the home care services themselves are provided through 20 not-for-profit and for-profit, external, third-party providers. These organizations submit a business plan and services are purchased from these care provider agencies on an hourly basis. There is a fairly wide variety of home care services but a number of these services are provided by other Departments. The home care program *per se* provides a limited number of core home care services.

In terms of coordination, case managers coordinate care within the home care program. They also facilitate the admission of clients into residential care. Actual approval for residential placement is determined by a placement officer. In addition, in some cases, home care nurses provide IV therapy to clients in long term care facilities. With regard to care coordination with other parts of the health and social services systems, there are care coordinators who work in hospitals. At a broader level there are also inter-departmental committees which deal with coordination issues. Another feature of the Nova Scotia system is that they have legislation related to adult protection and adult protection staff work closely with home care staff. Clients are income tested and pay user fees for non-professional services based on a formula which considers a number of factors such as income and the number of people in the household. There is no specific legislation for home care in Nova Scotia and the program operates on the basis of policy.

Nova Scotia is currently developing a 10 year strategic plan for its health services. An important component of this plan is to integrate a range of services into a broader, integrated model of continuing care service delivery. There is a commitment to the concept of a broader, integrated model, and a recognition of the potential benefits and efficiencies which can be realized from such a model.

8.10 Home Care in New Brunswick

In New Brunswick, home care is split between two Departments. The Department of Health and Wellness operates the Home Health Care (HHC) Program which provides short term, acute and short term palliative, home care. There are no user fees for this program. The Department of Family and Community Services (FCS) has a long term home care program. There are means tests for this program and a sliding fee schedule. There is a single entry system in which any of HHC, FCS or mental health staff can do the assessments for all programs.

In terms of coordination, case managers coordinate care through the single point of entry system. In terms of links with health and social services HHC has links with other health services. Home care nurses called Liaison Nurses work in hospitals in a discharge planning

capacity. HHC also coordinates with schools and has strong links with physicians and community services.

The strengths of HHC are that professional staff are employees of the program rather than of external, third-party providers, there is a high degree of involvement with physicians, strong links with institutions, provision of service without user fees, and no pay differentials between home care and hospitals for the same class of worker. The weaknesses of the system are that it is not closely linked to non-professional services and other services such as housing.

With regard to FCS, its strengths are its self-managed care and client self-determination initiatives. Its weaknesses appears to be that there is a high turnover of home support workers due to low ages, and there is means testing which may deter people from seeking assistance.

8.11 Home Care in Prince Edward Island

Prince Edward Island is in the midst of major changes to its health care system. Thus, it is not clear exactly what model of home care will evolve.

8.12 Home Care in Nunavut

Home and community care are located in the Department of Health and Social Services in Nunavut. There are three geographic regions for purposes of care delivery, each with a regional manager. Nunavut has an almost exclusively Inuit population and has a sparsely distributed population. There are usually nurses to provide home care in larger communities in each of the three regions. The vision of the program is to provide care "closer to home" in a culturally appropriate manner to meet the social, emotional and spiritual needs of clients and to maximize the ability for people to be independent.

In terms of care coordination, this is done by case managers who also facilitate access to residential services for both respite and ongoing care. There is also coordination with hospitals for respite beds. There are no user fees for home care services in Nunavut.

The strength of the program is that it can provide a high level of service in remote areas. The weakness of the program is that there is high staff turnover both for professional and support staff.

8.13 Discussion and Conclusions

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 simple comparison was not possible. It is, however, fair to say, that most jurisdictions offered a similar range of services to those in Saskatchewan. The home care program in Nova Scotia had fewer services, as services are provided through two different Departments. Manitoba and Ontario seemed to have a reasonable number of specialty home care services.

There was a mix of alternatives in regard to user fees with Manitoba, Ontario and Nunavut not having user fees while there are means tests in some areas of Atlantic Canada for non-professional home care services (means tests relate to all assets, not only annual income). However, no jurisdiction charges user fees for professional home care services such as nursing, case management and physiotherapy.

It was not possible to obtain detailed financial or service utilization data in 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%, or more, compared to expenditures in Saskatchewan.

Finally, it should be noted that many of the issues raised in Chapter 6 on the Saskatchewan Home Care Program are also issues in other jurisdictions. While there are some exceptions, information systems, indicators and evaluation appear to be common issues, as is the matter of recruitment and retention of staff.

9.0 DISCUSSION AND RECOMMENDATIONS

9.1 Introduction

As part of this review we were asked to provide our comments and recommendations about the Saskatchewan Home Care Program. We do so in this Chapter. However, home care, at least in Western Canada, also has a long tradition of being part of a broader, integrated system of care delivery for the elderly and other persons with ongoing care needs, referred to as Continuing Care. Thus, we also discuss home care in this broader context because it is in this broader context that home care can more readily become a vehicle for bringing about efficiencies in the overall health care system.

9.2 A Fundamental Choice

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. Taking this approach would have several major implications and would, to quote one respondent, be a means of "standing the health care system on its head." In this approach home care becomes the first and preferred line of service and people only go into long term care facilities, and only stay in hospitals, to the extent that home care cannot provide the care needed in a safe, effective and cost-efficient manner. In this model home care is charged with bringing about efficiencies in residential care and hospital care. Moving to this view of home care can have significant implications for how services are organized and where monies are expended. As one respondent from outside Saskatchewan noted it takes a "leap of faith" to journey down this road. But it is not a blind leap, as the second slogan that also applies is "trust but verify," that is, if one takes the leap of faith one must also carefully monitor that one is actually achieving the expected efficiencies.

While the above sounds black and white it is not. The two approaches are actually two ends of a continuum and there are many intermediate points along the way. One may choose to only go part way, or to phase in changes over time. Saskatchewan Health has a decades long tradition of already having a continuing care system. This tradition is currently carried on by the Community Care Branch which has under its administrative umbrella most of the components that would constitute a comprehensive integrated continuing care delivery 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.

We initially thought that we might structure our comments in regard to the two approaches noted above, that is home care as a program or home care as a vehicle for increasing overall efficiencies in health care delivery. However, there are many intermediate points along the way. Thus, we structure our discussion based on major topic areas and indicate what steps may be appropriate, irregardless of which function home care is to serve.

Finally, we make a number of recommendations for possible enhancements to home care in this report. Some or all of these enhancements can be achieved by adding additional revenues to home care. However, they can also be achieved, while maintaining revenue neutrality, if they are adopted at a measured pace over time with offsets from the residential care sector. There appears to be a good basis, given the number of existing beds, for cost-effective substitutions of home care services for residential care services, even if one simply just holds down future bed construction. This approach was used quite effectively in British Columbia in the 1980s and early 1990s when resources were shifted from residential care to home care, essentially by freezing the construction of additional new beds over a 10 year period.

9.3 Our View of the Saskatchewan Home Care Program

The self-ratings of Saskatchewan Health and RHA officials noted that the home care program *per se* is a sound program. The self-ratings give the program a solid B (low 70% range), except for the north which has a number of unique challenges and seemed to be rated at about a C+. We concur with these assessments but, given the current Canadian context, actually have a somewhat more positive view of the program than the officials interviewed. The program also has a solid basis for evolving into a state of the art integrated system of care.

There are many strengths to the current home care program. These include knowledgeable leadership at the provincial level, and very impressive home care executives and managers at the field level. In addition, having the home care staff be regional employees, and 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. One must also consider the system within the current, broader, national policy context which currently does not provide incentives for preventive home care and supportive, or long term, home care. Finally, it must be stated, as seen in Chapter 8, that many of the issues and concerns noted by respondents in Saskatchewan are common challenges across the country and are not unique to Saskatchewan. The challenges noted in our report should be understood in this broader context.

It has been our experience that even in exemplary systems, those who work in the system are, most clearly, able to see its faults and shortcomings as there is no such thing in the real world as a perfect system, which always functions perfectly. The closer one is to the front lines of service delivery the larger the warts appear. As one pulls back and starts to look at one's system across RHAs, across provinces, and across countries, these warts become smaller and one can have a better appreciation for the strengths of one's own system, and a clearer focus on what

elements may impede optimum operations and should be improved. Using this broader perspective, it is our view that there do not appear to be any glaring, or fundamental, flaws in the current Saskatchewan Home Care Program. Thus, the comments and recommendations we make below are presented in the spirit of making a good system even better.

9.4 Communication and Collaboration

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. However, it was noted that currently there may be more of an emphasis, in the above noted committees, on sharing information than on aggressively driving policy. It is our view that home care and continuing care are complex and that there is sufficient variations across RHAs to make sharing of information an important function in its own right, as well as a tool for learning from each other and developing policy.

One of the points noted in our interviews was that some officials in the RHAs may not fully appreciate the complexity and potential of home care and continuing care. This, if true, would not be unusual. This sector is very complex. It mixes a wide range of services, interacts not only with other health services, but also, with social services, education, and other sectors. It uses a socio-medical model of care rather than the medical model used in acute care, actively involves family members, and provides care in unsupervised settings. Given this complexity, it is important for all parties and key stakeholders to have a better understanding of the home care delivery system.

The revised policy manual is quite comprehensive and provides a sound policy framework for delivering home care services in Saskatchewan. It is our view that policy development should be an active and ongoing process and that there should be an appropriate process to update the manual on a regular basis, as circumstances warrant.

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. Based on our review, and the above discussion, we would make the following 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.

9.5 Organization of Service Delivery

As noted above, if home care is to be seen as one program among many then it can fit within a range of different organizational structures. If, on the other hand, the approach of having home care be a key driver of overall system efficiencies is adopted, then there are certain steps which should be taken. The efficiencies noted in the literature review come from having one administrative umbrella and one funding envelope. Most of the models of integrated care delivery had these features. This arrangement gives program managers the administrative and fiscal levers to realize efficiencies. Good coordinating mechanisms between continuing care, hospitals, and primary care, further enhance the potential efficiencies which can be attained.

Given the new federal initiatives, it will be possible to expand home care services in several areas such as more medically oriented, short term home care, mental health home care and home care for children with special needs. These enhancements will allow for a more comprehensive home care program, irrespective of how home care is integrated into the broader health care system.

Persons with ongoing care needs require a wide range of community services (horizontal integration at the community level) and seamless linkages to residential and institutional services (vertical integration), irrespective of how home care is structured in relation to other components of the health care system.

9.6 Service Delivery

9.6.1 Expanding the Range of Home Care Services

There are a number of issues that have been raised in regard 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 home care services to allow people to maintain their independence for as long as possible, and prevent admissions to hospitals and residential care.

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.

9.6.2 Case Management

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.

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.

9.6.3 Adult Day Care and Other Centres

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.

While we do not necessarily advocate the direct adoption of a CHOICE model, it is our view that some services could be provided in a single location and home care clients could come to that location, if doing so would be feasible and cost-effective. Thus, adult day care centres could be a focus for the provision of a wider range of needed health and social services.

Based on the literature review, it may also be feasible to look at providing health related services for home care clients in other locations, such as health clinics, where it makes sense to do so.

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.

9.6.4 Service Coordination

Home care can be conceptualized as having three, related components of care. The first would be in home care delivery by professionals and home health aids or assistants. This service would be carried out directly by the home care staff and be core "direct" services. The second component would be all of the services which require coordination or facilitation. This would include transportation, SAIL, housing options and so on. In each case, another organizational entity is responsible for the type of service but coordination is required for home care clients to access these services.

The third component is a community development function which may require some funding but would not require the addition of actual staff. Funding should be provided for a community development function which would allow case managers to develop and/or enhance existing community services and resources. Thus, 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.

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.

9.6.5 Group Homes and Adult Foster Care

It is our view that it may be useful to provide group home services, and/or adult foster care services, particularly in more rural areas. It is our understanding that home care already provides funding for professional services in group homes. Group homes would house 3-8 people in a comfortable housing environment, with care being provided through the home care program. Adult foster care would allow one or two people to be cared for by a family in that family's home (usually by a family member who is a health professional). Group homes and adult foster care are alternatives to residential care services and could be provided to clients at all levels of care. These options could provide an alternative to poor clients who cannot afford a PCH, and to communities where PCHs do not exist. It was noted in the interviews that there may be an important service gap for poor people who cannot safely remain at home but are at Level 1 or 2 and would not be admitted to a residential facility.

We recognize that some changes would have to be made to existing legislation if this option were to be adopted. We also recognize that monitoring to ensure care quality and safety may be more costly, on a per client basis. Nevertheless, the above noted options provide creative alternatives to residential care, are used in other jurisdictions, and may be particularly useful in rural and remote areas.

> **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.

9.6.6 Other Services

There are a range of other services such as quick response teams, home IV and ventilator therapy, home monitoring and other such services which were mentioned in the interviews and are noted in the literature review. Rather than enumerate each potential service we would recommend that Saskatchewan Health and the RHAs work to review which home care services should be added or enhanced. Once there is agreement on a new service, or an enhancement of an existing service, Saskatchewan Health could formally sanction the service and add funding so the service could be provided. RHAs could also on their own decide to add a service, and fund it from their existing budgets.

> **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.

While not discussed extensively, there were some comments related to collaboration with physicians. It is our view that RHAs could consider making a part-time consulting physician available to the home care team to liaise with physicians in the community and with physicians who discharge patients from hospitals, in order to further enhance working relationships between home care and physicians. It would also be helpful if the physician was senior and well respected, such as the head of family medicine in the local or regional hospital. We also think that it would make sense to make a part-time pharmacist available to the home care team to assist with potential issues such as poly-pharmacy.

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

Finally, 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 (e.g., joint funding of a common program in the north), be considered, or other steps be taken to reduce discrepancies between the two programs.

> **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.

9.7 Home Care User Fees

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 were also told that some people refuse to pay and that in some areas there are "bad debts" where fees could not be collected. Finally, we expect that there is, at best, a very modest net financial benefit from having the fees.

If Saskatchewan Health and the RHAs wish to review alternatives to current user fees, they may wish to consider the following. One option would be to establish some cut off point below which people do not have to pay any fee. That cut off point could be OAS/GIS, the GST tax rebate level, the Statistics Canada poverty line or some other reasonable level. Thus, only people who are above whatever level is instituted would have to pay, saving considerable staff time in doing income tests. In addition, a large proportion of clients would have minimal income so contrasts with Health Canada (for First Nations) and Manitoba could be lessened, and the province could have one system for all of the province including the north. To compensate for lost revenue one could increase the current ceiling on fees paid (currently a maximum of $383 per month) to a higher amount, so that those who can afford it would pay a bit more.

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

9.8 Health Human Resource Issues

Based on our interviews, there appear to be some challenges with regard to health human resources in the home care sector. We were told that current collective agreements may inhibit flexibility in the provision of services. In addition, recruitment and retention is a major issue. Community infrastructure in the north is 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. While we have no unique insight to offer in this area we would, nevertheless, make the following recommendation.

> **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.

9.9 Information Systems, Analysis and Accountability

This is a complex area and there are very few jurisdictions which have gotten this right to date. Procura and the MDS assessment forms are a good start. There will, however, be considerable work required to fully implement these software packages. The main issues will be in getting people to use the software properly, and in a consistent manner. Furthermore, there needs to be a clearer picture of what these packages will, and will not, deliver even if they are well implemented. There seems to be a misconception that by simply adopting these tools home care will have an integrated information system. This may or may not be true depending on how these data are merged with other data on staff, hospitals, primary care, costs and so on.

> **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.

In terms of analysis, it is our view that the continuing care sector, and all of health care, suffers from an analytical deficit. Home care and continuing care are complex and a higher level of analysis is required to address complex issues. There is a great deal of money spent on information technology and software which provides basic data, and comparatively little on the analysis which turns that data into new and useable knowledge. Dashboard systems and data warehouses typically provide simple, descriptive data. This is useful but seldom sufficient to inform more complex questions.

> **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.

With regard to accountability, there is already a good start in the home care sector, and we simply think that there should be an ongoing process to improve accountability between Saskatchewan Health and the RHAs.

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

9.10 Funding and Financing

The issue of funding and financing is very complex. There is a long chain of decisions which are made from the point at which taxes are collected to the point at which home care services are delivered. These decisions are based on overall tax revenues, historical precedent, and existing policies, politics, and values. Each of these decision points can have a material impact on the funds which flow to a particular area such as home care.

If home care is seen as a distinct service, then 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. Thus, one could argue for increased funding based on comparisons with other jurisdictions. It was also pointed out, by one respondent, that in 1995 Saskatchewan and Manitoba had reasonably similar per capita allocations for home care. Thus, one could argue for more funding based on a rationale of re-capturing lost ground and at least "providing the same level of home care which was available 10 years ago." Given the increases coming from the federal government to fund the FMM Accord, some additional funding will flow into home care. If one could argue for a modest budget increase based on the value of the program, historical precedents, inflation, increases in wages, and increased utilization, it may be possible, with the addition of federal funds, to obtain a modest but meaningful overall increase for home care services going forward.

Another option, or an additional option, would be to freeze new facility bed construction and re-allocate resources from residential care to home care. One could set targets such as 9,000 beds to 2021 or 90 to 100 beds per population 75+. One could achieve re-allocation from residential care to home care by closing beds, simply phasing them out at the end of their useful life, or moving funds for future bed construction to home care.

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 can be cost-effective, without reducing the quality of care.

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

9.11 Consistency of Service Delivery

As noted in the interviews, services are not always delivered consistently within RHAs or across RHAs. There is little we can say about this other than that the solution is in the hard, grinding and difficult work of effective administration. The solution is in the hands of the RHAs and Saskatchewan Health. Hopefully, the recommendations noted above related to funding, health human resources, and other factors will assist in bringing greater consistency. The infrastructure of committees between Saskatchewan Health and the RHAs already exists, and such committees should be mandated with the responsibility to provide services more consistently across RHAs.

There should, however, also be latitude to innovate and experiment. There could be a distinction between what are defined as core services which must be delivered consistently and what are "developmental" areas, where experimentation can flourish without being seen to compromise the consistency of core services.

9.12 Superstructure Issues

Again, there is little we can add. It is an administrative process to ensure that legislation, regulations, and policies exist and provide a helpful framework for care delivery.

9.13 Our Report in Context

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.

> **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.

We have very much appreciated the assistance we have received from Saskatchewan Health and the RHAs in conducting our review. We hope that our efforts can, at least in some small way, contribute to improving the delivery of home care services in Saskatchewan.

10.0 LIST OF 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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