House calls: building 21st century community-based care policy

by

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Project Rationale

Over the last several years, in all provinces, home care services have been directed to patients recently discharged from hospital, elderly patients in acute care settings with chronic conditions who are waiting for alternative care settings, and those defined as in need of end-of-life care. This prioritizing reflects both direct and indirect policy emphases set by the First Ministers Health Accord in 2003 and the subsequent foci of health care budgets. One result is the virtual disappearance from policy priorities of supportive services to elderly frail persons living in the community – the traditional home care clients. The negative effects of such program changes on service providers, the home care labour force, elderly persons and their informal support networks continue to be documented (Armstrong & Armstrong 2002; Aronson et al. 2004; Aronson & Neysmith 2006; Guberman et al. 2005; Gagnon, Guberman et al. 2001; Grenier 2005; Montgomery et al. 2005). Of concern is the fact that, although pressing at the moment, the above focus on acute care discharge patients distracts from the development of a much needed debate about what kinds of community-based services will best serve the needs of a changing aging population and family members providing care. This research provides data on how the needs of frail elderly seniors residing in the community and innovative service approaches that have the potential to improve their quality of life are shaped by changing policy priorities.

Despite the acknowledgement by health care professionals that supportive home care has important maintenance and preventive, if not substitutive, functions it continues to disappear off the policy priority agenda (Hollander et al. 2007). Some of these Canadian policy trends are occurring even in countries such as Sweden where home

care is well developed and comparatively still well financed (Johansson & Sundstrom 2006; Szebehely 2006); in the U.K. (Bowes 2007; Hancock et al. 2007; Pickard et al. 2007) and Australia (Fine & Chalmers 2000), two of the partners in this study. However, there are differences in policy assumptions about entitlements of elderly persons to community-based services. A catalyst for the international collaboration from which this paper emerges was the realization that one way to open up a narrowed vision of home care was to insert alternative realities, based on existent practices elsewhere, into the Canadian policy debate.

Study Focus

The research questions focus on both provisions (supply) and need (demand). On the need side are the emerging realities resulting from Baby Boomer population aging and demographic diversity. Consequently, the research questions assume: (a) a thinning of kin available to provide care because retirement and employment trends indicate that aging women (who provide much of the care) will be employed continuously and longer than in the past; (b) that Canada, as well as Australia and Sweden, will actively pursue an immigration policy aimed at alleviating predicted labour sector shortages in the next decade. If successful, this generation will be employed full-time and present the added policy and programming challenges of developing services that meet the community based care needs of a multi-ethnic aging population; (c) that those persons who on a daily basis deliver and receive services, whether categorized as new Canadians or Baby Boomers, as service recipients or providers, as part of the formal or informal system, must be part of policy development if creative responses are to be found that can address

these new realities. 1990 service packages will not meet the needs of Canadians in the 2020s.

On the supply side, it is assumed that despite the above pressures kin will continue to be responsible for ensuring that quality care is provided on the ground. Organizing services to support this work, rather than demanding more of women as care providers and recipients, will mean policy changes (see Decima (2002) for a national profile of family care givers; see Keating et al. (2003) and Lavoie (2000) and Lavoie & Guberman (2007) on the capacity of caring networks; see Hollander et al (2007) for three briefing notes to policy-makers based on their systematic review of the literature documenting the deterioration of long-term home care; see Cohen et al. (2005) for an assessment of the effects of funding changes on supportive home care in BC). Over the last decade Canadian provinces have developed funding approaches that reflect a "mixed economy of care" policy, albeit to differing extents across the country, that allow for user-pay options. In fact, at this particular historical moment in Ontario buying extra hours of home care continues to be the only option open to elderly persons who need more hours than are publicly available or do not meet increasingly stringent standards for personal care (Aronson & Neysmith 2001).

Across the country there have been innovative approaches to providing community-based services. For instance, demonstration sites using cash-for-care schemes and Carer Allowances have been mounted in several provinces (Keefe 2005). Canada has limited experience, however, with the broader ramifications of these programs but they have been extensively developed in Europe (Ungerson 2004) and evaluations suggest that Canada will need to proceed with caution if existent income,

gender and ethnic inequities are not to be exacerbated rather than diminished. In addition, organizations such as the Canadian Home Care Association, national commissions (Commission 2002) as well as policy academics (MacAdam, 2000; Neysmith 1995) have argued repeatedly for the development of national home and community care legislation such as that existing in Australia. Without it, advocates fear that infrastructure will continue to deteriorate as provincial differences and acute care health priorities impede the development of supportive home care. This is exactly what is happening as *House Calls* completes its first complete year of service.

All four research sites are examining approaches to supportive home care with a particular focus in what works, under what conditions, and how such services affect the quality of life of different groups of elderly persons. Following are the questions that informed what is being documented and compared across the project sites. In each site a "promising practice" has been chosen. Its characteristics are being documented and impact on clients and service providers assessed:

- What innovative service approaches have been developed in each site that mesh with their funding and organizational specifics while meeting the changing needs of their diverse elderly clients? Describe the project that was chosen as a "promising practice"
- What does each party, in the four jurisdictions, consider "best practices" in program design – whether or not these are part of the chosen "promising practice"?
- What do program managers, service providers and users consider to be the strengths and weaknesses of their local and regional funding and program structures?
- What measures of service outcomes are being used in the four jurisdictions? Do these incorporate indicators of the social determinants of health and quality of life? What costs are included and excluded?

The “promising practices” at each site are: Toronto – *House Calls;* Montreal - CSSS Cavendish's PALV program ("loss of autonomy related to aging“); Sydney, Australia – Benevolent Society care packages model; Stockholm – Municipal Home Care model.

House Calls – A “promising practice”

This paper focuses on the Toronto site (See attached poster). Features of the model are:

- an interdisciplinary team of community-based service providers consisting of a physician, social worker, community nurse, an occupational/physio-therapist and an array of home care and community services available through one of the sponsoring agencies;
- a distinctive client group is served – frail elderly individuals living in the community in isolated situations;
- designated team personnel that ensure on-going team relationships that can facilitate fast communication and flexible service while relationships between clients and individual team members are the basis for building trust that extends to other team members;
- continuous monitoring the social/health situation of clients, facilitated by mobile technology that also allows team members to be in constant communication;
- a collaborative governance structure with a guaranteed number of hours/month of service over a two year period.

This model reflects the importance of relationships in home care work documented in earlier research, including that done by the researchers (Aronson 2003; Grenier 2005; Mears 2007; Neysmith & Aronson 1996; Szebehely 2006).

Data collected:

- Assessment & follow-up data that are continuously updated
- Quality of life indicators, using both open-ended questions and a scale, from clients and family members - if the latter is a caregiver
- Service team dimensions – roles & functioning of individuals & as team members assessed
- Management team dimensions – "co-operative governance" as a model & as operationalized
- Services delivered – description & assessment of client impact & costs
- Researcher sits in on service and management team meetings as participant observer

This paper focuses on those dimensions of *House Calls* that are seen as local experiences that can travel.

The Immediate Policy Context: The Ontario Aging at Home Strategy

On August 28, 2007 the Ontario provincial government announced that it would invest $1.1 billion over four years through its Aging at Home (AAH) Strategy to expand community services for seniors and their caregivers, allowing them to stay healthy and live safely at home with dignity and independence while relieving pressures on hospitals and long-term care homes.

Six principals guide the implementation of the Aging at Home Strategy:

- **Senior centered** – services must respond to the needs of seniors
- **Community based and integrated** – with broader healthcare system
- **Equitable** – must recognize demographic and geographic challenges

- **Cost-effective** – best care at optimal cost recognizing benefits of volunteerism and community economic development
- **Results oriented** – results defined and measured to ensure outcomes
- **Local community oriented** – strategies that rely upon and leverage capacity in local neighbourhoods and within communities of like interest (ethno-cultural, linguistic, religious, sexual orientation)

In the introduction it was noted that a structural feature shaping policy and programs in most Canadian jurisdictions is that existent home care services are shaped by hospital based "problems". This continues to be the Ontario reality as I write this paper. In fact most observers would agree that, despite its original goals, the Aging at Home Strategy has shifted its emphasis such that now:

1. Home care is seen as addressing the waiting times in the emergency room (ER)
2. Home care is considered part of the answer to what in Ontario is called the Alternative Level of Care bed issue (aka, bed blockers)

House Calls operates within this structural reality. As the researcher who has tracked the project closely over the last 18 months, I am suggesting that it developed, and ultimately survived, at the innovation stage because of four features – reflecting activist visions:

1. A co-operative governance feature in which several agency heads committed two days/week of staff salary to the model. These agency heads met every other month to engage in hands-on problem solving. Since they were the decision-makers actions could be approved at the table – there were no delays because of approval required from higher authority.
2. A physician who chose to close his office practice to work full-time doing house calls for frail elderly isolated seniors – rare in the Canadian context because physicians are paid on a fee-for-service schedule.

3. A pro-active media campaign where the model was presented at service conferences, in documentaries, newspaper features, talk shows and photo exhibits.
4. Management Team members sat on key policy committees that affect the funding and practices of home care services: For example, the physician was a member of a combined Ontario Medical Association and the Ministry of Health Committee which is changing the fee-for-service structure for physicians making house calls to frail elderly patients; others sit on policy committees of the Local Health Integration Networks (LHINs) - all provincial health monies flow through the provinces 14 LHINs. The initiatives funded under the provincial Aging at Home Strategy (AAH) are being evaluated. I sit at the provincial level on a "panel of experts" that decides what are evaluation priorities and appropriate methodologies. Thus the Management Team is very tuned in to the rapidly changing political context

This is both the good news and the bad news. The good news is that vision and strategic planning is alive and well within what are sometimes seen as service bureaucracies. *House Calls* was initiated and up and running before the AAH Strategy was announced. Thus it was operational and able to quickly access opportunities available when the AAH strategy opened a policy window that was previously closed. The bad news is that organizational resources are put at risk in such undertakings. Also, innovation can only thrive in a policy environment of change. The latter is a critical feature in allowing innovations to develop and adapt over time. As the conclusion suggests *House Ca**lls*** is now facing this challenge.

Analysis:

In this paper I am focusing on the collaborative approach to program innovation that made this inter-disciplinary service team possible. However, we have been collecting client and team data and a few points are worth noting.

Clients & Family members:

After a year as an operating model with a two-day/week service team, *House Calls* was serving about 50 clients (because he was full-time, the physician saw many more patients individually). Discussion of quality of life amongst older persons is frequently equated with what is now termed health related quality of life. Health, along with income and social relationships, seem to be key ingredients to quality of life but even together they are not the equivalent. Equating poor health with poor quality of life negates the ability of people to overcome ill health, make adaptations that allow them to pursue goals (Hyde et al., 2003: 187); and reduces people to a medical category. In a "meeting of needs" policy perspective function per se becomes less important if the need can be met in another way. Such a model of quality of life postulates four domains of need: control, autonomy, self-realization, and pleasure. Control is understood as the ability to actively intervene in one's environment; autonomy is defined as the right of an individual to be free from the unwanted interference of others; self-realization and pleasure capture the active and reflexive processes of being human (Hyde et al. 2003).

The scale used with *House Calls* clients was developed/verified on a younger elderly population but its focused on the above quality of life dimensions, not just health. A strong argument from one of the community partners that at-home services was about quality of life in general, lead to the decision to use it here. The use of this scale is based on the argument that there is no reason to suspect that the same factors that affect the quality of life of younger seniors cease to operate on people as they get increasingly frail. Research does suggest that loss of mobility and other life losses are a negative but the argument could also be made that the health focus of so many quality of life scales

reflects a professional pre-occupation with health and its related resource issues. Because *House Calls* was a pilot project, there was an opportunity to move beyond conventional health related measures. Not surprisingly, *House Calls* clients seemed to score somewhat lower on quality of life measures (X=37.47 sd= 9.0) than the 65-75 year olds upon whom the scale was validated (X= 42.2; sd 7.8). I use the word 'seemed' because the numbers in the House Calls sample are small, e.g. 27.

The Service Team

Teams such as *House Calls* are usually developed to serve both client and professional interests (Bronstein 2003; Cashman et al. 2004; D'Amour et al., 2005). Thus, two important elements to consider are:

- the construction of a collective action that addresses the complexity of client needs, and
- the construction of a team life that integrates the perspectives of each profession and in which team members respect and trust each other

These dimensions interact. Their dynamics were assessed by asking each team member to:

1. Articulate the shared vision (the common goals) of the *House Calls* Team
2. Describe the way the team works together
3. State the rules (professional, organizational/ formal, informal) that guide team member actions
4. Express what each thinks organizationally needs to be in place in order for the *House Calls* team to work effectively

5. Complete a 26 item scale that taps into individual and organizational values that affect team dynamics

There are a number of influences that affect the dynamics and effectiveness of interdisciplinary collaborations, e.g. differing professional role expectations, personal characteristics, structural characteristics and the history of particular collaborations (Bronstein 2003: 303). Furthermore, teams go through stages of development. In a review of the literature in this area Farrell et al. (2001) referred to these as (1) the testing and dependency, or the "forming" stage; (2) conflict or the "storming" stage; (3) cohesion and consensus or the "norming" stage; (4) functional role development or the "performing" stage. Notes from bi-weekly team meetings indicate that the inter-disciplinary team went through the "forming" and "storming" stages as Farrell et al. (2001) suggest but after a year was developing cohesion, albeit challenged with two personnel changes.

The Management Team

House Calls used a collaborative governance model. After a year into the project management team members were asked to complete a scale that measured the relationship between partnership synergy and partnership functioning. It covered the following areas:

- Synergy – 8 items
- Non-financial resources – 6 items
- Decision making – 3 items
- Benefits of participation – 11 items
- Drawbacks of participation – 6 items
- Satisfaction with participation – 5 items

The results were consistent with the Weiss, Anderson & Lasker (2002) national study which showed that leadership effectiveness was the dimension of functioning most closely related to partnership synergy. Specifically, high levels of synergy are associated with leadership that effectively facilitates productive interactions among partners by bridging diverse cultures, sharing power, facilitating open dialogue, and revealing and challenging assumptions that live in thinking and action. Studies consistently show that effective partnerships need leaders that are able to understand and appreciate partners different perspectives, empower partners, and perform boundary spanning functions. Second is the dimension of partnership efficiency, that is, the degree to which the partnership optimizes the use of its partners' time, financial resources, and in-kind resources. Unless the assigned roles match particular interests and strengths, partners are likely to reduce their contributions. It supports other research that has emphasized the necessity of using partners' time well, given that the work is frequently not a partner's primary responsibility (Weiss et al. 2001: 693-94). This was the case with *House Calls*. In all of the interviews the partners noted that the time given was given willingly but it took a disproportionate amount of time given that the project was a very small part of agency budgets that ran in the $50 million range. The challenge is to figure out what promotes such leadership.

. In a review of the literature in this area and a study of several different models Nylen (2007) basically organized interagency collaborations into three models: assignments reallocation; commitment-based networking; and formalized team building, I would argue that, at the Management Team level, *House Calls* reflected the commitment-based networking model closest. This model builds on close, mainly

informal interaction among professionals, jointly producing new or improved services. Reputation, commitment and trust are essential components but the effectiveness consequences can be substantial. Such collaborations often combine limited resource commitments and can be accommodated within existing structures. However, its potential does depend on medium to high intensity commitment and interaction. Such a collaboration strategy is more dependent upon personal commitment than formalized structures (Nylen 2007: 163-164).

Conclusion – lessons learned

House Calls is moving into a new phase as I write this. It has received provincial funding to deliver service full-time. The original management team has changed and is expanding with new players at the table. The change was captured in a phrase used by one management team member – we are moving from innovation to the operational stage. In its new form there will be designated persons on a policy-making committee that provides guidelines for the service team. So at this moment of transition what are the lessons that can travel?

1. A catalyst gets things started – this is often an event or action that gets public attention. In this case, a NFB film and media profiling caught the attention of agency CEOs who were struck by a lone physician doing house calls and offered help to expand into an inter-disciplinary service approach that could serve more clients with a range of supports.

2. A shared vision amongst key players that maintains commitment of energy and resources. Data from interviews with management and service team members confirm that this vision was strong.
3. Leadership is multi-faceted. One aspect is the ability to act on the innovative idea. Risk-taking is part of providing leadership. In this case, agency resources were put on the line before a provincial policy was in place to support such a model. At another level, mobile technology was approved despite both its initial cost and training difficulties (studies elsewhere predicted this).
4. Anticipation that tensions/conflicts will arise; that they take different forms and thus requires different responses at management and service team levels. *House Calls* faced various forms of this. Amongst service team members an important one stemmed from professional power differentials. Amongst Management team members differences in priorities arose from agency jurisdictions and mandates.
5. Finally, recognition that the innovation stage of a project requires a different set of resources and skills than that needed as a project moves into the operation stage. In this case, success in getting the project publicly funded will mean changes in the dynamics of all players. Some things will be lost – as surely as there will be gains.

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