

SUBSTUDY 15

AN ANALYSIS OF BLOCKAGE TO THE EFFECTIVE TRANSFER OF CLIENTS FROM ACUTE CARE TO HOME CARE

**A Report Prepared for
the Health Transition Fund, Health Canada**

January 2001



National Evaluation of the Cost-Effectiveness of Home



and

Canadian Policy Research Networks Inc.



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**by Canadian Policy Research Networks Inc.
Health Network**

**Caryl Arundel
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PREFACE

The National Evaluation of the Cost-Effectiveness of Home Care is an integrated program of research with 15 studies being conducted across Canada. There is an overall strategy for the program of research to make it as useful to administrators and decision makers as possible. The program of research is designed to determine whether or not home care is a cost-effective alternative to institutional care, that is, care in long term care facilities and acute care hospitals. However, the program of research is also designed to provide an educational function to inform decision makers and the public about home care and to provide advice about issues related to implementing new and cost-effective home care initiatives. Thus, the overall strategy has the following components:

- Conduct studies to determine whether or not home care is a cost-effective alternative to institutional care, and if so, under what conditions it is cost-effective.
- Conduct studies to inform decision makers about the nature and scope of home care services across Canada. These studies provide a baseline of information about home care clients, costs, and utilization. This baseline is important because there is currently no national database on home care in Canada.
- Conduct studies to explore opportunities for potential savings in the hospital sector by substituting home care services. At present there are relatively few areas noted in the literature where home care has been shown to be a cost-effective alternative to hospital care.
- Conduct studies to provide decision makers with information about some of the issues they may face if they try to implement new initiatives to enhance the cost-effectiveness of the health care system.

This study, *An Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care*, was designed to identify blockages to systems efficiencies and some of the issues decision makers may need to address if they choose to implement programs to increase the cost-effectiveness of continuing care services.

The effective transfer of clients from hospitals to home care is coming to be an increasingly important policy issue. Substudy 15 provides an overview of the key issues decision makers may have to address if they wish to implement more effective transfers between hospitals and home services. The report identifies the key problems or blockages related to transferring clients from hospitals to home care. It also provides a list of best practices for streamlining the movement of clients between hospitals and home care.

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EXECUTIVE SUMMARY

Background

Home care is an important component of health care services in Canada. It serves three main functions – to support individuals to stay in their homes and communities, to facilitate in home convalescence and care of postacute patients and to prevent institutionalization and/or hospitalization. This study looks at one component of home care – the substitution function of care in the home for hospital care. Specifically it looks at acute care patient discharge from hospitals to home care and the effectiveness of the discharge process.

Acute care support is an increasing component of home care programs in Canada. While the proportion of acute to nonacute care service varies considerably across the country, it is estimated that approximately one third of all home care is acute care service. As hospitals are pressured by financial pressures, early discharge policies, emergency backlogs and admission waiting lists, quality home care becomes critically important. This has put pressure on the home care system as a whole and in particular on the discharge relationships and processes between the two sectors. Jurisdictions have responded in a number of ways and the literature documents a range of process and program best practices.

This study looks at discharge practice from a broader, systems perspective by investigating how roles, relationships and structural boundaries between the home care and hospital sectors impact on patient discharge. A systems framework developed by Mintzberg and Glouberman¹ was valuable in focussing attention on those boundaries at the hospital and home care levels and at the system level where they interact. The authors argue that the current way of thinking about the elements of the system overlooks this separation and differentiation and ignores the dynamic nature of the system.

Substudy 15 is based on a series of interviews and focus groups with hospital and home care-based practitioners in seven jurisdictions in Canada. These included people who provide care, are responsible for patient cure, represent the community and represent the administration, financial and policy controls on the system. The seven sites demonstrated a range of barriers that impede effective patient discharge. Barriers were identified within each of the interview subgroups, between them and between the two separate organizations. The sites also provided evidence of a number of best practices that served to span the boundaries and move towards greater program integration and coordination. There was limited evidence of system or structural integration.

The study has also been informed by an Expert Panel, representing a range of professions, organizations and interests. Their insights and expertise were valuable in reinforcing the importance of a systems approach to the study of patient discharge and in contributing to the identification and discussion of barriers and best practice issues.

¹ “Managing the Care of Health and the Cure of Disease: Part 1: Differentiation, Part 2: Integration” Mintzberg, H. and Glouberman, S. Accepted for publication in Health Care Management Review, February 2001.

Key Findings

Barriers to Discharge

The study identifies a wide range of barriers to effective patient discharge. They have been summarized into six main types of system barriers:

1. System Barriers to Working Together – includes barriers resulting from definitions of roles and responsibilities as well as the scheduling, availability and assignment of human resources.
2. Family/Caregiver/Patient Barriers – barriers resulting from resistance to discharge, lack of education/awareness of benefits of early discharge and lack of family or caregiver capacity to provide support to discharged patient.
3. Geographic Barriers – includes barriers in rural access to services, supports, equipment and supplies. Interjurisdictional barriers are also evident in “out of region” patient discharge.
4. System Management and Control Barriers – barriers resulting from inflexible governance structures, rigid systems, processes or controls. Financial controls put different pressures on each sector. Organizational focus on incompatible performance measures can similarly inhibit effective discharge relationships. Lack of common access to patient information is a significant barrier to patient discharge in some jurisdictions.
5. Constant system change – this overarching barrier inhibits the development of external formal and informal relationships and the focus and energy available for boundary-spanning initiatives.
6. Resource Barriers – three main types of resource barriers are identified. First, the system does not seem to be resourced appropriately to respond easily to new demands for service or to provide the range and scope of supports necessary to patient discharge. Second, shortages of trained health care professionals can result in barriers to discharge. And finally, limited community supports for discharged patients as well as few alternatives to home care discharge create barriers.

Lack of system resources is a significant barrier to more effective discharge in that it restricts organizational and program capacity to respond and diverts attention from quality service and care to rationing and coping. Cost shifting between acute care and home care sectors complicates the relationship often creating a win-lose climate for the interface. Cost shifting is also occurring between sectors, for example, as resources are shifted from long term care home supports to acute care home care supports. Not only is this anticipated to lead to greater demand on acute and institutional care, but it also leads to competition for resources within the community sector. The community sector in general is not resourced to support increasing postacute patients discharged from hospital. Costs are also shifted to the patient and caregivers as the types and hours of service are reduced and patients must pay much of the cost of

medications, equipment and supplies, which would otherwise have been covered in the acute care setting.

Best Practices

Effective discharge practice is a relationship between formal systems and structures, relationships and system capacity. Formal systems, processes and procedures are necessary to structure the relationship between the two sectors. They set parameters and define formal roles. Relationships and informal networks are important to bridge gaps between the formal systems and extend the effectiveness of the discharge practice. These relationships develop and endure outside the formal structure and role assignment. The third element, system capacity, is critical to support the two sectors to achieve effective discharge. Adequate budget, resources and program capacity are essential underpinnings of an effectively functioning system.

The study proposes a set of eleven factors important to best discharge practice.

Formal Systems:

1. Legitimization of the relationship between acute care and home care
2. Access to compatible and/or common information systems
3. Flexible use of resources

Relationships and Informal Networks:

4. Formal opportunities for communication and the development of working relationships
5. Continuity and stability of staff assignment
6. Boundary spanning positions

System Capacity:

7. Program resources
8. Access to home care – availability of referral and assessment service
9. Home care supports
10. Community supports
11. Continuum of care

Not surprisingly, no jurisdiction involved in the study demonstrated best practice in all the factors. Some focussed their energies within one of the three areas, formal systems, relationships and system capacity, while others attempted to make progress in all three. In many jurisdictions strong informal relationships between hospitals and home care staff were able to counterbalance barriers associated with formal systems and processes.

The findings also suggest that there are thresholds beyond which little additional progress can be made towards best practice. For example, most jurisdictions realized discharge-related improvements when roles and relationships were better defined between hospitals and home

care. Further progress appears stalled because of problems associated with client information. Until patient information is accessible and shared many are uncertain about further improvement in the discharge process.

Interface issues are complex. The study found that old methods of coordination based on standard responses to situations did not work well in the complex health care environment. Networks based on informal relationships were more important as approaches to develop best practices and to improve communication and education. The findings also suggest that there is no one approach to hospital to home care patient transfer that will work. Instead there is a need to recognize the unique characteristics of each jurisdiction and to capitalize on opportunities to strengthen relationships between the sectors and develop a common focus. A number of the jurisdictions are introducing boundary spanning positions or “boundroids” to informally support the development of stronger relationships between the sectors as well as to educate and facilitate the discharge process where necessary. Others are designing discharge positions to work within both the hospital and home care sectors.

The current climate of ongoing financial, policy and structural change also served to complicate the discharge interface. Two of the sites appeared better able to provide an effective discharge process in the current changing environment. Both home care programs were long-standing, well-focussed programs with “strong cultures” and positive reputations built on client focussed care. They had consistent leadership and direction. Both programs had managed, over a period of time, to build a strong set of formal and informal relationships with the hospital and community sector which served to support them when the formal relationships and environment were changed.

Related Issues

It has been estimated that families and informal caregivers provide approximately 80 per cent of all home care supports. Further work needs to be directed at understanding the linkages between families and informal caregivers and the formal discharge systems and programs. Not only do acute care and home care have to work together to effect patient discharge but they also have to work with the prime caregivers, the family.

The study cautions that changes to the relationship between acute care hospitals and home care programs will have impacts on relationships with other sectors. While it is important to achieve effective and efficient acute care discharge processes, attention must be directed to unintended impacts on the community sector and the continuing care sector in particular.

Substudy 15 raises some additional issues that deserve further attention and study. The relationship of home care to emergency departments is an important component of the hospital to home care interface that was outside the scope of this study. The study highlighted the need to build a stronger and more robust community service system to provide a broader range of community supports and to support care in the community. And finally, many involved in the study urged the development of more creative options to care for postacute individuals and individuals requiring higher levels of care than can be supported by current home care programs. At present, there are few alternatives to acute care hospitalization or institutionalization.

ACKNOWLEDGEMENTS

Many people participated in interviews, focus groups and telephone discussions and contributed enormously to this substudy. They patiently explained and described processes and how things worked and contributed insights based on their experience. The authors are grateful for their significant efforts and contributions.

In addition to those who contributed their time and ideas, there was a small group of people in each jurisdiction who helped organize the site visit, shared background material, identified contacts, helped organize focus groups, booked rooms and provided support. This was always in addition to their already overloaded work schedules. A special thanks to each of these people. Without their efforts the substudy would not have been possible.

And a final thanks to the Expert Panel for Substudy 15. Their insights and advice shaped the report.

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INTRODUCTION

This study is one of a set of fifteen interrelated substudies in the National Evaluation of the Cost-Effectiveness of Home Care being funded by the Health Transition Fund, Health Canada. The National Evaluation has two objectives: first it aims to directly evaluate the extent to which home care is a cost-effective substitute for care in long term care facilities and second, to directly evaluate the extent to which home care is a cost-effective substitute for acute care. Six of the substudies focus on the first objective, the cost-effectiveness of home care compared to long term care facilities, while the remaining eight studies consider the cost-effectiveness of home care compared to acute care. The substudies are being conducted across Canada by senior experts and academics in the field of home care and health economics. Together they will reveal a picture about the cost-effectiveness of home care in Canada.

Home care programs are an increasingly important component of the continuum of health care services. The success of in home programs as strong components of the health service continuum depends on a variety of factors including the quality of care, cost of care, access to services and relationships between the various organizations and providers involved in planning for and providing home care services.

Home care programs are generally described as having three important functions: a substitute function for services provided by hospitals and long term care facilities; a maintenance function that allows clients to remain independent in their homes/communities; and a preventative function, to prevent institutionalization or hospitalization.² This study focuses on home care and its role as acute care substitute.

If home care is to be a substitute for acute care, a smooth discharge process from acute care hospitals to care in the community is critical. Patients want quality, reliable and safe care both in the hospital and in their homes. They want the transition from one site to the other to be as smooth as possible. Substudy 15, *An Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care*, focuses on that critical transfer point of patients from hospital to home care. It explores the discharge process in a number of jurisdictions in Canada and uses findings from the sites to contribute to the understanding of the dynamics that impact on discharge processes.³

In 1996/7, approximately one third of home care clients were receiving home care to respond to acute care needs.⁴ This varied from a low of 20 per cent in P.E.I. to a high of 56 per cent in British Columbia (the B.C. number included palliative care clients).⁵ Acute care is an increasingly important component of all home care programs in Canada.

The reduction of hospital beds has resulted in acute hospital care for the most sick patients and has increased pressure on home care programs to provide in home care for the

² Portrait of Canada: An Overview of Public Home Care Programs (prepared by the Canadian Home Care Association in collaboration with l'Association des CLSC et des CHSLD du Quebec). February 1998, p. 1.

³ A copy of the Project Proposal is attached as Appendix 1.

⁴ Provincial and Territorial Home Care Programs: A Synthesis for Canada, Health Canada, June 1999, p. 29.

⁵ Ibid, p. 80.

others. Hospital discharge is occurring earlier and many patients are asking to return home, preferring to convalesce and receive care in their communities. And as the population continues to age, pressure will build on the acute care hospital and home care sectors.

Policies and practices respecting the transfer of patients from hospitals to the care in the home differ from province to province, within provinces and from institution to institution. There is much to learn from the variety of approaches across the country. This substudy considers the impact that the organizations, accountabilities, roles and relationships, mechanisms for coordination and formal and informal authorities have on the effectiveness of the transfer process in seven jurisdictions in Canada. These sites have been chosen to represent different geographic regions, different governance and accountability structures and different approaches to the organization and delivery of service. Focussing on the interface between hospital systems and home care systems, this study identifies existing blockages to the adoption of optimal discharge planning processes for transfers between hospitals and home care.

Canadian Policy Research Networks (CPRN) is working on the development of a framework for improving the understanding of health care organizations and systems. One important aspect of this framework considers the coordination of services across the many boundaries in health care. Substudy 15 builds on CPRN's work and considers boundary issues from a hospital to in home care perspective. It is an important opportunity to further understanding on system interfaces and barriers created and maintained by system boundaries. It also provides an opportunity to identify discharge best practices and to reflect on why they are successful and what system elements support the best practice.

PERSPECTIVES ON THE HOSPITAL TO HOME CARE DISCHARGE INTERFACE

There is a growing literature on acute care hospital discharges. While it is helpful in identifying specific discharge issues and interventions, typically it does not address the system interface issues between hospitals and in home care programs. This section summarizes the review of literature conducted for this research project. It looks at it from a system perspective and focuses on relationships, roles, and boundaries between the hospital and home care sectors. A synthesis of the relevant literature is included as Appendix 4.

Literature on hospital to home care discharge does not take a systems view of the interface between the two sectors. Many studies reviewed for this project focussed on discharge practices within a specific environment. Some consider the interface from either the home care or the hospital policy and organizational environment. Other studies use the patient care environment to review the relationship between hospitals and home care from the perspective of patient satisfaction and outcomes.

Within these limited contexts, attention is further narrowed on one or more elements of the environment or relationship. Frequently research attention is focussed on the roles and interrelationship of specific professionals in the discharge process, such as physicians, nurses, case managers, social workers, and discharge planners, as well as on the tools they use, including assessment criteria, case management protocols and coordination mechanisms.

The health care environment is complex. There are many players who operate on different levels. There are different funding mechanisms, goals, performance measures and policy contexts. The system is characterized by changing relationships. There is growing recognition in the literature that the discharge interface should be looked at from an organizational perspective as part of the broader health care system. This approach directs our attention to boundary issues between the hospital and home care sectors and to barrier and boundary-spanning opportunities.

Barriers and Boundaries

The literature identifies a wide range of barriers to an effective interface between hospitals and home care. These include barriers associated with relationships between different professional groupings in the health system. Others can be grouped into system barriers including the following: policy, funding, and system organization; information barriers; program and process barriers; and structure related boundaries.

Interprofessional barriers are described in the literature as major barriers. Barriers occur between professionals, between specific home care and hospital organizations, and at the system level between professional interests or groupings. Many different participants, each with a different but very narrow involvement in a process, can make communications more difficult and can result in poor relationships among those involved.

Differing perceptions and attitudes between professions also result in barriers. Patient referrals, care-based interventions and discharge can be delayed because of the requirement for physician authorization. Much of the system is based on the referral of physicians who are not

accessible to either the home care or hospital setting. Finally, the degree of professional specialization and bureaucratization within the hospital or home care environments creates additional barriers. Forms, processes, approvals and rigid procedures serve to increase workloads and constrain patient-centred approaches to discharge.

Similarly, the literature describes a range of broad system barriers to more effective patient discharge. Examples include lack of common system priorities, overemphasis/dominance of acute care and lack of incentives to change practice or approach.

Strong or long-standing organizational philosophy and culture pose system barriers to an effective hospital to home care interface if they are incompatible. The literature also identifies that organizational independence can lead to strong system barriers to collaboration and integration. System barriers can follow from policy, process or relationship entrenchment – using the past ways of doing things to define future solutions perpetuates existing boundaries and barriers and leads to narrow responses.

Many other specific types of barriers were identified in the literature. Perhaps the most important of this final grouping were the barriers created by lack of information and the challenges of incompatible information. Despite information systems and technological advances, basic patient-based data barriers continue to exist between hospitals and home care. And finally, many of the health care systems in Canada are undergoing significant policy, organizational and structural change. These changes tend to focus organizational attention and energies inward and divert attention from boundary-spanning, coordinating initiatives. Further barriers have developed as a result of this internal refocussing and activity.

Best Practices – Working Across Boundaries

The health care system is somewhat fragmented. There is a need for responses that work across boundaries and integrate processes and relationships. Research has recognized that there has been a great deal of project improvement but that it has been ad hoc and fragmented and has offered separate responses that address specific barriers or inefficiencies in the current systems. This includes the application of patient transfer tools, such as pathways, eligibility criteria and screening forms and mechanisms to coordinate the discharge process or various professionals involved in the process. Coordination can include the introduction of new discharge related functions such as discharge planning, social work and home care case management functions or working differently as in multidisciplinary teams. The literature also identifies some elements of system and organizational best practice and of patient focussed best practice.

Increasingly efforts like these are seen to be tinkering with the discharge relationships and processes and not tackling the nature of the problem. These initiatives are criticized for separating the broad discharge relationship into segments or increments and for tackling only a piece of the interface. They are usually discipline specific and focus within a function or area in either the hospital or home care systems. This serves to restrict and narrow the focus within the discharge planning process and will naturally favour tool and process focussed coordination. While many argue for better coordinated and more structurally integrated health systems, few

best practice examples of comprehensive change were identified in the discharge interface literature.

Coordination and Integration

Home care spans the acute care and community service systems and represents a unique opportunity to link and coordinate the sectors. This was recognized at the 1998 National Conference on Home Care when it defined integration as one of five elements of a national home care program⁶ as well as in a 1999 synthesis of home care initiatives and trends.⁷ It was argued that home care could be integrated with other health and community systems to form a coordinated system of home and community related service, embracing a broad definition and including a wide range of services. This new system was described as being seamless, comprehensive, well-planned, integrated with other health care services and having a single entry point. The creation of a new system may not be desirable or achievable, but the point remains that there is a need for the complex acute care and home care sectors to work better together. Unfortunately the literature does not provide much direction on how this could occur.

As health care organizations expand and the number and type of organizations they interact with expand, collaboration across external boundaries and/or structural integration become more important. Not unlike the discussion on barriers and best practices, current forms or levels of integration within the health care system reflect an incremental approach to integration. Coordination can be achieved through the integration of certain common or parallel functions between two or more organizations. Typically this could include administration, information systems and human resources. Clinical integration focuses on the coordination of care to a patient and crosses boundaries associated with different sites, processes and professions. The literature also identifies a third type of coordination – among physicians. This is described as occurring when there is a shared vision and set of values among physicians and the presence of economic motivations to physicians to participate in the system. System integration is described in terms of strategic alliances and partnerships, and contractual arrangements or mergers into single ownership. None of these adequately address the complex and dynamic nature of the health system and the need to span boundaries both within the different quadrants of the hospital and home care sectors and between the elements of the health care system.

Two types of integration are particularly important to the “systems” framed discussion of discharge. First, system integration could include structural, strategic policy and funding boundaries between the two sectors while program integration could include coordination, collaboration and more comprehensive service integration at the program level.

The development of a single point of entry has resulted in some coordination in the discharge process and relationship between hospitals and home care. It is recognized that other types of coordination and integration are needed. There are differing opinions about the ultimate form of a more effective hospital and home care system. Some argue that home care should not become an independent program and that the focus should be on its integration with the other

⁶ National Conference on Home Care - Proceedings, March 8 – 10, 1998, p. 81.

⁷ Health Canada, “Provincial and Territorial Home Care Programs: A Synthesis for Canada”, June 1999, p. 31.

parts of the health care system to which it presently connects, including acute care. Another perspective recognizes the integrity of the home care system as an important part of the continuum of care and cautions that it should not be merged into the acute care model. Rather, a new model and set of relationships, building on the strengths of both systems, should be developed.

Linked to the discussion of integration is increasing attention on organizational form and function. Again, while it is recognized that the current organizational forms do not adequately respond to the changing environment and the need for increasing integration, there is little consensus on the solution or organizational approach.

Implications for Substudy 15

The review of current literature is valuable in highlighting a number of issues for further review in this Substudy. Appendix 4 discusses the ideas presented in this section in more detail and provides further examples of barriers and best practices. While it is important to further our understanding of specific barriers to the hospital to home care transfers, much of the literature contributes little to our understanding of the overall system relationships and dynamics.

Reflecting on the issues raised in the literature review, there are some observations that must inform Substudy 15. First, existing hospital to home care interface discussions tend to reflect narrow discipline or practice specific perspectives. This limits attention on the broader system interface and relationship issues and results in ad hoc, separated, and fragmented responses at the margins of the discharge process. It does not support boundary-spanning initiatives which integrate structures, process or relationships. Second, while system change is widely supported, there is not agreement on the model and on the relationship between the hospital and home care sectors in that model. Case studies have therefore been selected which illustrate different hospital to home care relationships.

The literature identified barriers to change that tended to concentrate in profession related barriers – specialization, dominance of acute care, professional interaction – and those related to organizations – resistance, communications, lack of common goal/vision, entrenchment, lack of incentives to change. This study will test whether these barriers are reflected in the case studies in Substudy 15. And finally, the literature identified that best practices include a wide range of interventions within a hospital or home care sector or between similar functions or areas in each sector. These usually affect clinical practice and process, interprofessional relationships and patient related practices. Few system-wide best practices were described. In addition to other integrating mechanisms, Substudy 15 will look for evidence of system-wide best practice.

FRAMEWORK

A study of the discharge of patients from acute care to in home care is not new – it has been examined from a number of perspectives including policy, procedures, processes and players.⁸ What few have done is look at discharge as a relationship between two health providers or sectors, which in turn are part of a much larger health system. This project will take that approach and in doing so will contribute more broadly to the ongoing discussions about health system boundaries and efforts to overcome the barriers and span the system boundaries. Much of the thinking about this research has been guided by a paper by Henry Mintzberg and Sholom Glouberman⁹. Its relevance to the research is explored below.

In “Managing the Care of Health and the Cure of Disease”, the authors describe the current health care system as being characterized by extraordinary and increasing differentiation between the various service sectors. They argue that the current way of thinking about the elements of the health system reinforces this separation and often results in fragmentation and ignores the dynamic nature of the system. A new way of thinking about health care, they argue, is urgently needed.

In the paper, the authors divide the health sector into four worlds or ways of organizing. The four “quadrants” at the system level are: the acute hospital which focuses on “cures”; long term care facilities and primary care practitioners focussing on “care”; the “community”, represented by elected officials and advocacy groups; and the system “controllers”, the regulatory agencies, public health authorities and managers. These relationships are illustrated in Figure 1.

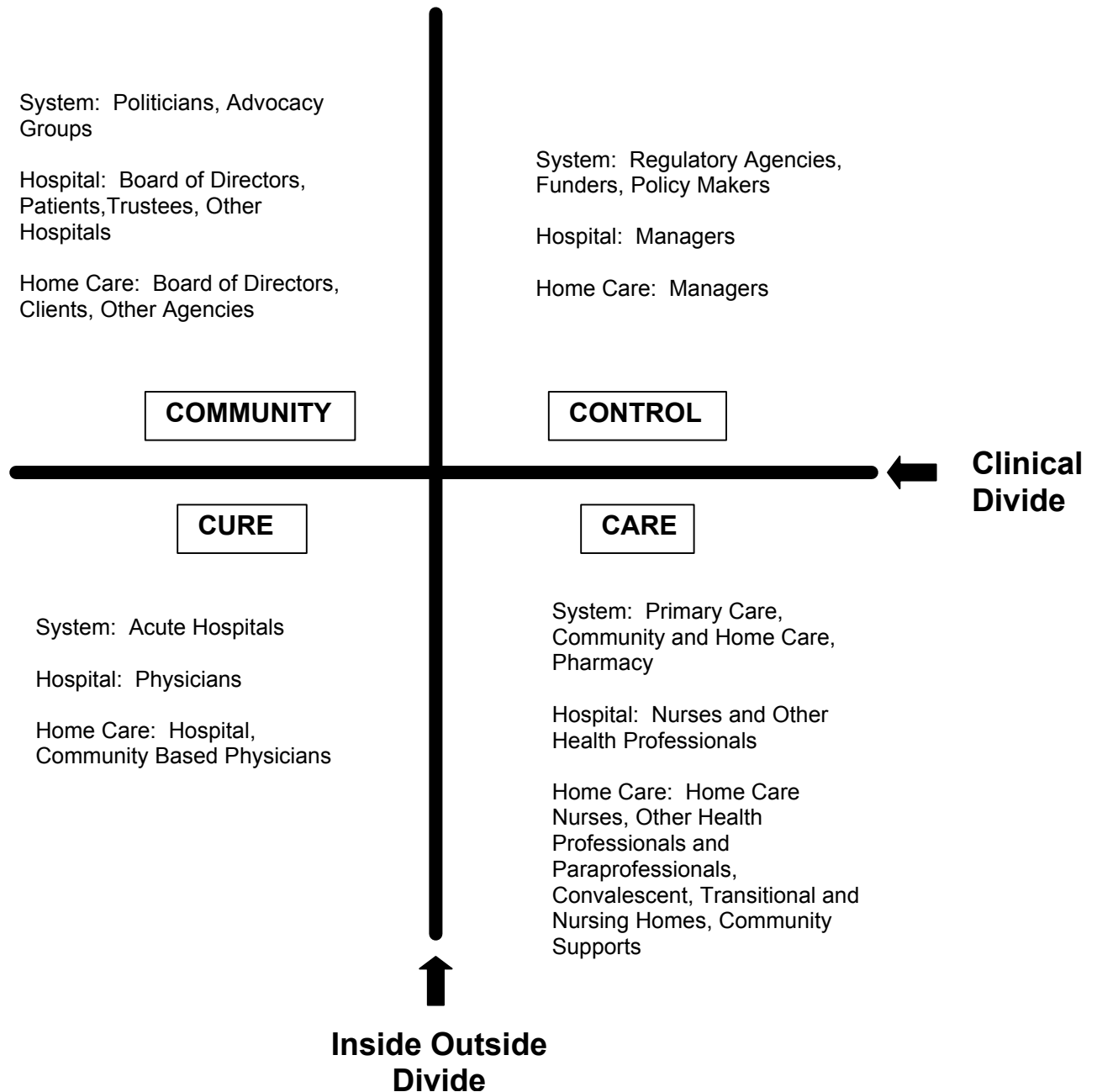
The four worlds of health care are divided by horizontal and vertical boundaries or cleavages. Hospitals focus on highly specialized delivery of “cure” based services to the acutely ill; other professionals outside acute care, including chronic and long term care hospitals, focus on “care”. Together they focus on direct delivery of service to the public. This focus separates them horizontally from the control world and the community. Control, exercised by regulatory agencies, governments and others, works above the services they are supposed to control. The control world is part of the health system. Community, elected officials and advocacy groups influence the system from outside the formal institutions and service delivery quadrants. A vertical cleavage separates the care and control quadrants from the community and cure quadrants based on the degree of connection and formal commitment to the health system as a whole.

The relationships can also be illustrated by applying the model to acute hospitals. For example, in the acute care sector, a horizontal divide separates those who operate clinically (the care and cure) and focus on the delivery of patient services, from those who work up and out of the clinical operations (community and control). A vertical cleavage separates those who work directly within the system, the nurses and managers, from those who are involved but not as committed to the system, the doctors and the trustees.

⁸ These are described in the literature review contained in Appendix 4.

⁹ “Managing the Care of Health and the Cure of Disease: Part 1: Differentiation, Part 2: Integration”, Mintzberg, H. and Glouberman, S. Accepted for publication in Health Care Management Review, February 2001.

Figure 1: The System View of Hospital to Home Care Patient Transfer¹⁰



¹⁰ Adapted from model in "Managing the Care of Health and the Cure of Disease: Part 1: Differentiation, Part 2: Integration", Mintzberg, H. and Glouberman, S.

Similarly, the model can be applied to home care. In home care, the care sector includes home care staff, nursing and convalescent care, community resources, etc. Community based and hospital physicians represent the cure side. The community includes Boards of Directors, Trustees, advisory groups, patients and caregivers. The control quadrant is similar to that in the acute care sector model.

The model presents a valuable way of thinking about the organization of health care because it reflects the multi-layered nature and the ensuing complexity of the health system. More importantly, though, it focuses attention on the boundaries between the quadrants. These boundaries serve to complicate efforts to integrate the different systems and coordinate the delivery of health care services. To the extent that the cleavages are not bridged, health care systems will remain out of control.

Efforts to smooth the boundaries between the system elements have either been unsuccessful or have concentrated on integration within one of the four “worlds” and not on the system as a whole. Until that happens, the various sectors in the health care system will remain separate and distinct, and attitudes and approaches to health will be inconsistent. Commitment to purpose, desire to advance knowledge and urgency were identified in the paper as three forces that serve to draw the different worlds closer.

In Part 2 of the framework the authors propose six basic ways to organize work. These are identified as:

- mutual adjustment – includes informal communication adaptation as people work together
- direct supervision – hierarchy of authority directs work and people
- standardization of work – procedures are simplified and the design of work changes
- standardization of output – there is a focus on the interface of different activities
- standardization of skills and knowledge – people are trained to know what to expect of each other and react with standard, automatic responses
- standardization of norms – common values, beliefs and people work towards common expectations

They argue that specialization in health care has led to standardization of skills, knowledge and procedure as the main mechanism for coordinating work. In reality, though, standard, automatic responses are not sufficient to coordinate work in increasingly complex medical cases or in large, complex health care organizations. The system becomes increasingly uncoordinated and work coordination by specialization is typically replaced by “informal communication embedded in a strong culture” as the main way of coordinating work. This second way of coordinating work occurs through processes of mutual adjustment and standardization of norms and values. Mutual adjustment promotes informal communication, networking and problem solving beyond the organizational hierarchy. Common values and norms refer to shared values between the hospital and home care sector which are consistent with the broader health system. Given the reality of strong and competing cultures imbedded in the different health sectors, this may be difficult to achieve.

The challenge identified in the framework is how to lever best practice by promoting coordination and integration between and within the four quadrants of the health care system.

This framework highlights the importance of understanding the complicated relationships and boundary issues between the various components of the health care system. It will be used in the study to identify and describe both the relationships at the health system level between the various “worlds” and the relationships between and within the home care and hospital sectors. Whom are the relationships with, and how do they evolve? What can be learned from attempts, successful and unsuccessful, to cross the “great divides” inherent in the current health system? The application of the framework to Substudy 15 represents an important contribution to the growing body of research on hospital to home care discharge interfaces and boundary issues and will enhance our understanding of broad health system boundary issues.

STUDY DESIGN, PROCESS AND METHODOLOGY

Objectives of the Study

Substudy 15 has been designed to look broadly at Canadian hospital to home care patient transfer experiences. It is based on insights from practitioners and other experts on the discharge relationship between home care and acute care hospitals. Learnings from these discussions and a series of study sites will be used to inform policy makers, planners and service providers about opportunities to improve the discharge process. The study has considered the hospital to home care relationship from a systems perspective and will also contribute to the understanding of how complex systems work together. The study has three objectives:

1. To identify key issues and challenges relating to the effective transfer from hospital to home care.
2. To describe and document case studies or examples of best practice.
3. To contribute to the understanding of the hospital to home care transfer process by identifying key learnings from the case studies which could inform future policy and program development.

Policies and practices respecting the transfer of patients from hospitals to care in the home differ from province to province, within provinces and from institution to institution. The diversity of experience suggests that there is much to learn from the variety of approaches across the country and from academic and professional studies and research on the issue.

Definitions

This study is based on a broad definition of home care which includes formal and informal community based care coordinated and/or provided by a publicly funded organization. The organization assesses eligibility and refers clients for service, provides case management supports and ensures access to the services provided by long term care, home support and home care. Home care organizations define the type of service they provide differently, but usually there are three elements: short term acute care, ongoing or chronic home care, and preventative supports which prevent early institutionalization or hospitalization. Some home care programs distinguish palliative care as a fourth service element. Using these definitions, home care is both a substitute and a complement for acute care and long term care.

Acute care has been defined as including acute hospital admissions and day surgery. While discharge does not formally happen in emergency departments, there are some innovative approaches to reducing backlogs and redirecting patients to supports in the community. Experience in emergency departments has therefore been included as it affects the discharge interface. It also must be noted that the study looked at one aspect of acute care discharge – the interface between hospitals and community based care. It does not consider the relationship between social services, housing, income supports, community supports and the health sectors.

Integration is used frequently throughout the study and it is useful to clarify its intended meaning. Two types of integration are particularly important to the “systems” framed discussion of discharge. First, system integration could include structural, strategic policy and funding system boundaries between the two sectors. Program integration could include various forms of system coordination, collaboration and more comprehensive service integration at the program level.

Synthesis of Relevant Literature

The literature review identified a wide range of hospital to home care discharge barriers and best practices. As discussed earlier in this paper, the literature review findings reinforced the need for a systems approach to the analysis of the hospital to home care transfer process. It summarized some perspectives on system integration and reinforced the need to better integrate hospital and home care systems. The literature discussion is attached in Appendix 4.

Expert Panel

A panel of experts, representing a range of professions, organizations and interests across both sides of the acute/home care boundary, has functioned in an advisory capacity to the project. They include medical, nursing, service and administrative experts from acute and in home care organizations and researchers who are knowledgeable about the issues. The Panel contributed to the development of the framework and the design of the process, and they provided input and comments to the project report and acted as a resource throughout the research project.

The Expert Panel met in June 1999 to discuss the framework, the approach and the design of the research project. The Panel was helpful in identifying study sites. They reviewed the findings and have had input into the final report. This input was valuable in applying and extending the framework based on their research and professional experiences and has informed the discussion of the issues in the paper.

Applying the Systems Framework

The framework, literature synthesis and expert panel discussions reinforce the value of using a systems perspective to examine the discharge relationship between acute care hospitals and home care. Boundaries between the two sectors and internal boundaries in hospitals or home care create barriers to effective patient transfer. Applying this framework, best practices are redefined as boundary-spanning initiatives that reduce or remove system barriers.

Substudy 15, then, is based on the application of this overarching systems framework. It explores boundaries, barriers and best practices through interviews and focus groups with key professionals to varying degrees in each of the four quadrants (care, cure, community and control) in the hospital and home care systems. Perspectives on boundaries, barriers and opportunities will vary depending on a key respondent’s position and role in his or her organization and in the broader health care system. These unique perspectives will contribute to a deeper understanding of the complex patient transfer boundary issues.

A survey instrument was designed to collect information on the discharge process in each jurisdiction as well as specific information about relationships, barriers, best practices and problem solving processes. Seven jurisdictions were selected for focussed study. Three agreed to be site visit jurisdictions, while the remaining four agreed to participate in a more limited way, through a series of telephone interviews. A copy of the interview template is included in Appendix 5.

The seven sites were chosen for a number of reasons. Some were identified by the Expert Panel or the researchers as having an innovative approach to hospital to in home care transfers. Others proactively indicated an interest in becoming part of the study. And finally, several jurisdictions were selected to achieve overlap with Substudy 6, which is investigating decision making processes of home care program case managers as they assess the most appropriate service for seniors applying for supports. It will be interesting to compare the results of Substudy 6 with those of this study and to identify areas for further analysis.

In addition to the home care and hospital interviews, a small survey was undertaken of clients recently discharged from acute care to home care. Each jurisdiction randomly identified 40 patients discharged within six months of the site visits.¹¹ The interview questions, included in Appendix 5, solicited their perspectives on the discharge process, how it worked and who was involved.

It was expected that between 8 to 10 individuals would participate in the study at each site. The response rate was 4 and 6 at the first two sites. Individuals interviewed tended to focus their remarks either on the care they received in the acute care hospital or the care they received from home care. They also commented frequently on the “speed” with which they were discharged – many were anxious about their early discharge. Few were able to comment on the discharge process itself and how they were involved and communicated with. Because of the low response rate and the difficulty in soliciting comments on the discharge process, the discharged patient interviews were not conducted at the third site. Patient and caregiver input is an important component of a study of effective patient discharge; unfortunately, the sample size was too small and the input too limited to draw meaningful conclusions.

Site Visits

Site visits were conducted between October 1999 and February 2000 in three jurisdictions in Canada: Simon Fraser Region in British Columbia; Thunder Bay, Ontario; and Fredericton, New Brunswick. Interviews and focus group discussions were held over three days with hospital and home care professionals in each jurisdiction. Between 16 to 30 people were interviewed at each site. Interviews varied from one to two hours in length. A consistent set of interview questions was adapted to the unique local circumstances and organization in each hospital and home care jurisdiction. Focus groups ranged in size from 2 to 10 people and were approximately 1.5 hours long. Detailed notes were taken at each interview and focus group

¹¹ A letter from CPRN was mailed to discharged patients inviting them to participate in a brief ten minute telephone interview. They also received a copy of the interview questions and a consent to participate form which they were asked to complete and return to CPRN.

session. Some were tape-recorded. The notes and tape recordings were analyzed to identify similar and divergent themes and to identify any patterns or relationships.

Professionals from each quadrant of the hospital and home care sectors in the model were included in the interviews and focus groups. In the acute care sector, the community quadrant was represented by interviews with members of the Board of Directors/Trustees for the governing body or bodies and a telephone survey of a sample of clients, discharged from hospital to home care. Interviews were conducted with one or two doctors/physician liaisons practicing in the hospital setting for the cure perspective. The care quadrant included interviews with hospital staff involved in the discharge process. This varied from site to site but could include charge nurses, discharge coordinators, social work, physiotherapy, utilization staff, home care coordinators, etc. The control quadrant was represented by two or three interviews with Provincial staff and staff in the acute hospital at a more strategic financial, operational and organizational level.

The community quadrant in the home care sector was represented by interviews with one or two members of the Board of Directors or the governing body as well as the discharged patient interviews described above. Where possible, interviews were arranged with up to two physicians working in the local community to provide input to the cure quadrant. Care included interviews with home care staff involved in the discharge process and involved in coordinating care in the community. This could include discharge planners, care coordinators, supervisors, intake, physiotherapy, social work, etc. The control perspective was contributed by two or three interviews with Provincial staff and senior staff in the home care organization with a strategic financial, operational and organizational perspective.

Phone Interviews

Four jurisdictions participated in a series of telephone interviews: Queens and Southern Kings Regions, Prince Edward Island; Sherbrooke, Quebec; Toronto, Ontario; and Saskatoon, Saskatchewan. Interviews ranging from 45 minutes to 1½ hours were conducted with between 5 and 8 professionals in each area. Because of the sample size, it was not possible to have adequate representation from the four quadrants with the small sample size. Instead, interviews focussed on staff involved in the process of planning, managing and delivering programs which supported effective and efficient discharge from hospital to home care. These included director/administrator level positions in home care and the hospital sector, staff from both sectors involved in discharge (which could include social work, discharge, nursing, etc). The interview and focus group questions used in the site visit jurisdictions were used in these key informant interviews with site specific modifications.

Findings and Analysis

This study has been designed to solicit insights from practitioners and other experts on the discharge relationship between home care and acute care hospitals. Interview methods and questions have been standardized and a consistent group of professionals has been interviewed at each site. However, it must be noted that this study was not designed as a formal social science

qualitative study and that qualitative survey and analysis techniques were not used in the survey or analysis of the interview subjects' input.

The systems framework is used to organize the findings and conclusions of the site based study. The literature summary has informed the research and members of the Expert Panel have provided input to the report and have helped shape the key observations of the report. The report summarizes the findings from the seven sites and identifies issues and trends based on the research. It includes a detailed discussion of barriers to effective discharge and examples of best practice as identified in the interviews. A preliminary list of factors leading to best discharge practice has been developed. Issues raised in discussions with the seven jurisdictions that did not fit with the systems framework or the study terms of reference are raised in the Other Issues section.

Appendix 1 of the Substudy contains summaries of each of the seven jurisdictions included in the research.

HIGHLIGHTS OF EXPERT PANEL FORUM

The six-member Expert Panel¹² met in June 1999 in Toronto to discuss the systems framework and the approach to the project. The literature synthesis and proposed study design were also presented for their input and comment. It was a very productive and stimulating meeting. Despite their different backgrounds and experiences in the health care system, all members reiterated the need to develop a better understanding of the system issues affecting the acute care hospital to home care interface. They observed that a blurring of boundaries was occurring as “cure” was moving increasingly from the hospital setting to the community. It was expected that funding shifts from acute to community care would change the dynamics of the scale and power relationships as the community sector grows. Other evidence of the blurring boundaries was the growing interest in boundary “extenders” to extend the traditional roles of doctors and nurses and cross the care and cure boundaries.

The Expert Panel cautioned that health care is viewed as episodic fixes of illnesses and disease. It is not structured or focussed on the coordination of a continuum of services. Until this changes, it will be hard to focus attention on building a strong community care system. It also highlighted the difficulty the system has in serving people with multiple, chronic illnesses that do not fit easily into the current narrow model. They argued that there needs to be a distinction between discharges for episodic, acute patients and ongoing patients who have multiple, chronic illnesses. The needs of ongoing, complex care patients were felt to be harder to assess and serve in a system where both the hospital and home care programs are focussed on specific acute care interventions and quick discharges.

The cost shifting from hospital to home care was identified as a tremendous obstacle to discharge as patients are increasingly unable to afford the necessary supplies or the personal care supports that they need. In addition it was noted that some home support services are not available or sufficient to meet client need through home care. Patients who can afford to augment their home care services do well, while others struggle and their informal caregivers and family members come under increasing pressure to provide care and support to fill the voids. Both health and community system funding is rigid and tends to focus on specific interventions rather than the needs of the client. This makes it difficult to integrate with other funding to provide an appropriate package of services.

The Panel questioned the current emphasis on efficiency in both the hospital and home care sectors. Hospitals are measured on their utilization and discharge statistics rather than the requirement that they ensure there is an appropriate care plan in place for the discharged patient. Increasingly the home care system is also measured by length of service and the emphasis is similarly on quick and efficient discharge. A tension was identified between efficiency and effectiveness. Performance measures are not consistent between the two sectors and rarely reflect population based outcomes. Until the health systems are more responsive to their population there will be no incentive to prevent crisis and medical intervention.

The problem with discharges is not the planning for the discharge but the implementation of the plan. The Panel noted that the biggest barrier to implementing best practices is time.

¹² See Appendix 3 for a list and brief description of the Expert Panel.

They observed that the discharge interface is given less than enough time in the system – in a system that expresses its value of a program or intervention in terms of time, discharge is clearly a lower priority. This message filters down the system and discharge barriers result. They also noted that a great deal of time is spent on parallel work, assessments and evaluations at various levels and at various points in the process. There is clear duplication of effort among hospital staff and little integration of perspectives and knowledge concerning what is already known in the community about the individual.

Finally, the Panel cautioned that the study was focussed on one element of the broader community system. Supportive housing, adequate income and other social supports are necessary components of a community system that are outside the parameters of this study.

The Expert Panel discussion was extremely useful to the design and conclusions of the study. First the Panel validated the use of the systems approach in the review of acute care to home care discharge practice. Second, the Panel Members accurately identified a range of issues that would be important to the study based on their extensive experience in the area. In a number of examples, these issues were not discussed in the literature and could only have been identified by people with experience in the health care system. While not always directly noted, their valuable insights have informed the discussion throughout the paper.

ANALYSIS OF FINDINGS

How does discharge from hospital to in home care happen? What are the barriers to more effective and efficient patient transfer, and what hinders best practice?

What are some of the discharge best practices? Is there a set of common best practice elements?

What factors support “best” practice, and why do they work?

These important questions will be used to focus the discussion of findings from the seven study jurisdictions.

Organizational and Structural Contexts

Discharge happens differently in each jurisdiction reflecting the different organization of health and social services in each of the provinces. There are some common practice elements but there are also a number of important distinctions. To understand them, it is useful to have a brief overview of the organizational and structural context in which acute care hospital to home care discharge occurs.

There are two basic models of organizing. In four of the areas (Saskatoon, Sherbrooke, Simon Fraser Region and Prince Edward Island) home care and hospital services are part of a regional board that provides and manages a range of health services to a defined geographic region. In New Brunswick, home care and hospitals are part of a Regional Hospital Corporation established in 1996 that manages hospitals, home care and rehabilitation services. Other services including long term care supports are managed separately. In the two Ontario jurisdictions, home care and hospital services are separate. Under any of the organizational arrangements, home care services can be directly provided, purchased from profit and/or non-profit organizations or a combination of both.

Home care agencies have experienced change associated with budget and resource pressures, increasing demands for service, and changing expectations regarding service but have usually retained their organizational integrity within their governing structure. In Ontario, new community based non-profit organizations were established in 1997 combining the service access, case management and administration of direct service.

Most jurisdictions are facing some type of hospital reorganization/restructuring as a result of funding pressures and/or policy changes. The results are more significant in some areas; however, the pressures and the actions taken to reduce costs by closing beds and reorganizing appear to be consistent. Mergers of hospitals to form larger organizations have occurred in many of the jurisdictions and changes within the existing hospital groups have reoriented some facilities to serve new or different target groups.

Most jurisdictions, with the exception of Toronto, have a single governance structure for their acute care hospital(s). It is important to note that this could be expected to lead to some consistency in policies, procedures and cultures, but there were few examples where this has happened. In situations where hospitals report to a regional board they seem to have maintained a degree of their operating autonomy. Differences between the hospital institutions were noted regularly in the site interviews/focus groups. In situations where hospitals have been merged, the new organization is too new to have addressed inconsistencies and differences. While the number of independent hospitals in Toronto has decreased as a result of mergers and closures, the Toronto CCAC must still liaise with five separate acute care organizations, many of which have more than one acute care site.

While there are different models for governance and organization it must be noted that each jurisdiction also faces different issues based on their differing stages of organizational development and change. It is likely that some of the barriers identified in the following discussions may be related more to the state of change and organizational transformation than the actual model of organizing and governance.

Service Delivery and Policy Contexts

It is also necessary to understand the service delivery and policy contexts. Again there are important differences that may affect the effectiveness and efficiency of the discharge process. In Sherbrooke and P.E.I. the in home care staff respond to written referrals from the acute care hospitals. They do not have staff who visit or work in the hospital. In all other sites, home care staff work in the acute care setting to assess eligibility for home care services. Fredericton has combined the two hospital and home care positions responsible for discharge and has created a new integrated position, staffed by hospital and home care staff. Some jurisdictions are more proactive in case finding – having home care staff review hospital records to identify patients who may be nearing discharge and might need home care supports. In others, staff respond to referrals for service from hospital professionals. Because they are located in the hospital they are able to conduct an assessment and to discuss service options with the patient.

A variety of service models are evident in the acute care hospitals. Nurses, including head nurses, charge nurses and/or nurse managers, are actively involved in discharge and transfer of patients to home care. Physiotherapy, occupational therapy, social work and other professionals also play important roles in the transfer process. All jurisdictions require a physician's signature if medical orders are required for the discharged patient. Practice varies regarding physician signature if medical orders are not required – some locations are able to proceed to arrange the necessary in home services based on a request from any authorized hospital professional. Some hospitals have discharge planners, utilization coordinators, admission/discharge coordinators and other similarly focussed positions.

It is important to note that most of the hospitals participating in this study are larger regional hospitals, tertiary care hospitals and/or teaching hospitals. Only two hospitals are smaller community-based facilities. Discharge appeared to work more smoothly in the smaller facilities. Teaching hospitals were identified as requiring different responses, but they were neither consistently easier nor more difficult than nonteaching hospitals.

Provincial staff were interviewed in Thunder Bay, Simon Fraser Region and Fredericton. In Ontario, hospitals and home care report to different branches in the Ministry of Health. There is a Ministry of Health staff member with responsibility for home care in Thunder Bay; there is no Ministry of Health representative for hospitals in or near Thunder Bay. British Columbia integrates acute and continuing care in regional program advisors based in Victoria. In Fredericton the Extra Mural Program reports to the same division in the Ministry of Health as the hospital corporations although to different Directors in the division. Other than setting broad program policies and standards and providing funding, the provinces are not identified as having much of a role in any of the jurisdictions. They are not seen as proactively supporting or facilitating new approaches, innovation or change. Usually they are described as a “hands off” level of government.

There is very limited connection at the Provincial level of either the hospital sector or the in home care sector to the broader range of community and social supports. In P.E.I. the Ministry of Health and Social Services is responsible for both health and social services. Despite this linkage, provincial policy and coordination appear to occur along more traditional, segregated lines and there is little integration at the delivery level. In Sherbrooke, the CLSC (Centre local des services communautaires) delivers in home care and delivers or provides access to a broader range of community services. The CLSC model is the most integrated of those studied. New Brunswick is considering the establishment of regional health corporations, which would integrate the long term care program in addition to other program supports with those currently delivered at the regional level. All other jurisdictions maintain a separation between the two human service systems.

System Pressures that Impact on Patient Discharge

Increased attention to in home care services is a result of two related forces. First, there is a political and policy direction which recognizes that people prefer to receive care in their home than be hospitalized, and there is some evidence that they recover more quickly than when hospitalized. Second, a resource squeeze which has reduced the number of hospital beds (and sometimes hospitals) available in an area necessitates more efficient use of the existing beds to accommodate the demand or need.

All the hospitals that participated in the study felt ongoing and intense pressure to move patients through the hospital system as quickly as possible. Whether the reasons for this pressure related to backlogs in emergency rooms for people waiting to be admitted to hospital, or the actual or potential cancellation of surgery due to lack of beds, or the need to reduce costs by reducing average lengths and costs of stay, the pressure was the same. Rarely was changing patient care philosophy (patient does better and wants to be at home) offered as the primary reason for the pressure to discharge.

In these jurisdictions, home care then is both a continuation of medical and nonmedical (home and personal care) supports after hospitalization as well as a substitute for hospital care.

Barriers to Discharge

The barriers to effective patient discharge identified in the site visits were reasonably consistent with those identified in the literature search. The importance or impact of particular barriers varied from site to site, but they fit within the range of process, professional, organizational, program and administrative barriers.

Barriers are important from two perspectives. First, they indicate specific problems with the discharge process or the services available to discharged patients. These inhibit effective patient discharge and need to be reduced or eliminated for the process to function more effectively and smoothly. These tend to be addressed individually as they arise. Second, and most importantly, they highlight system barriers between acute care hospitals and home care programs. Literature on discharge interfaces increasingly calls for broader system change to address the barriers, noting that while incremental change focussing on a particular barrier may reduce that barrier, those types of improvements do not lead to significant system effectiveness. It is important therefore to consider discharge barriers from a systems context by looking at barriers between the four quadrants (care, cure, community and control) in the hospital and home care sectors.

Barriers occur at different levels in the health system. They can occur at the system level between different quadrants or within a specific quadrant. They can also occur within the hospital and home care sectors, either in or between quadrants in those sectors. They can even occur within a sector which is accepted as integrated. For example, while hospitals are considered to be integrated systems, barriers continue to exist in the care and cure sectors. Figure 2 illustrates the complexity of the barriers. The description of barriers has been organized to reflect the different types of barriers at the different levels of the system.

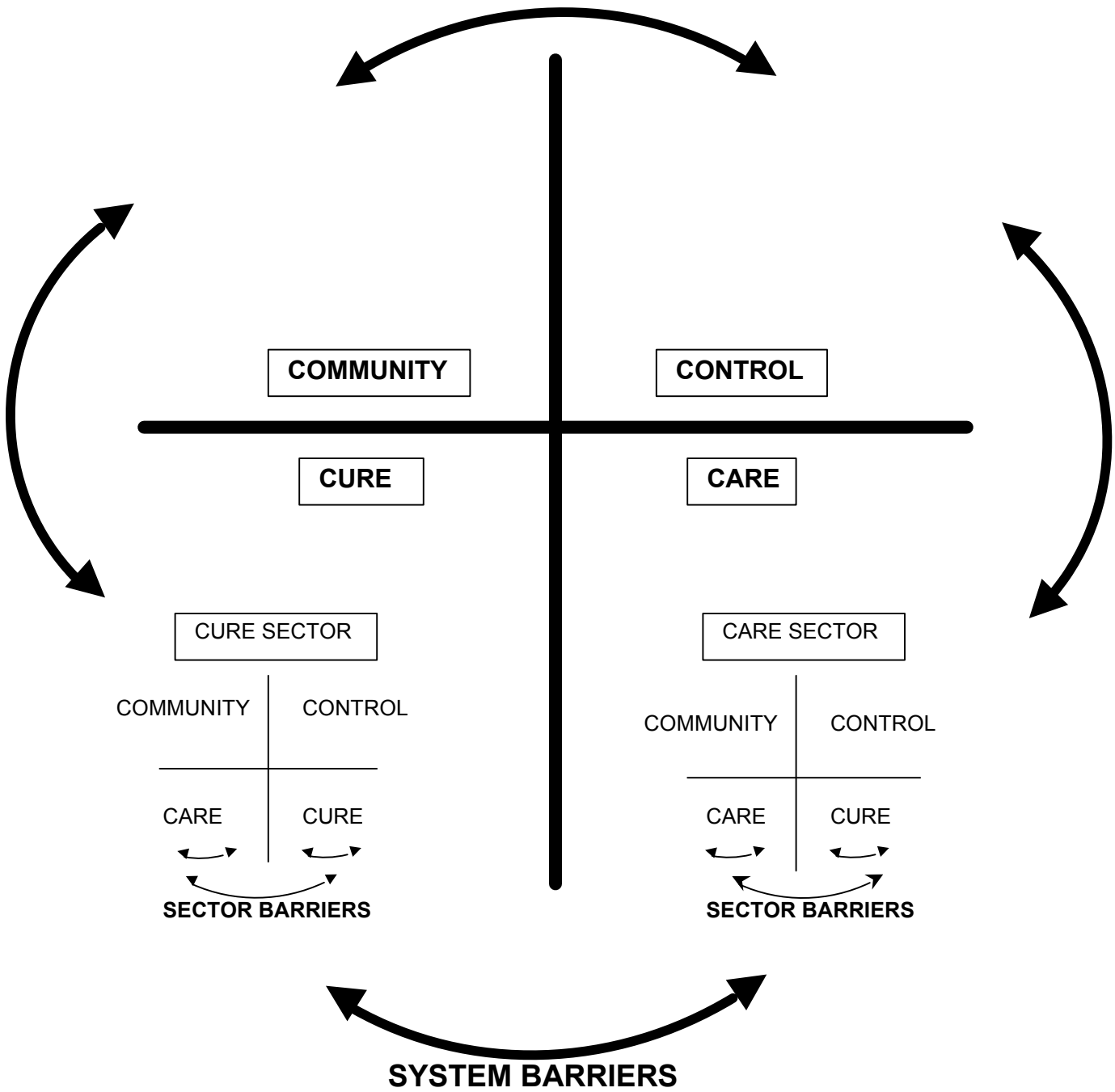
Hospital Sector

Care

“Care” in the hospital sector includes those professionals who and services which care for and support patients receiving medical treatment or interventions in hospital.

Some hospitals have made changes to nursing positions and staffing in hospital wards. In a number of situations they have replaced head nurse type positions with positions like primary care nurse (a nurse with focussed responsibility for a limited number of patients) or nurse manager (with greater administrative, scheduling and management responsibility). The loss of the coordinating head nurse was reported as having a negative impact on the time it takes to coordinate discharge on a ward or floor. Hospital-based professionals commented that they could always go to a head nurse for information on a patient and they could rely on the head nurse to coordinate or direct what needed to be done to effect a discharge. Without that one pivotal resource, discharge is more complicated and takes more of their time. Many hospitals have also made changes to other positions, changing roles, reporting relationships and accountabilities. This further exacerbates the difficulty of building effective internal relationships.

Figure 2: The System View of Barriers



Delays in tests, laboratory results and consultations with specialists result in both minor and major delays to discharge. In addition, shortages of Occupational Therapists, Physiotherapists and Geriatricians also contribute to discharge delays. As the population ages these professionals become critical components of a decision to discharge and of the decision regarding a patient's placement after discharge. Delays can range from a few days to weeks in some jurisdictions.

Responsibility for patient discharge is not always clearly assigned. Some hospitals reported that they previously had discharge planner type positions but that these have been eliminated as part of the budget reductions and restructuring, and discharge responsibilities have been transferred to the nursing team. In reality, "no one has responsibility for it.... There is no accountability."

In addition, a number of hospitals have moved to 12-hour nursing schedules. It was reported that this makes communication more difficult between the nurse and the other professionals involved in discharge. Widespread shortages of RN's have resulted in greater use of temporary, part-time, contract and agency staff. Communication is affected by the lack of continuity and discharge delays occur.

Cure

Physicians are the hospital-based professionals involved in patient "cure".

Physicians were consistently identified as an important barrier to effective discharge. Physicians do not always participate in rounds, nor do they make their patient visits regularly or in the mornings. The result is that discharges may not have been discussed in advance with the care team and/or they may occur in the afternoons or evenings. While this frees up a hospital bed, it is usually too late to have an impact on cancelled surgeries. Frequently professional staff commented that "they are expected to be mind readers" to have plans in place and anticipate when the physician will discharge.

Physicians tend to work Monday to Friday. They cover weekends on a predetermined shift. It was identified that physicians will not usually discharge another physician's patients on the weekend but will wait for their colleague to return after the weekend. Many physicians were described as having a poor understanding of home care, its limitations and capacities – this was seen as limiting their discharge options. Of other physicians, a "handful" were identified as resistant to "early discharge" and home care. Both groups contribute to longer hospital stays and less efficient discharge processes.

Within the "physician grouping" two subgroups were identified: specialists and residents and/or interns. Specialists were identified as not having an interest in discharge. It was suggested that their focus on a specialization prevented a broad perspective on how and when a patient could be discharged. Teaching hospitals created different challenges because the regular turnover of residents and interns resulted in continuity and communication problems.

Conversely, it was noted that interns and residents spent more time with a patient and could therefore better support patient discharge.

Community

The Board of Directors, Hospital Trustees or Community Advisory Groups are examples of the “community” sector in an acute care hospital.

The hospital sector is seen as having weaker links with the community than home care does. In jurisdictions where hospitals are separately accountable to the Province, they have Boards of Directors; however, members of these boards represent a variety of interests, not just the local community. In other jurisdictions where hospitals report to regional boards, there is no independent and separate hospital board or advisory committee to involve the community.

Home care is seen as having stronger links in the community. It was criticized in one jurisdiction by a Board member because it did not play a bridging role between the hospital and community. “Home care has valuable input from the community that the hospital needs to benefit from.”

Patients discharged from acute care to home care who agreed to be interviewed for this research do not appear to be affected by the relationships between hospitals and home care organizations. They were more concerned with in hospital care and the services they received from home care than the process of transferring their care from one sector to the other.

Control

“Control” is represented by the administrators and managers within the acute care institution.

Hospital managers and administrators have many issues competing for their attention. The dominant ones relate to the financial cutbacks and organizational and structural changes to the hospital sector. Understandably, for the past few years, hospitals have focussed most of their energies internally, within their own organization and within the sector. The attention that has been directed at patient discharge tends to be from the hospital’s perspective of bed utilization rather than the continuum of care to the patient. The development of a more effective system relationship with an external sector like home care or the broader community has not tended to be a priority. Similarly, most provincial governments have been focussed on sector-wide policy and structural reform. Little attention has been directed to better coordinating acute care hospitals and home care to provide more effective patient transfers.

Home Care Sector

Care

“Care” includes community-based nursing and professional staff who care for patients discharged from acute care hospitals.

Home care usually serves two main client groups: the chronic, ongoing clients (the largest group) who are supported to remain in the community, and the shorter term, acute care clients. The different client groups may lead to tensions and competition within the home care organization for resources and attention. In more than one jurisdiction home care staff noted that their ongoing clients had service reduced in order to move resources to support the acute care clients. In this example, cost shifting occurred among the different client groups, acute care and long term care, within the home care program. Similarly, tensions were noted between home care staff working in the acute hospitals and their colleagues who coordinate and manage service in the community. The community staff often felt that their hospital counterparts authorized too much service which led to unreasonable client and family expectations regarding continuing service levels. They commented that they “felt set up” because they would have to take away and reduce the service levels.

Similar problems occur between home care organizations regarding out of district clients. In some jurisdictions, out of district clients represent the majority of the caseload. Often the home base home care organization has different program criteria or entitlements based on their resources and capacity. Problems occur when the patient is assessed as eligible and is authorized to receive a level or type of service that the home base organization will not or cannot support.

Each home care organization spoke of the challenges it faces in responding to increasing numbers of requests for greater amounts of service. While they may have received additional funding or resources to allow for service expansion, it was not enough to meet current demands. In some jurisdictions services are rationed among existing clients as new priority clients are taken on. Other clients are placed on waiting lists that vary from a few days to weeks in length.

A widespread shortage of nurses and physiotherapists also leads to delays in home care service and delays in discharge. Only one jurisdiction participating in the study reported that it had closed its intake to new clients. Most cited jurisdictions near them which had closed new intake for at least two weeks at a time because they did not have enough nursing staff. All had long waiting lists for physiotherapy.

Thunder Bay was unique because it covered a very large and remote geographic area. Additional care barriers in Thunder Bay included basic service access issues such as whether the patient could be returned home in the winter and travel time for home care staff. In addition to barriers of basic sanitation, running water and indoor toilet facilities, there are barriers of access to less common medical supplies and equipment and challenges regarding home care staff training in more recent or less common techniques. Fredericton also covered a large urban and rural geographic area and cited similar problems with travel time, weather and access to expertise.

As medical interventions rely more on technology and advanced techniques, skills and experience of home care staff training can also create barriers. Difficulties in finding staff with appropriate training and experience or in training existing staff were identified as discharge barriers. As care becomes more complex this will become an increasingly important issue.

Most hospital-based home care staff work in challenging conditions. They do not have adequate access to computers, they have limited/no clerical support, and they often do not have adequate office space or equipment. In some settings they have limited contact with their counterparts because they are located in different areas of the hospital.

Not all of the home care programs included in the study have adequate information systems. One of the larger home care providers commented that it manages its clients using an accounting database system. They hope to develop a client-centred system in the future. Part of the design of a more effective discharge process would include a home care database with linkages to the hospital database.

The home care referral and assessment process varies significantly across the seven sites. The paperwork associated with a home care referral was identified as a barrier to more timely discharge. Some home care programs are more formal and require that the hospital complete the applications with the required information and signatures. Others are less formal and will process hospital referrals based on informal verbal or written requests. In both cases, the procedures and paperwork are time consuming.

Cure

Physicians are responsible for providing and coordinating “cure” in the community.

Home care staff must work with physicians in the community to coordinate care arrangements for their patients. They must also work with hospital-based physicians and specialists with regard to patient discharge from the acute care setting. Through their work as community care providers they often play a role linking the two physician groups.

Home care nurses are the dominant professionals in the community. They coordinate and manage the care to the discharged patient. Physicians hold the patient records and are required for prescriptions and orders; however, they are less dominant in the community care sector. Home care’s relationship with community physicians is uneven. Physician contact usually occurs when home care providers need interventions or changes that must be authorized by physicians. Often the two groups work in parallel within their separate sectors, with different patient records and information. Physicians who do home visits have greater contact with home care and involvement in ongoing patient care.

Home care’s relationship with the “cure”-based, hospital-based physicians is consistent with the issues and barriers identified by professional staff within the hospital sector. One possible advantage home care staff have over hospital staff is that they are not part of the acute

care system or power dynamics. In most situations they are able to approach the physician as a parallel service provider, more like an equal.

Community

“Community” is represented in the home care sector by the Board of Directors, Trustees and/or Advisory Groups. In addition relationships with other community providers, patients and their caregivers are important.

Home care organizations have varying relationships with the community and therefore identify different process and relationship discharge barriers. Ontario-based home care programs are governed by community-based Boards of Directors. Others have a less direct and formal community relationship. The barriers also vary depending on the form of the relationship – some jurisdictions contract with community providers to deliver all or part of the home care services while others deliver it all. All jurisdictions noted the limitations of the community system to provide the wide range of supports to meet increasing client demand and its impact on the home care clients. All commented on the fragmentation of the community system and its impact particularly on care to clients with complex and ongoing needs.

Cultural and family-based barriers were also raised in all jurisdictions as the home care sector struggles to make its services more broadly accessible and culturally sensitive. It was also noted that cultural and family expectations regarding acute care and the level and scope of home care support created real barriers to patient discharge. There is still a gap between patient and family expectations of the two sectors and the reality of what the sectors can provide.

Control

“Control” is represented by administrators and managers operating within the home care sector.

Home care sectors face many of the same control barriers as hospitals. Although their budgets have tended to increase, they are still limited and are usually insufficient to meet the demands on their system. Much attention has focussed internally on their systems and processes, performance measures and statistics. Some suggest that this internal control focus has overshadowed attention on quality service to clients.

System Barriers

Care

“Care” includes the range of community- and institution-based professionals providing care in the health care system. Home care is one part of the “care” sector at the system level.

Hospital staff from the care and cure quadrants frequently noted that the role, capacity and limitations of home care were not well-known or understood within the hospital setting.

Both the assignment of nurses in the hospital sector and the organization and assignment of home care staff can have a significant impact on the patient transfer process. Some of the home care organizations assign their staff to specific hospital wards. This seems to allow them to develop ongoing relationships with hospital staff and to develop some understanding of anticipated postacute service needs. Others assign a number of staff to cover the entire hospital. It appears that in larger hospitals, hospital-wide home care staff assignment is a barrier to the development of effective working relationships with nurses and other hospital professionals.

When hospital-wide home care staff assignment is used in hospitals where there is no head nurse or equivalent position to coordinate and manage a ward, barriers can be significant. No staff member from either organization has the knowledge or the capacity to coordinate or manage the complicated discharge process. Small hospitals appear to be able to foster the development of effective informal and formal relationships and this did not appear as a barrier.

In most of the jurisdictions, home care staff who perform the assessment and determine eligibility work regular business hours, Monday to Friday. Thunder Bay, Toronto, Fredericton and Simon Fraser Region have varying levels and types of evening and weekend service. As the hospital sector struggles to become more of a 24-hour facility, lack of access to home care assessments in nonstandard hours creates real barriers to discharge.

All jurisdictions recognized that the costs of medication and medical supplies in particular are a significant barrier to discharge. Most of the seven locations have programs or access to programs to allow discharged patients to borrow equipment needed for a set amount of time, usually a month. Some are more generous than others are and some allow more borrowing “time” than others do. It was noted that despite these lending programs, equipment is still a barrier to discharge.

Cure

At the system level “cure” includes all physicians in institutions, communities and other settings.

In more than one jurisdiction, physician shortages were identified as barriers to effective hospital care and to discharge. Decisions to discharge to care in the community are more difficult if the individual does not have a community doctor. The Sherbrooke protocol requires that patients be discharged to the care of a physician. When discharged patients do not have physicians this puts added stress on the CLSC to either assign one of their physicians or to more actively manage the care to the individual. In Thunder Bay there is a shortage of physicians and patients are discharged without physician follow-up – this places additional pressure on the CCAC to manage the care and the cure.

Communication between hospital physicians and general practitioners in the community was identified as a discharge barrier. Basic information sharing and communication between the two groups of physicians was described as a major problem particularly when physician follow-up was required. Home care staff commented that they frequently had to play the role of intermediary between the two sets of physicians.

In jurisdictions where there are multiple hospitals without any coordinating mechanism or common governance it is almost impossible to make system-wide changes. “I can negotiate projects, processes etc., at one but usually not all of the hospitals in my area.” It requires significant effort and time to effect change when there is no common forum for negotiation.

Community

“Community” refers to formal community involvement at the health care system level.

Except in jurisdictions where there is a Regional Board governing the delivery of health services to the region, there is little evidence of a formal system level community component.

Regional Boards can be either directly elected, appointed, or a combination of the two. Board members commented on the dominance of the acute care interests in the health region. Discharge tended to be discussed in terms of reducing costs, length of stay and utilization targets. Issues relating to the ongoing relationships between the acute care and home care sectors within the region are not generally discussed. As would be expected, issues before the Boards frequently related to budget, resource and service levels. Client and community perspectives are limited.

As in the acute care and home care sectors, families are repeatedly identified as barriers to discharge for a number of reasons. Unreasonable expectations of the hospital system and the home care system, unwillingness or lack of capacity to provide care to the patient in their home and cultural barriers contribute to discharge delays.

Control

“Control” is represented by system level administration, management and policy.

As described earlier, there are two models of organizing the relationship between the home care and acute care sectors. In the regional board model, the two sectors are included under the region and in theory face similar administrative and financial controls. In reality, they appear to have retained a degree of operating and financial autonomy and barriers continue between the two sectors at the control level. In the jurisdictions where hospitals and home care are separate, the control mechanisms are separate and different. Clear barriers to greater coordination exist at this level.

Regardless of the organizing model, hospitals and home care programs have separate budgets and performance accountabilities. Only rarely are funds directly shifted from one sector to the other. When this has occurred, or has been perceived to have occurred, it has complicated the relationships between the two sectors in the health care system. Different outcome and performance measures were also identified as a barrier to more coordinated services between the hospitals and home care organizations. It is difficult to effectively reduce barriers when the two sectors are focussed on different outcomes and measures.

Other barriers in different parts of the system also illustrate “control” type barriers. Access to a patient’s hospital chart is a good example of a “control” type barrier. Some of the hospitals included in the Substudy do not allow home care staff to access a patient’s chart unless the patient has agreed to a referral to home care. This serves to prevent the home care organization from anticipating the discharge and preparing for the necessary services. Other sites consider home care part of the continuum of health services (usually these are the sites that are part of a regional health board) and access is permitted. The extent to which lack of access is a barrier or access allows for proactive service planning depends on workload and service availability in an area. In some areas home care staff are able to prepare and coordinate services. In others they respond, crisis-like, to ongoing requests and access to charts in advance of discharge is less of an issue.

The home care and hospital organizations participating in this study had separate information systems. In some situations home care staff were able to access hospital databases to identify previous home care clients or to review new admissions and anticipate discharges. In most, however, there was no access. This impacted home care staff when patients are being discharged and hospital staff when home care patients are admitted to hospital. In both cases, delays were experienced while getting access to basic client information.

Lack of access to patient information and incompatible information systems have a direct impact on the potential for system coordination. Both originate in system control policies and procedures. Both are critical elements in an integrated service system that spans the boundaries between acute care and community care.

Best Practices

Discharge best practices can be defined as efforts to reduce barriers and boundaries. Like barriers, they can vary in scope and scale. There is a fair degree of consistency between the many site specific best practices identified in the seven study sites. Fewer system-wide best practices are identified.

Three types of best practices are identified: best practices which are restricted to a quadrant in either the hospital or home care system; best practices which link two or more quadrants within a sector; and best practices which link two or more quadrants at the system level. This model is illustrated in Figure 3.

Many best practices were identified which focussed on better processes, procedures, working relationships, etc., within the care quadrant in both the home care and the hospital sectors. They are usually narrow in scope and specifically targeted to address an operational problem. This type of best practice is generally well-identified in the growing literature on the topic. Because of the limited application of these best practices to the discharge interface these best practices will not be discussed further in this paper.

A number of best practices were identified which spanned the boundaries between one or more quadrants in the hospital or home care sectors. A number of jurisdictions have specialized hospital positions to focus on more efficient discharge and use of hospital resources. These often

complement the home care staff and work with them from the hospital perspective. These types of positions include Patient Discharge Coordinator, Admission/Discharge Coordinator, and Utilization Coordinators. They have different roles: some focus on managing and overseeing hospital discharge, while others play a more analytical role. Most function in a problem solver type role and help the discharge process work more smoothly. Other hospitals have unique positions to cover evening hours or specific wards or floors of the hospital, i.e., emergency and palliative care.

Fredericton has recently combined its hospital and home care discharge positions into a new position. This is the only jurisdiction where the discharge staff working for the two organizations has been integrated. It is interesting to note that they both continue to be paid by their respective organizations at different salary levels.

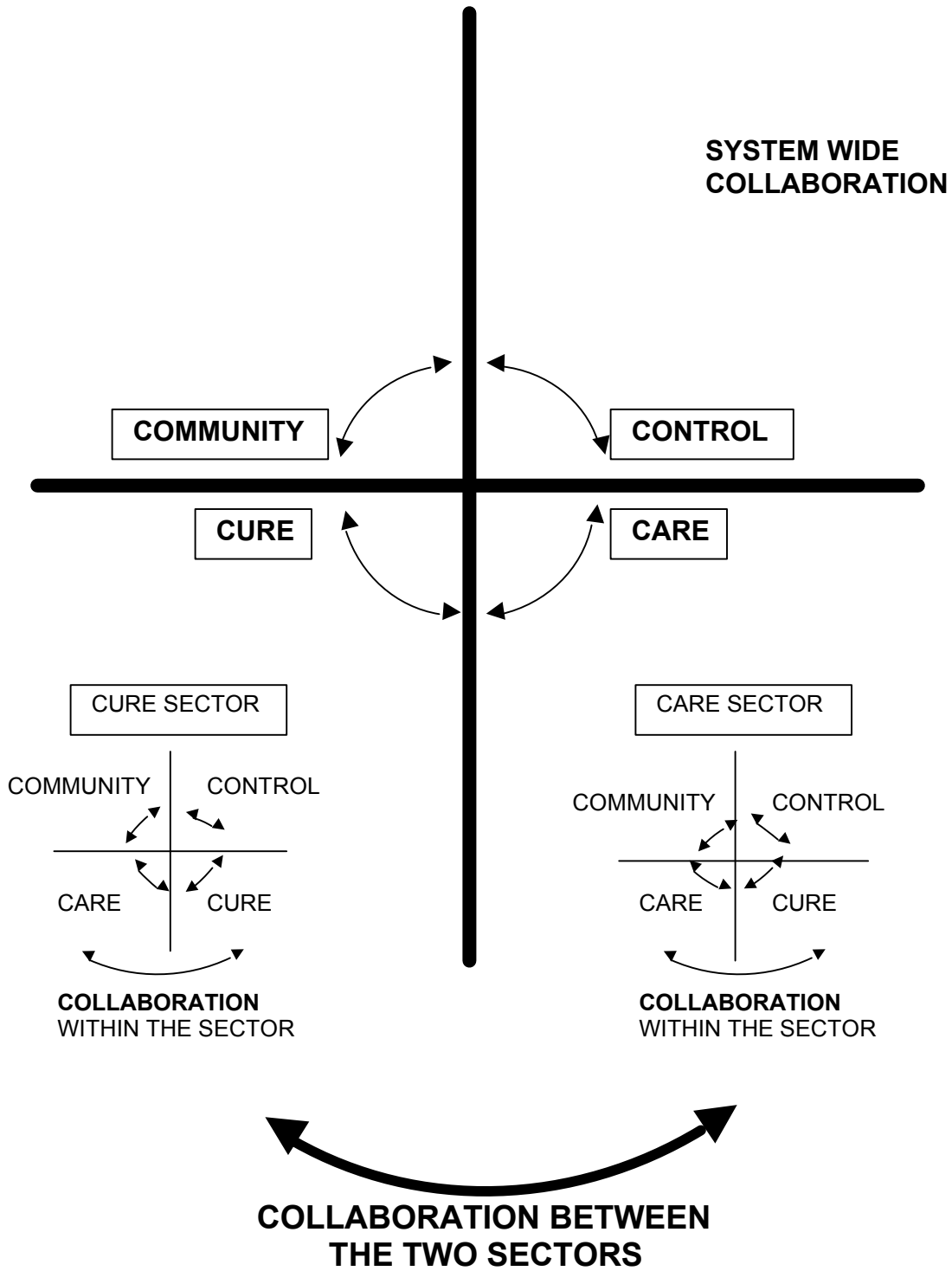
Two jurisdictions have introduced a physician advisor position. These physicians advise hospitals regarding discharge issues. In addition they play an important role in working at a peer level with their colleagues to resolve any physician-related discharge problems or barriers. A third home care jurisdiction has a physician advisor position, but was unable to attract a physician to the role and it was vacant at the time of the site visit.

The final category of best practices spans boundaries between different quadrants at the system level. They reflect an increasing recognition among professionals interviewed for this study that broader systems solutions are needed to resolve the complex discharge problems.

Various process mechanisms are used to develop formal and informal relationships between hospital and home care staff. Participation of both hospital and home care staff in regular meetings seems to encourage ongoing communication and to develop a better understanding between staff from the different organizations of the need to work together. Formal opportunities for ongoing communication included: rounds, bed management committees, utilization projects, evaluation processes, best practice processes, the development of operating protocols, joint projects, etc. These improved relationships led to more formal and informal collaboration and joint problem solving at the professional staff level. In addition, relationships between staff developed most easily when staff from both sectors are clearly assigned to specific areas in the acute care hospital.

P.E.I. has assigned one staff member to coordinate discharge of P.E.I. residents from New Brunswick and Nova Scotia hospitals. These patients can be discharged to receive care in their homes or they can be transferred to a P.E.I. hospital for additional medical or recovery care. This coordination function between quadrants located in different Provincial systems appears to have been effective in reducing the length of stay and associated costs for out of province hospitalization.

Figure 3: The System View of Best Practices



In 1997, the main hospital and CLSC in Sherbrooke, Quebec decided they needed a new approach to patient transfer. They established a joint committee and asked it to develop a protocol to improve and better coordinate ongoing patient care between the two organizations. The result was a binding protocol, which sets out the process, expectations and authorities regarding patient transfer. It also resulted in stronger working relationships, better knowledge about each other's environments and improved communications. Staff were identified in each organization to oversee the implementation of the protocol and to problem solve on an ongoing basis. The protocol was the first of a number of joint working groups and opportunities for communication. This best practice is important from a number of perspectives. It is a rare example of a formally negotiated relationship at a systems level between a hospital and home care sector. The joint process by which it was developed is also important. It was mutually agreed to be an important initiative; it was not mandated or required by the Province or the Régis Regionale. And finally, it was implemented with ongoing commitment from both sectors to problem solve and work together on the discharge boundary issue.

In Fredericton, the home care Medical Advisor is a formal position that is required by the province. The Advisor plays a system role within the Region by representing the program on the Region's Medical Advisory Committee with the other Medical Advisors (i.e., surgery, medicine, rehabilitation). As well it plays an important role within the care sector dealing with physician-based problems and proactively communicating and informing all new physicians in the hospital and community about the program and inviting input and comment on the Extra Mural Program.

Professionals involved in patient discharge are often consumed with the workload demands and stresses inherent in the job. This makes it difficult to look more broadly at the system and identify ways to improve discharge. In one hospital in the Simon Fraser Region, however, home care staff has also been encouraged to contribute to the analysis of bed utilization and the identification of system blockages and to anticipate possible discharge problems in the hospital. Changes have been made to hospital processes based on home care staff recommendations and analysis.

It is interesting to note that this input is one-way – from home care staff working in the hospital to the hospital. They have not made similar analyses for their home care organizations. It is also interesting to note that other staff in the hospital setting said that they had made similar types of recommendations in the past, but that their voices did not seem to carry the same weight as those of the “outside” home care staff. And finally, this best practice is occurring in one of the smaller acute care hospitals where staff know each other and have developed good working relationships and respect for each other's professional opinions.

Hospital-based home care staff operate quite autonomously from their organization, problem solving within their hospital and reporting to off site managers. While this can create problems in managing the program and ensuring consistency, particularly if there is more than one hospital site, it provides the opportunity to develop on site responses to the discharge barriers. These responses are more likely to fit with the culture, organization and unique characteristics of the hospital.

Increasingly there is recognition that acute care hospitals have a role to play in training home care staff in new or more complex interventions. Some hospitals commented that they do this informally, while others in the study do not appear to provide this support to the community sector. Not only do the community care staff learn new procedures, but both sectors begin to develop relationships and a better understanding of each other. There may be similar unexplored opportunities for home care service staff to train and educate hospital staff in patient care and preparing the patient for discharge. They can also play a valuable role in helping hospital staff better understand the social and physical environment to which the patient will return.

Discussion typically focuses on discharge from hospital to services provided in the home. However, there are a number of in-between programs that are used increasingly to deal with situations where the patient no longer needs acute care but is unable to safely be discharged to the community. The transfer process becomes a two-step process, from acute care to intermediate care and from there to the in home program. Alternative level of care, transitional care, step down units and rehabilitation units are used in some jurisdictions to enhance the continuum of care. These types of units tend to blur the traditional boundaries between the two sectors as they are neither acute care nor community-based care.

BARRIERS AND BEST PRACTICES – A DISCUSSION

Barriers

Barriers inhibit effective patient discharge from acute care hospitals to home care. Barriers occur at different levels in the health system and at different parts of the discharge process. Some are process- and procedure-related barriers that can often be overcome with specific changes to the process or procedure. Others reflect broader system barriers between the different sectors involved in acute care patient discharge. System change is needed to reduce these barriers.

The findings section summarized the range of barriers identified at three different levels of the discharge system. These can be summarized into six key barriers to effective patient discharge.

1. System barriers to working together

These have been well documented in the findings section. Barriers are created when professional roles and responsibilities are not well understood, when there is lack of communication between professionals within sectors or between sectors, and when roles and responsibilities are narrowly defined or are frequently changing. Scheduling and staff assignment can inhibit the development of formal and informal relationships between the sectors. Lack of weekend and after hours coverage creates challenges for service provision and the development of working relationships.

2. Family/Caregiver/Patient barriers

These barriers result from a lack of understanding of the benefits of early discharge and of the role that home care can play to support discharged patients in their home. There is often resistance from families, caregivers and patients to discharge and/or a lack of willingness or inability of families to provide the informal care and supports required.

3. Geographic barriers

There are clearly some differences in discharge between patients living in rural areas and those in urban areas. While this study did not adequately consider the challenges of discharge in a rural area, a range of barriers was identified in jurisdictions in the study which included rural areas. These include distance, weather, access to supplies and equipment, access to acute care hospitals, access to community supports and care professionals and access to basic services like water, roads, telephone, etc.

Large acute care and tertiary care hospitals are caring for increasing numbers of patients from other jurisdictions. This complicates the discharge relationships by adding an additional organizational player. Interjurisdictional barriers including authority to approve service levels on discharge, lack of knowledge of home jurisdictions' capacity to

provide postacute care supports, communication difficulties between G.P.'s and between discharge and home care create challenging situations.

4. System management and control barriers

Rigid processes and financial and control systems can restrict the flexible and creative use of available resources. Often they lead to different sector performance and outcome pressures which further impede collaboration and integration. Inflexible governance and accountability structures can similarly create barriers to an effective discharge interface. Lack of common access to patient information is a significant barrier to patient discharge in some jurisdictions.

5. Barriers resulting from constant system change

This is an overarching barrier which exacerbates and complicates the others. Frequent system change inhibits the development of formal and informal relationships. Organizational focus often turns internally, and staff focus inward on concerns over job loss and changes to programs and services. This leaves limited time or energy for boundary-spanning efforts.

6. Resource barriers

Overwhelmingly, inadequate system resources were cited as significant barriers to effective patient discharge. The need for service expansion and for enhancement of service levels and scope of services has been documented in the findings section. Availability and cost of equipment, supplies and medication needed to support patient discharge pose barriers to discharge.

Human resources shortages, particularly for nurses, physiotherapists, doctors and specialists, created barriers to discharge. Frequently, staff is not available to support patient discharge. In other situations, home care staff is not always up to date on use of latest hospital-based technology, equipment and interventions.

Discharge barriers were also created by the lack of alternatives to postacute home care service. In situations where patients cannot be safely discharged to their homes, there are few options (rehabilitation, convalescent care, transitional care units, etc.) available. Similarly, in the absence of family or other caregivers, the lack of community home supports to help support postacute individuals in their homes (friendly visiting, meals on wheels, day programs, driving programs, etc.) can create barriers to discharge.

Best Practices

The study has used practitioners' insight and experience to inform the discussion of discharge barriers and best practice. A wide range of discharge barriers has been identified from different perspectives and from different levels and parts of the system. Some are system-wide barriers and some are barriers resulting from ongoing changes to the two sectors and the systems

of which they are part. This creates a challenge for discussion of best practice. It is important to understand the relationship between the parts of the system, as well as the dynamics of change that affect the relationship and in particular, how best practice can be promoted during periods of change and transition.

Integration and Coordination Mechanisms

Understanding how best practice occurs is important. Many organizations have good ideas about how to design and organize programs. Not all, however, are equally successful at implementation. Discussion of mechanisms to coordinate and integrate practice between the hospital and home care sectors is central to the discussion of discharge best practices.

This section will consider the three mechanisms described in the framework paper and will assess their applicability to the discharge best practices in the seven jurisdictions.

The framework focuses on three mechanisms to organize work in health systems. The authors state that program coordination and structural integration initially occur in health care systems because skills and knowledge can be standardized. They argue that when environments and situations no longer lend themselves to standard responses, mutual adjustment and standardized norms become the dominant coordination/integration mechanisms. These are offered as ways of thinking about system coordination rather than prescriptions on how to achieve coordination.

Standardized skills and knowledge – leading to standard responses

Staff in both hospital and home care organizations have to problem solve, negotiate, and work within each of their systems and between their systems to achieve effective and efficient transfers. In each sector a number of different professionals may be involved, including social work, physiotherapy, pharmacy, physicians and dieticians, community agencies, community care coordinators, family members and caregivers. While there are standard forms and procedures, discharge was always described as a complex process that required case by case judgement.

Standard responses are difficult in situations like patient discharge where there are a number of different professionals involved from both sectors. Standard responses also become more complicated when roles are changing. One common theme in each jurisdiction was the ongoing policy, organizational and program change that was affecting their sectors and the health system in general.

Mutual adjustment

Overwhelmingly this was identified as the main reason that discharge works between acute care hospital and home care sectors. Mutual adjustment occurs at the professional level, between hospital staff involved in the care of the patient and the home care staff conducting the assessment and home care service referral. For the most part, these professionals understand each other's systems and the constraints and opportunities each have. They negotiate, collaborate and trade off within and between their sectors. This mutual adjustment works around

existing hierarchies and processes. Issues are taken to a supervisor only in situations where the relationship had broken down or where the situation could not be resolved by the individuals at their levels. Mutual adjustment tends to occur on a patient by patient basis or through efforts to redesign forms or processes. There was no system-wide evidence of mutual adjustment.

Adjustment also occurred, although to a lesser extent, between home care staff working in the hospitals and the physicians regarding level and type of care, readiness for discharge and other related factors. Home care staff commented that because they were outside the hospital system they were more comfortable questioning a doctor about his/her orders or intentions regarding discharge. Home care staff also has the authority to refuse to accept a referred patient if, in their opinion, the client would not be safe at home. The physician could challenge the decision but could not overrule it. Adjustment in these situations reflects the autonomy of the home care program and the physicians' recognition of the coordinators' authority to make home care decisions.

Standardization of norms

There is no apparent set of system-wide expectations, values or beliefs that apply to patient transfer. There are varying levels of frustration, skepticism and disagreement about the practice of early discharge and some professionals in each sector challenged whether patients are better off receiving substitute acute care in the community. There was, however, significant agreement that patients recover more quickly at home and they are happier in their home environment.

Instead of a shared set of values, all the jurisdictions in the study faced a shared or common crisis. None had sufficient resources to deal with the service demands on their systems. Collaboration and integration, to the extent that these occurred, were based on this fundamental challenge facing them all. They have had to work together to be successful and provide the best care to their patients/clients within the current system parameters and resources.

Other factors

Accountability and reporting relationships appear to have an impact on opportunities for improved collaboration and best practice. For example, it appears that there is greater opportunity for best practice in situations where the hospital(s) in the area report to a common governance structure. There may also be better opportunity for collaboration regarding acute care discharge when the home care organization and the acute care hospital(s) report to the same governing structure and share in common accountabilities. A more formal linkage to acute care, however, may create new barriers for ongoing and long term clients based in the community.

The scale and size of the health care system seem to affect the capacity of the system to achieve system-wide best practice. Smaller systems are able to rely to a greater degree on mutual adjustment and formal and informal networks. Larger systems face greater challenges in developing and maintaining relationships and processes that lead to consistent system-wide best practice.

Both the hospital and home care sectors have been undergoing tremendous change. Mergers, closures, new organizations, new regional governing structures, and new policy and financial contexts have led to an unstable system. It is hard to direct attention at system integration when most are uncertain about their future role in the system and are in various stages of organizational change. In times of organizational stress and major change, organizations have focussed inward and have tended not to have strong relationships with other sectors, whether other service sectors or the broader community. Some element of system stability or comfort is necessary for organizations to reach beyond their own boundaries.

Other factors, like differences in funding and measures of success, may also impact system integration. It was noted that the two sectors have different accountabilities. Home care has mixed accountability: accountability to the community and to the hospital, because it is part of two systems. Accountability of hospitals to their governing body, the Board of Directors, was seen to be clearer. There are differences in each sector's clients: acute care patients are the focus of the acute care hospital system, but they are often a smaller part of the home care client group. It was also noted that hospitals must see each client who presents himself or herself to the hospital. Home care programs can decide, based on their eligibility criteria and increasingly their budget allocation, whether they will provide service to a client.

The relationships between the hospital and home care sectors are complex and have impacts beyond the two sectors. There was early evidence in some jurisdictions that formal structural actions taken by the home care sector to link more closely with the acute care sector were changing relationships within the home care sector and between acute care and continuing care home care. Focus on informal mechanisms including partnerships and opportunities for collaboration may have less of an impact on the other relationships than formal, structural or governance-based changes.

Effective Discharge – A Preliminary List of Best Practice Factors

This study has highlighted earlier findings that there is no cookie cutter approach to effective patient transfer from acute care to home care programs. Different jurisdictions do things differently based on their organizational structure, policy and funding environment, organizational culture and history. Notwithstanding these distinctions, it is valuable to consider whether there are any elements, common to the various jurisdictions, which lead to and/or support best practice.

Effective discharge practice is a relationship between formal systems and structures, relationships, and system capacity. Formal systems, processes and procedures are necessary to structure the formal relationship between the two sectors. They set parameters and define formal roles. Relationships and informal networks are important to bridge gaps between the formal systems and extend the effectiveness of the discharge practice. These relationships develop and endure outside the formal structure and role assignment. The third element, system capacity, is critical to support the two sectors to achieve effective discharge. Adequate budget, resources and program capacity are essential underpinnings of an effectively functioning system.

Key learnings from the seven case studies can contribute to a preliminary definition of factors that support effective discharge. These factors have been organized into the three main areas below.

It is important to remember that the hospital to home care relationship is one part of a set of home care relationships. System best practices for acute care and home care must not have a negative impact on the relationships between home care and other sectors, like, for example, the long term care sector.

Formal systems

Factors that support discharge best practice:

1. Legitimization of the relationship between acute care and home care

This is an important foundation for effective patient discharge. Relationships have been legitimized or formalized in the following ways: a formal protocol defining roles, processes, and accountabilities; assignment of home care staff to work in the acute care setting; and collapsing of the home care and acute care discharge roles into one consolidated position. Some jurisdictions recognize the need to support their professionals in the relationships and created boundary-spanning, advisory functions. In all cases, the focus is on improving the relationship and understanding of the relationship and roles between the two sectors.

2. Access to compatible and/or common information systems

Access to common and shared patient information is crucial to discharge best practice. Some efforts are being made to share information between incompatible information systems but little progress has been made towards the development of common patient records. This appears to be a major hurdle which will continue to inhibit system best practice.

3. Flexible use of resources

Frequently interviewees were frustrated by lack of flexibility to provide the range of services, equipment and supports required to safely and effectively discharge a patient to home care. This rigidity may also prevent more flexible use of staff resources between and within the two sectors. It may also prevent the creative use of resources from one sector to provide priority services in the other sector even if it will directly benefit the “paying” sector. Resources need to be both sufficient and flexible to support best discharge practice.

Relationships and informal networks

Factors that support discharge best practice:

4. Formal opportunities for communication and the development of working relationships

Many jurisdictions use workgroups, committees, etc., for joint problem solving. This also serves to establish an expectation for continuing input and involvement in shared problem resolution. These formal processes support the development and maintenance of informal working relationships.

5. Continuity and stability of staff assignment

Stable staff assignment supports the development and strengthening of relationships between acute care and home care staff. Regular and somewhat consistent shifts, clear roles and responsibilities and ward-based assignment resulted in stronger informal relationships between the two sectors.

6. Boundary-spanning positions

Some jurisdictions support the development of formal and informal relationships with boundary-spanner positions. Typically these positions are associated with home care organizations and supported problem resolution between home care nurses and managers and acute care physicians and specialists.

System capacity

Factors that support discharge best practice:

7. Program resources

The home care system needs to have adequate resources – both budget and staff resources – to respond to the acute care demands for patient discharge support. This does not appear to be the case at the present. Most jurisdictions report waiting lists, delays in discharge and challenges responding to service referrals. All jurisdictions face similar shortages of home care nursing staff and other home care professionals which impact on their ability to provide services to discharged patients.

8. Access to home care - availability of referral and assessment service

Best discharge practice occurs when home care referral and assessment are available to support patient discharge on weekends and evening hours. Some jurisdictions have developed the capacity to respond more widely; however, others are restricted by the 9 to 5, weekday hours of operation and their limited funding.

9. Home care supports

Home care programs depend on timely access to equipment, supplies and specialized services like physiotherapy, occupational therapy and dietitians. This study has highlighted the challenges in discharging patients when these supports are not available when needed.

10. Community supports

Effective patient discharge also depends on the availability of other nonhealth community supports and an effective relationship between the health and community service sectors. Community supports could include meals on wheels, friendly visiting and transportation supports. One jurisdiction was structured to integrate health and community supports; all the others relied on a variety of informal relationships and referrals to community providers.

11. Continuum of Care

The discharge system relies on home care to provide postacute care. In situations where home care is not deemed suitable or safe, there are few if any alternatives to continued hospital stay. Some jurisdictions are developing alternatives like transitional care and convalescent care beds to provide care to those patients who cannot be discharged to their homes. A safe and quality continuum of care is essential to discharge best practice.

The final best practice is somewhat outside the scope of the study because it relates to relationships and formal and informal communications with families and informal caregivers. While some families have been identified as barriers to discharge, many more are facilitators and supports to discharge. Best practices must be developed to more actively involve families in the decision making and planning for discharge and to assure them of ongoing formal and informal support.

No jurisdiction involved in the study demonstrated best practice in all the factors identified above. Some focussed their energies within one of the three areas while others attempted to make some progress in all three. In many jurisdictions strong informal relationships between hospitals and home care staff are able to counterbalance barriers associated with formal systems and processes. This suggests that in some jurisdictions, some best practice factors may act as substitutes in the absence of others. This was not the case in all the jurisdictions and caution must be exercised in attempting to substitute them.

A second important observation is that there appear to be thresholds beyond which little progress can be made towards best practice. For example, most jurisdictions realized discharge-related improvements when roles and relationships were better defined between hospitals and home care. In most cases home care staff were placed in hospitals to respond to patient referrals and conduct assessments. They have developed formal and informal relationships and refined processes and procedures and are at the point where the lack of shared or compatible client information has become a major barrier to continued progress toward best practice. Until

information is accessible and shared, many are uncertain that much additional progress can be made to improve the discharge process. System resources also appear to be a significant barrier to more effective discharge in that they restrict capacity to respond and serve to divert attention from quality response to rationing and coping.

Finally, the list of best practice factors is based on learnings from the seven jurisdictions studied at a point in time. It is hoped that this can be augmented and refined as future studies consider discharge best practice. It is also hoped that future studies can build on this work and look at system incentives to adopt discharge best practice.

LIMITATIONS OF THE STUDY

The study is based on a model of health systems developed by Mintzberg and Glouberman. The model has been useful in highlighting the interrelationships between the two health sectors and in focussing attention on system barriers and best practices. It highlights the complexity of the acute care to in home care relationships and of relationships between sectors in the health system in general. The model, however, has some limitations which must be noted. It is static and does not recognize ongoing change in sectors and roles. While it is complex, it has been criticized as not complex enough to capture the dynamic nature of system relationships and change. It focuses on barriers to more effective relationships and systems rather than incentives which promote system integration.

Similarly, there are some important limitations which must be noted regarding the use of this model in the study of hospital to home care discharge.

First, the study has looked at the acute care patient discharge relationships between hospitals and home care. In limiting the scope of the study to these two health sectors, the study has ignored the role of patients and caregivers in the process. It has been estimated that families and informal caregivers provide approximately 80¹³ per cent of all home care supports. They are a critical element of patient discharge. The systems framework applied in this study does not recognize the role and contribution of the family and other caregivers regarding discharge. Further work needs to be directed at understanding the linkages between families and informal caregivers and the formal discharge systems and programs. Not only do acute care and home care have to work together to effect patient discharge but they also have to work with the patients and the prime caregivers, the family.

Similarly, the study has not included consideration of the role and relationships of the community care sector in the discharge process. The importance of this sector in supporting patient discharge and preventing acute care admission was noted in each of the seven jurisdictions. The study cautioned that system changes to the relationships between hospitals and home care may impact on the relationship between home care and the community sector. Home care has a role in the provision of both postacute care and continuing care and will need to balance the relationships with these two sectors.

Finally, the study identified the need for a broader continuum of postacute care options. Many interviewed argued that the existing range and number of community-based options for postacute patients who cannot safely be returned home must be increased. The study did not consider the important three-way relationship between the continuing care sector and the acute care and home care sectors. This also deserves future consideration.

¹³ From a Speech by Alan Rock, Federal Minister of Health, contained in National Conference on Home Care, March 8 – 10, 1998, Proceedings, prepared by Nova Scotia Association of Health Organizations, p. 66.

OTHER ISSUES RAISED IN THE STUDY

A number of other issues were identified during the study that are beyond the scope of this study. They are highlighted for further attention and investigation.

Emergency Services

Emergency department services were not specifically included in this study because they do not admit patients to the hospitals and similarly do not discharge patients. They were not seen as having direct relevance to the discussion of the acute care to home care discharge interface. However, emergency room backlogs, often with patients waiting to be admitted to a ward or floor, put tremendous pressure on the acute care system. There is an opportunity for home care to play a substitute or diversion role by assessing emergency room patients and referring those for home care services who could safely manage in their homes. The Quick Response Team program in Saskatoon is an innovative example of a program which actively diverts potential admissions to care in the community and reduces pressure and costs for the acute care system. Other emergency departments may refer individuals to home care services if the patient is in need of care but is not sick enough to be admitted. This type of referral is uneven and inconsistent. It also depends on the hours of operation for home care referral and assessment services.

In addition, emergency departments are not staffed so as to be able to assess community care needs and determine whether a patient can be safely returned home. Not all have immediate access to the necessary Physiotherapy, Occupational Therapy or Geriatric assessments. This causes significant delays in decisions to admit or return an emergency patient home and leads to backlogs, stress and tension.

Even with some creative approaches to emergency care, experience has shown that it may be difficult to change the culture and practice. Emergency nurses see themselves in a “life and death” role. They do not feel they are the right professionals to be involved in admissions or in discharges and there is resistance to a broader nonmedical role. Additional and different nonnursing resources may be required to achieve greater success in providing alternatives to acute care admission.

Home care can also play an important role by providing “home care in emergency departments” as an extension to the existing continuum of service. Real concern was expressed in the interviews and by the Expert Panel about the impact of excessive waits in emergency on a patient’s health. For example, it was noted that emergency is not able to provide the necessary range of supports to keep elderly patients mobile and functional. While waiting in emergency, bedridden seniors quickly lose mobility capacity, they become incontinent because of difficulty getting support to the bathroom or because they have been catheterized, and they become confused by the lights, movement and noise in an emergency room. The result is that they are admitted when initially it may not have been necessary. Others may contract medically caused or iatrogenic illnesses. And others may not be appropriately referred for community supports and care.

Barriers between Health and Human Service Systems

One Toronto hospital has started to benchmark length of stay and is finding it is a function of the type of patient and the lack of adequate supports for specific populations (homeless, underhoused, low socioeconomic status). This initial finding reinforces Expert Panel comments about the need to reduce barriers between other human service systems and the health system and to develop more appropriate supports for targeted at risk populations.

Expanded Range of Options for Care in the Community

The population is rapidly aging and its health problems are more complex. Infectious diseases are creating greater challenges for the medical system. Even with greater efficiencies in the use of acute care hospital beds through better coordinated discharge it is expected that there will be increasing pressure for those beds. It is anticipated that it will be increasingly harder to discharge complex care patients to their homes, even with home care supports. Many individuals interviewed called for greater attention to the development of a range of creative options for care, when neither hospital care nor home care is appropriate. It is interesting to note that the Quick Response Program identified the lack of respite beds and community supports a major barrier to returning people to the community.

System Capacity and Resources

Fourth, the focus in current hospital systems is on the efficient utilization and management of reduced acute care capacity. The focus in the home care system is on rationing limited resources among a competing and growing client group. Neither system is resourced to have excess capacity to accommodate the day-to-day stresses it faces. It may useful to consider whether the hospital and home care systems require additional capacity to support a more smoothly functioning system.

Use of Positive Incentives for System Change

Attention needs to be directed to the use of positive incentives to change the current discharge practice. This is beyond the scope of the current study but has a direct impact on reducing barriers and promoting adoption of discharge best practice. When incentives currently exist, they are negative – increasing costs, backlogs, cancelled surgery, complaints and media attention. Few examples of positive system incentives were found.

CONCLUSIONS

This study has focussed on improving the understanding of patient discharge from acute hospital care to home care by better understanding the system within which both sectors work. By looking at boundaries, barriers and best practices it has raised some key issues that need to be considered in designing more effective patient transfer systems.

The systems framework was valuable in furthering the understanding of the discharge interface and focussing attention on boundaries at the hospital and home care levels and at the system level where they interact. The seven sites provided clear evidence of a range of boundary barriers that impede a more effective discharge process. They also provided evidence of a number of best practices that served to span the boundaries and move towards greater system integration and collaboration.

Interface issues are complex. When the systems that are “interfacing” are complex and large, as in this study, the challenges multiply. Old methods of coordination based on standard responses and applications no longer work. Networks based on informal relationships become more important as approaches to develop best practices and to improve communication and education. There was significant evidence among the seven sites to support this observation. The research also suggests that there is no one approach to hospital to home care patient transfer that will work. Instead there is a need to recognize the unique characteristics of the jurisdiction and to capitalize on opportunities to build strong relationships between the sectors and to develop a common focus and set of values.

It is important to reflect on the differences between the seven sites in terms of their organization, governance, program and policy contexts. These differences may have an impact on the overall system and may contribute to unique site-specific barriers and structural boundaries and require unique site-specific best practices. It is also important to appreciate the impact that changes in the health system are having on the hospital and home care sectors. Fundamental policy, structural and resource-based change diverts sector attention inward as it redefines its role and organization to fit the new reality. This internal focus does not support formal sector efforts to address boundary issues with the other sector. Under these circumstances, if change is to occur, it will be through informal relationships at the professional level.

Both home care and acute care hospitals are competing for the same scarce public resources. The practice of trading system resources, or cost shifting, between the two sectors creates and maintains a sense of competition. Sectors are seen as winners or losers depending on their ability to successfully influence the flow of resources. In addition, home care’s role in diverting possible admissions and supporting early discharge or acute patients can be viewed as ultimately reducing resources directed to hospitals. In the short term, as roles change and resources are reallocated, it will be difficult to support an environment of collaboration and cooperation. Efforts must be made to strengthen working relationships, improve communication about system changes and reduce cultural barriers between the sectors.

Similarly there is evidence of cost shifting within each sector as resources are reallocated; for example, within home care programs from long term care clients to acute care clients, or within hospitals to transitional care units or expanded rehabilitation units. This creates internal dynamics similar to those experienced on a sector level. Cost shifting is passed on to the patient and caregivers as home care programs limit the range or scope of supports available in the home or as discharged patients are required to pay significant sums for medication, equipment and supplies which would have been provided within the acute care hospital.

Two of the sites appeared more successful at providing an effective discharge process than the others. That is not to suggest that they had not experienced the financial, policy and structural change of the others, but rather that they were better able to manage for a number of reasons in spite of these pressures. On reflection, both home care programs were long-standing programs with well-established processes and roles. They were described as having strong cultures and positive reputations built on client focussed care. They had consistent leadership and direction. Both these programs had managed to build a strong set of formal and informal relationships with the hospital and community sector. When change occurred in the hospital and home care sectors, the formal relationships may have been altered; but because of the organizational culture based on strong past relationships and the enduring informal relationships there was an expectation that the relationships would be rebuilt. And while they were being formally rebuilt, the informal relationships continued to keep the system working effectively. Clearly, it is not possible to draw firm conclusions from this limited study, but there were clear distinctions between these two sites and the other five in the study.

The range and scope of challenges to achieve a more effective discharge interface will grow substantially when the sectors involved in the interface are broadened. As noted at the beginning of this paper, Substudy 15 has focussed on the acute care hospital to home care interface. It has not considered the third sector involved in the interface, the community sector. The fragmented, uncoordinated and often poorly funded providers in this sector will further challenge efforts to achieve best practice. Yet they cannot be ignored because they have a profound impact on individuals in the community. More energy should be devoted to assessing the few projects currently underway which attempt to integrate health and community, such as the Integrated Care for the Elderly (SIPA) pilot project in Quebec. SIPA is designed to include the full range of services – medical, social, community and institutional – for the frail elderly. It is being implemented through the existing CLSC structures. Learnings from projects like this can inform policy and practice across the country.

Similarly, the study did not deal with the formal and informal discharge relationships with families and informal caregivers and their crucial role in facilitating and supporting discharge and care in the community. It is important that these be better understood.

Substudy 15 has also raised some related issues that deserve further attention and study. The relationship of emergency departments appears to be a critical component of the hospital to home care interface that was outside the scope of this study. Many identified the opportunity for home care to play an additional role, supporting patients while in emergency and providing options to hospitalization.

The need to build a stronger and more robust community service system to provide a broader range of community supports was noted by the Expert Panel as well as most of those interviewed for the study. Until that happens, the continuum of care will be unbalanced and home care will continue to struggle in a system dominated by acute care interests. Not only does the community side of the continuum of care need to be strengthened, it needs to be enhanced with the addition of more creative and different care and cure options.

As populations age and needs become too complex to be supported by current home care programs and levels of care, the only alternatives are acute care hospitalization or institutionalization. Many involved in the study urged the development of more creative options.

The system is functioning with very little slack. Attention to care mapping, utilization, best practices and other techniques to manage the beds or spaces efficiently and within available resources has resulted in a system that is inflexible and constrained. There is little or no capacity to respond to unique situations or demands. It is likely that both the hospital and home care sectors would be more effective in focussing on patient care and needs if there was some extra capacity in the system.

And finally, at a system level, there is little or no capacity to better integrate the two sectors to better use system resources. The jurisdiction which designed a joint position to manage both discharge and home care assessment has been constrained by system inflexibility. At the time of the site visit, the system had not permitted the transfer of funds between program areas to consolidate funding for the positions or to allow for wage harmonization between the two human resource systems.

In conclusion, the Expert Panel identified a blurring of boundaries and the beginnings of a shift in power dynamics between health and home care. Home care staff located in the acute care hospitals talked about being part of two worlds with two competing sets of accountabilities. Perhaps they are early versions of boundary extenders or boundroids, positions which span the traditional sector boundaries. Studies like this one, which add to the understanding of systems, may lead to more successful and innovative best practices which build on these early boundary extenders.

APPENDIX 1: Summary of Site Findings

Site Visit Profiles

The following site profiles provide an overview of the organization, structure, service and policy context for each site visit jurisdiction – Thunder Bay, Simon Fraser Region and New Brunswick. They highlight key issues, barriers and best practices identified in each site. They have been compiled based on information collected and interviews conducted in Thunder Bay in October 1999, Simon Fraser Region in November 1999 and Fredericton in February 2000.

Thunder Bay, Ontario

The Ministry of Health is responsible for a range of health services including home care and hospitals. Since the 1990's there have been significant reforms in the hospital and home care sectors in Ontario.

In January 1998, the Ministry of Health consolidated services previously provided by separate home care programs and placement coordination services into 43 Community Care Access Centres (CCAC). These are publicly funded non-profit agencies established to provide single point of access for a range of community services and programs and for long term care facilities. CCAC's are accountable through service agreements to the Ministry of Health. They are responsible for the assessment, case management, and discharge planning (from home care) as well as the coordination and delivery of services. They contract out all professional and home support service delivery.

The Ministry of Health sets broad guidelines and policies for CCAC's and allocates funding.

In 1997 the Provincial government established an independent Health Services Restructuring Commission with responsibility to restructure the provincial health system. Its mandate included hospitals, reallocation of resources to the community and the integration of acute and community care. It made recommendations that reorganized the delivery of hospital care in Thunder Bay.

The Community Care Access Centre in Thunder Bay is a relatively new organization. It provides access and case management services to people needing in home services or placement in long term care facilities. The organization has focussed on internal issues, a new office space, hiring staff, the contracting out process, and orienting a new Board of Directors and is now directing attention on external relationships and issues. CCAC Community Care Coordinators work at each of the two acute care sites to assess client eligibility for service and to make the necessary service referrals. They work Monday to Friday, 9 to 5. There is an on call evening and weekend CCAC service. The Coordinators report to a Manager at the CCAC office.

The CCAC serves a large geographic area which includes five district hospitals (20 - 50 acute care beds) as well as the City of Thunder Bay which has one acute care hospital with two sites. The Thunder Bay Regional Hospital with two acute care sites is included in this study. Comments made by both CCAC and hospital staff about the challenges of discharging and

arranging services for patients returning to remote areas in the region have been briefly summarized in this section. They provide a unique perspective on some of the additional discharge barriers that are faced in Canada's northern and remote communities.

Services to aboriginal people differ from other available services. Issues associated with serving this population group are not included in the scope of the paper. The relationships, processes and policies appear to be extremely complex and involve other levels of government in addition to an expanded range of service providers. The CCAC is working with an aboriginal organization to resolve a number of role, coordination and service issues.

Thunder Bay hospitals are also changing based on recommendations from the Restructuring Commission. One acute care hospital has become a rehabilitation facility and the previous independent acute care facilities, Thunder Bay General and McKellar Hospitals, have been merged to form one acute care organization, the Thunder Bay Regional Hospital. They are in the process of building a new hospital facility. Similar to the CCAC, the Thunder Bay Regional Hospital has been focussed on implementing changes associated with the reductions in resources and on responding to and now implementing the Restructuring Commission recommendations.

The Thunder Bay Regional Hospital has introduced a Utilization Program to significantly reduce alternate level of care bed days. Three Utilization Coordinators at each acute care site organize risk assessments for frail elderly and are involved in discharge planning and referrals to respite, long term care, rehabilitation, and hospice and to the CCAC. They also monitor avoidable delays to discharge by tracking the number of nonacute days of hospital stay when no discharge plan is in place. This relatively new program has focused on process, late discharge orders, delays in form completion, receipt of tests, etc., rather than system issues.

Hospital social workers may also be involved in discharges. They may have early discussions with families and patients regarding discharge and placement options. They also are involved in crisis intervention, advocacy and coordination of services in complex cases.

Any professional can refer a patient to the CCAC for service. The CCAC staff attend interdisciplinary hospital rounds and participate in the discussions regarding patient discharge but they are not permitted to access the patient's chart until the patient has agreed to a referral to home care. While not considered ideal, participation in rounds helps the CCAC staff anticipate the referral of complex cases. Despite this, many referrals are for same day discharges. CCAC Coordinators were described as "extremely accommodating for short notice discharges."

Discharge barriers vary in the rural areas from those in the Regional Hospital. Rural barriers include transportation, sanitation facilities, availability of home care services, travel time for home care staff, equipment and supplies and access to medical and community supports. It was noted that rural patients sometimes could not be returned to their homes in the winter months because of lack of access.

A range of discharge barriers was identified by the CCAC and Thunder Bay Regional Hospital. The CCAC is limited in its response to referrals by the availability of service in the

community and by the CCAC budget. Currently there are long waiting lists for homemaking as well as limits on hours and length of service a client can receive. They are also limited by availability of nurses, physiotherapists and other care professionals. Similarly there are long waiting lists for admission to St. Joseph's Chronic/Rehabilitation Hospital which has transition, rehabilitation and reactivation units. There are similar waiting lists for admission to hospice and continuing care facilities. The CCAC anticipates an operating deficit again this year and must reduce levels and length of service as well as plan for discharge on acceptance to the program of new clients.

Thunder Bay has a much publicized shortage of GP's and specialists. This impacts on the hospital in two important ways. First, it means that residents who do not have access to a family doctor will go to emergency for medical treatment, serving to further exacerbate pressures on emergency departments. Second, it makes discharge more difficult as there may be no community doctor to follow the patient's progress in the community. Physicians also create barriers to discharge. It was noted that as a group they have uneven knowledge about home care, it is hard to get them to plan ahead and their orders may come late in the patient care process.

Other barriers include a poor understanding of home care in the acute care system. The CCAC staff members commented on the challenges they face getting physicians to refer to them and were frustrated that they did not have enough time to "do education" within the hospital. The discharge process does not work well on evenings and on weekends. Hospital referrals are quite high and the CCAC does not have sufficient staff available to effectively respond. It was noted that there is some confusion between the various professionals involved in discharge, utilization, CCAC and social work, and that nurses sometimes do not know to whom to refer patients. While the CCAC and Utilization Coordinators work jointly to effect patient discharge, some issues were raised about the level of collaboration and opportunities for improvement.

Access to the patient's chart was identified as a major barrier for the CCAC. Up to 40% of the patients on the medical floor of the hospital may be existing home care clients yet CCAC staff is unable to access hospital charts. Lack of access to charts restricts their ability to anticipate service referrals and to "case find" or more proactively identify possible patient referrals. Coordinators also do not have access to the CCAC database in the hospitals. They have to telephone in to check whether a referral is an existing client. They have very limited access to computers.

Families can also be barriers to discharge. It was noted that the CCAC does not contract very well with families regarding expectations and service levels. Access may be an issue for outpatients – it was questioned whether they are able to access the CCAC services. As the population continues to age, there is a need to consider different approaches to care and community support for the elderly.

Thunder Bay received funding from the Ministry of Health for a Quick Response Pilot project. The goal of this project was to mobilize resources when a patient presented in emergency to prevent hospitalization. The pilot was reported as well-received in the hospital sector but there were problems with patient diagnosis and assessment and the pilot was not continued. Presently the emergency departments can refer people to the CCAC for service.

While it is recognized as an important extension of CCAC service, there are significant implementation challenges. Emergency is not well-linked to social work, physiotherapy or occupational therapy resources and it is difficult to arrange for mobility and other assessments. This puts increasing pressure on the CCAC Coordinators to accept clients who are not adequately assessed as being able to safely manage in their homes.

Thunder Bay Regional Hospital has a trial discharge program for complex care cases. The hospital will hold the patient's bed for two nights during which he or she returns home with home care services. The Hospital also makes nurses available 24 hours a day by phone and provides necessary supplies. If the discharge is determined not to be safe or sustainable, the patient is returned to hospital. In some other discharges, the Regional Hospital will provide an occupational therapist to go with the patient to conduct an in home assessment to determine whether the patient can manage in his or her home.

Recently a joint hospital and CCAC committee developed a trial discharge planning tool. CCAC staff is also beginning to develop a range of protocols for day surgery discharges to better support care to these patients.

There are a number of committees that bring the hospital and CCAC staff together. The Continuity of Care Steering Committee was originally set up by the Ministry of Health as part of the hospital restructuring process to "identify issues affecting continuity of care and to develop appropriate strategies and mechanisms to maximize use of resources and support clients in their residence." The committee stopped meeting for a number of reasons. There was frustration that there were no resources available to support the development of innovative responses to support clients in the community and that there were competing time pressures and organizations were focussed on their own internal restructuring and downsizing exercises. Efforts were being made in the fall to bring the players together again.

The CCAC Thunder Bay Joint Committee was described as a forum for communication and problem solving. It focuses on current processes and procedures and meets quarterly to discuss common issues like late discharges, issues related to emergency departments and special programs or initiatives.

Simon Fraser Region, British Columbia

The Ministry of Health is responsible for health care services for British Columbia. It establishes overall policy guidelines and standards for service provision. In April 1997, the Ministry devolved the delivery of home care to Health Regions. It allocates funding for health services to regions.

Health Regions are responsible for assessing community needs and resources, developing priorities and allocating resources. They plan and administer acute care, residential care facilities, community health services and resources and ensure program adherence to Provincial standards and legislation.

The Simon Fraser Health Region was established in 1997. Services it provides include acute care hospitals, mental health, rehabilitation, home care, public health and continuing care services. There are four acute care facilities in the region: Burnaby Hospital, 216 beds; Eagle Ridge, 90 beds (and 75 beds long term care); Ridge Meadows, 84 beds acute and 25 beds discharge planning unit; and Royal Columbian Hospital, 400 beds acute tertiary. The home care program provides single entry access to assessment, case management and discharge planning (from the home care program). It directly provides the professional services and contracts out the home supports.

The home care program reports to a Vice-President of Community Services and the acute care hospital sector reports separately through another Vice-President. The C.E.O. reports to the Health Region's Board of Directors.

Since its establishment, the Region has been concerned with the use of acute care beds and the hospital to home care relationships. Initially it was as a result of an acute care committee investigating bed blockage and bridging care. In 1998, the Region developed a pilot project to use the home care program to reduce the inappropriate use of acute care beds for particular client groups. Community care staff became involved in the discussions to extend the pilot as a regular program. They were able to raise issues and a second, broader pilot began. In 1999, following discussion between the two sectors, the Carelinks pilot project was introduced in the Royal Columbian and Eagle Ridge hospitals. Carelinks is a single entry program which places Client Care Coordinators in the acute care hospitals to identify, assess and refer appropriate patients to services in the home. The program includes an enhanced level of support for the first 60 days in the community. An evaluation of this pilot is currently underway.

This study focussed on the discharge interface between the Royal Columbian and Eagle Ridge hospitals and the Continuing Care program. Primarily this is through the Carelinks pilot project introduced in two of the three hospitals. Perspectives from Ridge Meadows hospital have been included because the Administrator has joint responsibility for Ridge Meadows and Eagle Ridge and both hospitals share similar experiences. Ridge Meadows expects to be included in the Carelinks program in 2000.

Carelinks was introduced at the same time that layoffs were made to nursing staff and 30 beds were closed at the Royal Columbian Hospital. Changes had also been made to the role the social workers played in the acute care hospital. Many acute care professionals associated these changes with the introduction of the pilot program and it got off to a very rocky start in late 1998.

Despite the joint work on the Carelinks program, the collaboration was seen as "forced." The two sectors were seen as competitors and did not share a "common position that working together would be good for everyone." The joint steering committee met for the first six months after the pilot launch but has subsequently stopped meeting.

Like other areas in the study, there have been changes to the hospital sector and funding and policy changes to the in home care system. Hospital beds are being closed and others are changing their focus and role in the community.

There are significant differences in the discharge relationship between the two Carelinks sites. The five Client Care Coordinators have an enormous workload and operate in a stressful and pressured environment at RCH. It was noted that it has been hard to develop strong working relationships with the acute care staff for a number of reasons. Initially it was linked to the negative introduction of the program. In addition, the hospital eliminated its head nurse roles and moved to team nursing. The loss of the central coordinating nurse position has made it harder for the Client Care Coordinator to obtain information and build relationships. Day to day workload pressures do not leave much time for informal relationship building. Staff does little advance planning or case finding. It has not been possible to develop effective working relationships with the many physicians and specialists at RCH. The Coordinators focus mainly on crisis and immediate discharges. They are assigned to specific units and wards of the hospital which allows them to develop a good understanding of the care issues but creates continuity challenges when patients are frequently moved to different wards or units of the hospital. These patients were described as “falling through the cracks.”

Client Care Coordinators at Eagle Ridge have a much closer relationship with the acute care staff. They work with lead nurses in each ward/floor. They “sense they have a greater control of their role and their environment” which they described as supportive. Carelinks staff works as a team and contributes to acute care best practices in the hospital. They have proactively suggested strategies based on their analysis of acute care backlogs and blockages to minimize problems and better facilitate client discharge. In addition, because of their hospital-wide assignment, they are able to follow a patient through the hospital and manage admissions and discharges to and from the Transitional Care Unit in the hospital.

Both hospitals experienced barriers to home care services in the community. Access to physiotherapy, occupational therapy and palliative care services were barriers consistent with most of the other jurisdictions in the study. Simon Fraser Region also shares in the shortage of nurses and had to close new admissions to the home care program once last fall. They face tight budgets that limit the range and scope of services they can authorize for a client. They recently withdrew services to some home care clients in an effort to find money for other program areas. Weekend service rosters are “filled up by Thursday – Friday discharges are unlikely to get service until the next week.” It was estimated that about 80% of the clients referred for service actually receive the service on the expected day.

Physician practice was identified as a barrier. Communication of physician plans for a patient, late discharges, reluctance to discharge to home care and physician catering to family demands for longer hospital stays were cited as examples of physician-related barriers. On call physicians (weekends) were described as reluctant to discharge another physician’s patient and hospital stay was extended. Patient and family cultures, attitudes and expectations also create barriers to discharge.

Carelinks has been criticized for being understaffed and for its limited hours of operation. Originally the program was to have operated 7 days a week, 24 hours a day. The restriction to weekday hours (the program hours vary between the sites) has limited the program’s capacity to support discharges that could occur 24 hours a day. The lack of program capacity represents a

significant barrier to the provision of a continuum of care and to its credibility in the acute care sector.

Barriers were also identified because of the confusion about the roles of the social workers, discharge planners and other continuing care positions in discharge. Ongoing education about the Carelinks role in the discharge process was identified as urgently needed at all levels of the acute care hospital.

Carelinks was designed to have an impact on emergency department backlogs by arranging community services for those in emergency who do not need to be admitted and can be safely returned to their homes and providing adequate community supports to prevent a patient from needing to go to emergency. The program has been more successful in the first goal than the second. Recent service cuts, particularly in homemaking and home supports, have been identified as pushing some borderline and vulnerable people living independently in the community into a crisis that results in a visit to emergency and admission to hospital. It was noted that delays in receipt of home care and other supports for patients discharged to the community might result in some readmissions, again particularly among vulnerable populations. In addition it was observed that some physicians refer patients to emergency because they do not want to wait for the necessary community supports to be organized to prevent the admission.

Most professionals interviewed noted that there was an increasing understanding between the hospital and community service sectors but that there were few, if any, examples of better system coordination. The Client Care Coordinators were described as the link between the two systems. They were also described as not being part of either system; they had stronger ties to the acute care system but were part of the community system. Few linkages between the two sectors were identified at other points or levels.

Tensions were identified between quality and care and finance and efficiency at the regional level. It was noted that “neither had a good understanding of each other’s issues or concerns.” Tensions were also identified between the Continuing Care staff in the hospitals and those who work in the community. Staff on the community side felt Carelinks staff authorized too much service and resented the role they were forced to play in reducing and or removing the supports.

Most respondents commented on the need for expansion of nonacute program options like transitional care beds, rehabilitation beds, and alternate level of care beds to meet the needs of patients who cannot be discharged to the community but no longer require acute care beds. Delays in accessing long term care facility placements were also identified as a significant barrier to discharge.

Simon Fraser Region also provides a Planned Early Discharge program that provides support to long term care facilities. It follows acute care admissions from residents of those facilities and coordinates the discharge process back to the facility. This can include arranging for supplies, equipment and any staff training required to care for the discharged patient. There was mixed comment on this program. Some staff interviewed felt it was not a good use of resources and that it should be eliminated and the money allocated to Carelinks. Other staff,

including Carelinks staff, valued the role the P.E.D. team played in handling long term care clients.

Both RCH and Eagle Ridge have transitional care units which provide limited options for nonacute care. Many of the patients in both units are waiting for placement in long term care or rehabilitation type facilities. There are waiting lists in both hospitals for admission to these units. Transitional care units are providing care to sicker patients than in the past as acute care acts on pressures to move patients through their system.

And finally, the Regional Board has identified integration as a priority in its strategic plan. It was suggested that not everyone has the same understanding of what integration means – some think it refers to administrative integration at the regional level. One Board member thought that Carelinks may be a “starting point for program integration” between the acute care and community care sectors. Others interviewed described the vision for Carelinks as being good but questioned the wisdom in implementing the pilot program in the region’s largest and most complex hospital which has dominated the health system for years.

Fredericton, New Brunswick

The Department of Health and Community Services has two divisions that work in partnership to administer home care services in the Province. The Extra Mural Program (EMP), administered by eight Regional Hospital Corporations (restructured in 1996), reports to the Institutional Services Division. This division also includes hospitals. The 1999 Provincial budget for hospitals was \$660 million and the EMP budget was \$36 million. The Province sets overall policy, plans for and provides funding to the hospital corporations. The second division, which reports to the Family and Community Social Services Division, is the Long Term Care Program which provides home supports and long term care residential services. Home supports are provided to individuals requiring those supports on a longer term, ongoing basis. The Province is considering moving to a regional health services board model in the next two or three years.

The Regional Hospital Corporations manage hospitals, facilities, community health care centres and the extra mural service delivery units. The Extra Mural program provides assessment, case management and discharge planning and all professional in home services. Home support services are contracted out. The prime focus of the Extra Mural program is acute care substitution. The program also provides limited home support and long term care services. The Extra Mural program serves four groups of clients: acute care, continuing care, preventative and palliative care clients.

Like other jurisdictions, there has been significant change in the health system in New Brunswick. In 1996, the extra mural programs were divested to the Regional Hospital Corporations. In 1997, all rehabilitation services were amalgamated into one program to be administered by the Extra Mural Program. Currently the Province is developing standards for home care. It is also working on the design of an automated client charting system for long term care clients, which will form part of a larger database to be used by the Extra Mural, Family and Community Social Services and Mental Health programs. The Extra Mural, Family and

Community Social Services and Mental Health use the same criteria and standard assessment tools.

Also like other jurisdictions, the Extra Mural Program has identified a key challenge as “helping Regional Hospital Corporations, which are heavily burdened with the problems of managing complex hospital facilities and services, to understand, be sensitive to and supportive of their Extra Mural Programs.”¹⁴

Region 3 is the largest hospital region in New Brunswick, covering about one third of the province. It provides care at 19 regional sites, including hospitals, health centres, EMP sites, and a rehabilitation hospital. The Substudy 15 site visit focussed on the Chalmers Regional Hospital in Fredericton and the south EMP program for Region 3.

The Chalmers Regional Hospital is the main hospital in Region 3. Chalmers is considered a tertiary care facility and is a teaching hospital. Four Continuous Care Coordinators are based at Chalmers to respond to in hospital referrals to the home care program.

Approximately 60% of the referrals that are made to the Extra Mural Program in Region 3 are from the acute care sector. Most of these will come from the Chalmers Regional Hospital, but others will come from the tertiary hospital in Saint John, other community hospitals in Region 3, out of Province hospitals and other nonacute care hospitals. The remaining 40% may come from physicians or other professionals in the community. This rate of acute care referral is higher than elsewhere – it is important to note that long term care supports for services over 90 days are provided through the Provincial Family and Community Social Services program.

Recently a Discharge Planning Committee at the Chalmers Regional Hospital reviewed the discharge planning process. They recommended that the hospital Discharge Planners and the Extra Mural Liaison Nurse positions be merged on a pilot basis to create the role of Continuous Care Coordinator. An evaluation of the pilot concluded that this change had a positive impact on the discharge process. It simplified the referral process, made it easier for interdisciplinary teams to access the staff, heightened team awareness of discharge planning due to weekly team conferences and broadened the teams’ understanding of the multidisciplinary nature of discharge planning. A recommendation is currently being made to continue and expand the continuous care coordinator positions.

Many of the individuals interviewed for this Substudy identified similar benefits of the combined position, although it was noted that there had been an initial learning curve as staff gained experience and competency in the other position. The Continuous Care Coordinators thought that the new position would result in a reduced workload as inefficiencies and duplication were eliminated. Instead their workload has increased as hospital staff make more referrals and they get involved earlier in the discharge process.

The Continuous Care Coordinators work within the acute care facility to assess discharge needs and organize the necessary services, equipment, supplies and referrals to other programs.

¹⁴ “Portrait of Canada: An Overview of Public Home Care Programs” prepared by the Canadian Home Care Association in collaboration with l’Association des CLSC et des CHSLD du Quebec, February 1998.

They work closely with physicians, nurses, Occupational therapists, Physiotherapists, Social Workers and other hospital professionals.

When the Province transferred responsibility for EMP to the Hospital Corporations, it protected the program and set certain conditions for transfer. The Province specified that the Program must report to a Vice-President level and that the program's Medical Director must be a voting member of the Region's Medical Advisory Committee. The EMP budget was protected allowing the addition of resources to the budget but not permitting any transfer out of the program. There is also a fairly complicated system for Regional involvement in the development of provincial EMP policies and procedures, program monitoring and evaluation.

The Extra Mural is a well-established program. It was described as having a good reputation and a very strong culture based on high quality, responsive and patient-centred service. Some individuals interviewed were concerned that these elements would get "lost" in the regional hospital corporation, that it would be dominated by acute care interests and that it would lose its autonomy. Others argued that regionalization of the EMP provided an opportunity to create better linkages and connections at the local level, and that it could influence and change the acute care culture of the hospital. Since regionalization it was observed that the "edges have been softened, the barriers reduced" between acute care and in home care.

It was noted that the EMP program is working better in some Regions than others. Region 3 was described as being very supportive of the program and having a strong staff, Medical Advisor and Vice-President to represent its interests. It was also noted that the transfer of the EMP to the region had a financial impact on the region. Only the direct program staff and resources were transferred – the region had to assume the costs associated with supports like material management, finance, human resources, etc.

Many of the barriers identified in Region 3 are similar to those in other jurisdictions. The Extra Mural program has had difficulty keeping up with the demand for community nurses and sometimes hospital discharge is delayed. They may also have difficulty finding staff with the necessary training and experience in more complex or technology supported discharges. One physician commented that it "was frustrating" when patients can't access services because of lack of nurses, expertise or money. After hours and weekend service is available through an on call system although it was noted that sometimes there are not enough resources to accept new patients outside regular working hours. Continuous Care Coordinators were reluctant to organize weekend discharges in complicated care situations. They felt there would be better support for the individual if the discharge occurred on a weekday.

Access to homemaking and home support services was identified as a barrier. The Provincial Family and Community Social Services Division provides home support under its Long Term Care Program, but an individual must require the supports for more than 90 days. The assessment and approval process for the service takes a long time. It was estimated that a patient waits an average of 12 days (up to 30 days) for an assessment – service provision takes longer. Under some circumstances the EMP may use some of its very limited budget to provide homemaking services while the person is waiting for the Long Term Care assessment. Staff noted that they had good working relationships with the Long Term Care staff, but that the assessment and approval process was the barrier.

There is also a shortage of Physio and Occupational Therapists in Region 3. Delays in receiving care in the community are common. Equipment, supplies and medications were identified as potential barriers to discharge.

The EMP program was described as “working on bare bones” and that it was hard to respond to extra demands without additional and consistent resources. The program had its first operating deficit, covered by the Hospital Corporation, in the 1998 financial year.

The program was described as having good working relationships with physicians in the hospital and in the community. The Continuous Care Coordinators go on weekly rounds and play a continuity role as “part of the team”. It was noted that it is important to keep nurses involved in discharge decisions, both the head nurse and the nurses providing patient care. One nurse commented that she was “lost” because her Continuous Care Coordinator was away sick. Continuous Care Coordinators participate in daily bed meetings where professionals from different areas of the hospital look at emergency, surgery and discharge statistics and try to manage bed utilization for the day. It was noted that EMP participation in these meetings has also served to raise awareness of the supports it can offer and builds informal relationships between the CCC, head nurses and admitting staff.

The Program has a Medical Advisor who is paid to work with the program 2 days a month. The Advisor feels it is important to be part of the region’s formal Medical Advisory Committee and raise issues related to EMP but that it is also important to build interpersonal relationships with other physicians. He sends introduction letters and EMP information packages to all new and replacement physicians in the Region. He has also written to all physicians a couple of times to ask for their comments and feedback regarding their experiences with the EMP.

While EMP plays a limited role in the Emergency Department, the program has identified that it needs to look at expanding its role and presence. The EMP program works with day surgeries to provide supports when required to day surgery patients.

There is a very limited availability of alternate level of care beds in Region 3. Some see this as a discharge barrier for some patients; others feel that because the EMP program can provide such high levels of resources and supports that there is not as much need for alternate level of care beds in the community. In some cases patients can be discharged to their homes on a trial basis and others will have their homes assessed by an EMP professional prior to discharge to ensure the patient can manage in his or her home.

Telephone Interview Profiles

Prince Edward Island

The Department of Health and Social Services is responsible for the overall efficiency and effectiveness of the provincial health system. It has responsibility for establishing policy guidelines and service standards, philosophy, program content, and evaluation. It provides funding to five Health Boards.

P.E.I. is divided into five Regional Health Boards that have responsibility for financial management, strategic planning, program delivery and the operation of various programs, including the provincial hospitals and the home care support program. While regions are funded to provide consistent levels of programming, it is recognized that they may need to tailor their program content and develop their programs to reflect the unique features and needs of each region. Each Health Region is governed by a Board of elected and appointed members.

A Provincial Continuing Care Advisory Committee provides advice to the province and regions regarding planning, policy development, coordination and implementation of the home care, long term care and community care programs and services.

There are 474 hospital beds in seven acute care hospitals on the Island, although most home care referrals are made by the two larger hospitals in Charlottetown and Summerside. P.E.I. residents may also receive acute care in New Brunswick or Nova Scotia hospitals. It is estimated that P.E.I. residents use the equivalent of 50 out of province hospital beds. P.E.I. has an out of province liaison nurse who assists in coordinating those patients' return to P.E.I. as soon as possible.

Regional home care program staff respond to referrals for in home support from the hospitals. Care Coordinators assess referrals and provide care planning, reassessment and discharge planning (from the home care program). Clients are grouped into four categories: short term care (up to 30 days), intermediate care (an additional 30 - 60 days), continuing care (ongoing, chronic support), and special needs/specialized care.

Admissions to acute care hospitals declined from 1997/8 to 1998/9 and the average length of stay decreased from 8.1 to 7.9 days over the same time period. Patients 75 years and older used 35% of all hospital days in the Province. The Queen Elizabeth Hospital reported that 47% of inpatients in 1998/9 were 65 years and older. Rural hospitals in P.E.I. reported that patients 65 years and older used 65 to 75% of all hospital days.¹⁵ Outpatient surgeries increased by approximately 50% from 1997/8 to 1998/9 at the Queen Elizabeth Hospital. In 1999, outpatient surgeries represented approximately one third of all surgeries.¹⁶

¹⁵ 1998/9 Annual Report, Health and Social Services, p. 41.

¹⁶ 1998/9 Annual Report, Health and Social Services, p. 42.

P.E.I. has identified the “need for a hospital to home care protocol, strategy and funding as home care services for discharged hospital patients continue to increase.”¹⁷ They are working to develop care pathways, reviewing cost issues and reviewing the interface between hospitals and home care. The Province recently established a Provincial Geriatrician Position to act as a resource to seniors’ services, home care and continuing care programs. It also completed a study that examined the use of acute care hospital beds. P.E.I is currently participating in three federally funded programs. The Integrated Mental Health Response for Seniors in Home Care focuses on the development of a screening and diagnostic protocol for early identification and diagnosis of seniors. The Telehospice project provides up to 24 hours a day of live visual and audio contact with a home care nurse and/or other health professionals for palliative care patients, and the Rural Palliative Home Care Project is a pilot project in three areas of Nova Scotia and P.E.I.

Interviews were held with staff in Queens Region, which includes Charlottetown and the Queen Elizabeth Hospital, a 274-bed acute care hospital, and with Southern Kings Region, a 436-square mile area with 15,000 residents. The Social Work Department at the Queen Elizabeth provides discharge planning for the hospital. The small 30-bed Kings County Memorial Hospital serves Southern Kings Region. Multidisciplinary weekly meetings are held in Kings County to discuss discharge issues. They are “a small group who know each other well” and there are “not too many obstacles” to discharge. Southern Kings Region has a liaison nurse assigned to the Queen Elizabeth Hospital to handle the discharge of patients back to that region.

It was commented that the hospital and home care sectors have different goals: “hospitals focus on moving people out, home care focuses on supporting people in the home.” Physicians were identified as a barrier to acute care discharge to home care. G.P.’s are central to medical care in P.E.I. – there are issues with their availability and interest in being part of a care team to manage services in the community for the patient. Barriers were also identified because of limited community resources, the inflexibility of the home care program and shortages of nurses. The system’s capacity to support neurotrauma patients was identified as a growing problem. Similarly the province has a significant proportion of seniors – increasing needs for a wider range of supports is anticipated. Finally, discharge was described as “a lot of paperwork.”

Sherbrooke, Quebec

The Province, through the Department of Health and Social Services, is responsible for home care and hospitals.

The Province has established 18 Regional Health and Social Service Boards, Régie Régionale, with responsibility for planning, budget allocation and coordination of health and social services, including home care. They do not have service delivery responsibilities.

Centre local des services communautaires (CLSC) was established in 1972 as a local public organization and is managed by a Board of Directors. The Board of Directors reports to

¹⁷ Canadian Home Care Association and l’Association des CLSC et des CHSLD du Quebec, Portrait of Canada: An Overview of Public Home Care Programs, February 1998, P.E.I. section, p. 2.

the Régie Régionale. The numbers of CLSCs are changing due to mergers and reorganizations; however, in June 1999, there were 146 CLSCs in Quebec. They provide assessment, case management, discharge planning and professional services, some home support services as well as medical care, public health, education and information and some social services. They may refer to community-based agencies and voluntary associations for services like meals on wheels, friendly visiting, transportation, etc. They have three guiding principles:

- integration of people with disabilities in the community and the prevention of institutionalization
- provision of community services as a substitution for hospitals and nursing home services
- participation of individuals and their communities in decision making and community services

In 1995, the Province announced significant hospital bed closures, hospital closures and staff losses as part of a package of reductions in hospital funding. This resulted in substantial pressure on CLSCs to provide care for patients being discharged earlier from hospitals as well as services for long term patients no longer cared for in acute care hospitals. Community agencies, particularly those who provided programs related to medical care, also felt stress. For example, one study noted that they experienced problems finding volunteers for the increased and more demanding day surgery transportation to and from the hospitals.

Sherbrooke, an area of 275,000 residents, is part of La Région de l'Estrie. La Région de l'Estrie is made up of eight Centres locaux des services communautaires. The Region has responsibility for regional standards and policy, resources allocation, planning and coordination for a wide range of hospital and community supports. The main acute care hospital is the Centre Universitaire de Santé de l'Estrie.

In 1996, the CLSC in Sherbrooke and the Centre Universitaire de Santé de l'Estrie established a joint committee to develop a contract type agreement for the transfer of patients from hospital to home care. This protocol defined the relationship between the hospital and CLSC and clearly described responsibilities, expectations and roles. The protocol asks for 48 hours notice for complicated discharges and 24 hours for simple discharges. It was estimated that about 40% of discharges meet these time parameters. The joint committee also recognized that the CLSC needed additional resources to take on their stronger community role and that there would have to be an increase in the capacity of the community sector and an increase in the service availability and hours of care. In 1995/6, funding for 52 R.N.'s was reallocated from the hospital to the CLSC to support the expansion in community-based services. One hospital was closed. The protocol identified staff in both sectors to oversee the discharge process and problem solve when necessary.

This initiative has led to regular reviews of the protocol and other ongoing joint work between the two organizations. The process for the development of the protocol was described as a best practice because it forced everyone to get together, to share information and to develop a better understanding of expectations.

There are still problems with the process. Hospital staff, nurses, doctors or other professionals involved with the patient must complete the referral to home care. It is described as “requiring a lot of effort, from completing the necessary forms to home care agreeing to provide the services.” The process to get the forms and information to home care was described as “cumbersome.” It involves faxing, phoning and follow-up between hospitals and home care and is seen as a significant time demand. Often the forms do not contain enough information and they are returned to the hospital. It is hoped that many of these barriers can be overcome by e-mail and information systems at some point in the future. Home care responds by authorizing and arranging for the necessary services and supports, often, as noted above, in tight time lines. It was noted that discharges were previously handled by liaison nurses but that these positions had since been eliminated.

The Province is currently developing a new assessment tool for home care and institutional care programs. It is also working on a revised system for client and service data for CLSC that is expected later in 2000. Other initiatives include the SIPA, a system of integrated care for the frail elderly. It aims to provide comprehensive continuous care through all professionals, services and institutions involved. The Province is also piloting an Integrated Palliative Care Project.

The *Portrait of Canada: An Overview of Public Home Care Programs* (February 1998), reported that the hospital – CLSC interface was identified as a significant challenge in the Province. It noted the increase in referrals to CLSC programs, the broadened accessibility and range of nursing and rehabilitation services that were required, the need to integrate staff transferred to CLSC following hospital and facility restructuring and the need for consistency and service protocols.

Saskatoon, Saskatchewan

The Ministry of Health has devolved the development and management of integrated health service networks to local/regional health boards. The Province provides overall direction; establishes provincial objectives, policies, procedures, and standards; provides consultative/advisory services; monitors outcomes; and allocates funding. Health Boards provide a continuum of care including: tertiary, acute, rehabilitation, long term care, public health, home care services, mental health services, addiction services and ambulances.

Saskatoon District Health is one of 32 Health Districts in southern Saskatchewan. It is governed by a 14-member elected and appointed Board of Directors. The District includes 232,000 residents in more than 50 rural and urban communities within a 65 km radius of Saskatoon. The Health Board has an annual operating budget of over \$300 million.

Saskatoon District Health is responsible for a range of health services and supports including hospitals, long term care, mental health, women’s health, family health and the in home care program. They have been operating a Coordinated Assessment Unit since 1984 to provide single entry and case management for community and long term care services. Home care is defined as including the following elements: acute care – the provision of a service that might otherwise have been provided in a hospital or the provision of a service to eliminate the

need for admission to hospital; palliative; and supportive – indefinite home support and respite care to avoid admission to a long term care facility. The Coordinated Assessment Unit also works with informal and community providers to support individuals in their homes and avoid hospital admissions.

The District is served by three acute care hospitals – the Royal University Hospital (tertiary care), Saskatoon City Hospital and St. Paul’s Hospital, an independently owned affiliate which has been integrated within the District. The District also has service partnerships with special care homes, diagnostic laboratory, ambulance services, the University of Saskatoon, research agencies, etc. It is estimated that 50% of patients requiring overnight stay in Saskatoon acute care hospitals are from out of the District.

The Coordinated Assessment Unit has a strong history in Saskatoon. It was developed in 1984 by a joint committee with representation from special care homes, home care, hospitals and housing. It reports to the General Manager, Family Health. Twelve Coordinated Assessment Unit staff are assigned to the acute care hospitals. They describe themselves as “part of the acute care team” and commented on the strong commitment by both the hospital and home care sectors to work within the continuum of care. The program appears to be well-accepted in the acute care setting and many of the challenges experienced in other jurisdictions appear to have been addressed in Saskatoon. The staff access the hospital database and contribute to discussions about bed utilization in the hospitals. Coordinated Assessment Unit staff do “case findings” because they “can’t assume timely referrals.”

It was noted that waits for rehabilitation placements and geriatric assessments, transportation costs for chronic patients, insufficient/lack of community supports and the limited number of beds for cognitively impaired patients are barriers to more effective discharge. Concerns over overlap with hospital-based social work functions has prompted some recent discussions between the two areas. And finally, staff in the Coordinated Assessment Unit share information with patients about private services and programs when concerns are raised about the service levels or scope of the home care program.

In 1993, the Health Board began to change the way hospital services were delivered in the District. New roles were identified for the acute care hospitals which focussed on particular services and areas of expertise. District services and programs are coordinated and organized around eleven care groups and a number of support and professional groups. Saskatoon has made other changes to its acute care hospital system – it has closed a significant number of beds over the past couple of years and, following the nurses’ strike in 1999, made a decision to close additional beds.

Saskatoon is developing a system for registering a client/patient with Saskatoon District Health which will record basic client information on a person’s entry to the health system. This information will be accessible as the patient moves through other parts of the health system. They are also working with Saskatchewan Municipal Affairs, Culture and Housing to encourage collaboration between Housing Authorities and District Health Boards to develop creative housing options for residents who cannot manage in their homes, but who do not require

institutional facility-based care. The Ministry is designing an integrated health information system/network for the Province.

Saskatoon has developed a number of programs to meet increasing pressure on the acute care sector. The Quick Response Program works in the emergency departments from 6 a.m. to 12 midnight to coordinate community care for emergency patients who do not need to be hospitalized but still require some care. Not unlike the Coordinated Assessment Unit, it was developed by a “carefully chosen steering committee with representation from all jurisdictions.” It is described as being “everyone’s program.” The Quick Response Program is being reviewed in one of the other Substudies in the National Evaluation of the Cost-Effectiveness of Home Care set of studies.

The acute care hospitals also have a recent Admissions-Discharge Program. This program focuses on patients waiting to get admitted to hospital and “juggles” bed use within the hospital and sometimes between hospitals to create necessary space. There are daily conference calls between Coordinated Assessment Unit staff, the Admission-Discharge program and the three acute care hospitals regarding bed utilization and waiting lists.

Toronto, Ontario

The Ministry of Health is responsible for a range of health services including home care and hospitals. Since the 1990s there have been significant reforms in the hospital and home care sectors in Ontario.

In 1996, the Ministry of Health consolidated services previously provided by separate home care programs and placement coordination services and in 1997, 43 Community Care Access Centres (CCAC’s) were established. These are publicly funded non-profit agencies established to provide single point of access for a range of community services and programs and for long term care facilities. CCAC’s are accountable through service agreements to the Ministry of Health. They are responsible for the assessment, case management, and discharge planning (from home care) as well as the coordination and delivery of services. They contract out all professional and home support service delivery.

The Ministry of Health sets broad guidelines and policies for CCAC’s and allocates funding.

In 1997, the Provincial government established an independent Health Services Restructuring Commission with responsibility to restructure the provincial health system. Its mandate included hospitals, reallocation of resources to the community and the integration of acute and community care. It made recommendations which reorganized the delivery of hospital care in both Thunder Bay and Toronto.

Another important change affecting home care was the shift to managed-competition and the 1999 tendering of service contracts to private and non-profit service providers. This has created significant upheaval and controversy in the service community.

The Toronto Community Care Access Centre covers the old City of Toronto boundaries and any hospitals located within those boundaries. It is an area of 97 square miles and approximately 652,165 residents. This base population is doubled each day by commuters, students and visitors who spend their day in the city and return to their homes outside Toronto each night. The CCAC serves approximately 8,500 clients per day. Over two-thirds of the clients served are 70 years or older.

The CCAC has a community-based board to direct its operations. It is a relatively new organization, having been created in 1997 from the regional Home Care Program and the Placement Coordination Service. It is responsible for the assessment, case management and coordination of access to in home, community services and long term care facilities for eligible persons. The CCAC reports directly to the Ministry of Health and Long Term Care.

The Toronto CCAC has assigned Care Coordinators to the acute care hospitals in its area. These staff respond to referrals and conduct in hospital patient assessments. It was estimated that approximately 60 – 70% of referrals are for same day service. The client health information they collect is sent to their central unit for processing and referral to the contracted service providers. The process was described as cumbersome. There is no computer system to support the sharing of data – referral forms must be faxed or sent by courier to the central intake office at various points in the day. Different hospitals provide different levels of access to patient charts and information.

Hospitals in the Toronto Area are in the process of being restructured based on recommendations from the Health Services Restructuring Commission, established by the Minister of Health. Some are merging to create larger health care corporations, some are closing and others are changing their focus to other forms of health care. This adds to the challenges in developing a relationship with the new CCAC regarding patient discharge.

Each hospital is different in its set-up and practices; “how well discharge works depends on the CCAC team and the nature of its relationships with the hospital.” A Toronto Area Discharge Planning Group met for 6 – 8 months, but it stopped when the Toronto Academic Health Sciences Council was disbanded. Representatives from the Toronto hospitals and the CCAC do not get together regularly as a group.

A wide range of barriers to discharge was identified in the interviews with St. Joseph’s Health Care Centre, the Toronto Western Hospital, St. Michael’s Hospital and the Toronto Community Care Access Centre. They included concern about doctors’ roles in the discharge process and their “emphasis on moving patients through the system” and the lack of knowledge in the acute care sector about home care and limited understanding of the community sector. Nurses’ roles and capacity to manage patient discharge processes were also identified as a barrier, particularly with the move to primary nursing. CCAC staff members do not have time to go on rounds or to do much advance planning for discharges. They function in a reactive mode, “coming in at the end of the patient stay.” Community nursing shortages have a significant impact on discharges – from time to time certain areas of acute care hospitals are told not to refer clients to the home care program. There are very long waiting lists for physiotherapy (not a

service funded by the CCAC) and occupational therapy supports in the community and for assessments of patients in the hospital. Access to long term care beds is also a problem.

Both sectors expressed concern about the lack of choices for acute care discharge of patients who are unable to return home. Alternative community supports, step down units, convalescent care, transitional care, rehabilitation beds and subacute beds were some of the alternatives that need to be available to better support patient discharge. Cost of medical supplies was also identified as a barrier. For example, it was noted that surgery, in particular, is moving to more expensive but better wound dressings that need to be changed less often. Clients cannot afford the dressings in the community and use the less effective and less expensive ones that require more frequent home care visits. The cost is shifted from the hospital to the client and the home care system.

There is increasing recognition of the need to work together for the client. The CCAC is participating in some hospital staff training and orientation programs and is meeting regularly with liaison staff in each hospital. Interpersonal relationships are important to the success of the discharge process. A good relationship with the CCAC staff assigned to one hospital has led to flexibility, understanding and a better discharge process.

Two projects were highlighted during the interviews that may have an impact on the hospital to home care transfer process. The first was the development of a comprehensive medical referral form and system access for both the acute care hospital and the CCAC. The second was a care mapping project to look at outcomes for facility and community supports and develop process support pathways and information and supports for patients and caregivers.

APPENDIX 2: Project Proposal: An Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care

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Rationale/Problem Statement:

Home care programs are an increasingly important component of our health care systems. The success of home care programs as substitutes for hospital care is dependant on a variety of factors including the quality of care, the cost of care, the access to services and the relationships between the various organizations and providers involved in planning for and providing home care services. This study will focus on a critical part of the success formula – the transfer process, when clients are discharged from hospitals to home care in the community. Discussions with people in the home care field have indicated that the efficiency of this transfer process varies across sites. It has also been noted that some hospitals work more collaboratively with home care providers than others. While there is knowledge about the differences in arrangements among jurisdictions in Canada, little has been documented about the challenges, common elements and learnings from these various approaches.

This study will provide an understanding of the dynamics which impact on the discharge processes. Through directed research and an examination of three case studies, it will consider the impact that the organization of services in a jurisdiction, accountabilities, roles and relationships, mechanisms for coordination, and formal and informal authorities have on the effectiveness of the transfer process. The study will focus on the interface between the hospital systems and the home care systems in selected jurisdictions. It will provide a qualitative context to inform policy makers, planners and service providers in order to help them to improve the transfer of patients from acute care to the home. And finally, it will identify existing blockages to the adoption of optimal discharge processes for transfers between hospitals and home care.

This Substudy is meant as a companion to Substudy 6.

Goals and Objectives:

The goals of Substudy 15 are to provide information about the blockages to an effective interface between hospitals and home care, suggestions about how to overcome these blockages and information about what would constitute an optimal discharge process for transfers from hospital to home care.

It will achieve this by:

1. Identifying key issues and challenges relating to the effective transfer from hospital to home care.
2. Describing and documenting three case studies or examples of best practice. These more detailed studies will describe and contrast how different jurisdictions in Canada have responded to the need for effective systems of client transfer between hospitals and home care providers.
3. Contributing to the understanding of the hospital to home care transfer process by identifying key learnings from the case studies which could inform future policy and program development.

Policy Relevance:

Substudy 15 will provide valuable contextual information needed by service providers, planners and policy makers to design policies and programs which streamline the transfer of clients from hospital to home care. It will also be relevant to those involved more broadly in planning for integrated and seamless service systems.

Design and Methodology:

This research project will study the interface between the hospital system and the in home care system. Seen in this systems context, the transfer of patients becomes a complex boundary issue involving individuals, professions, institutions and systems. We will articulate our understanding of complex health care organizations and systems based on our work in another,

complementary area – the development of a framework to understand the management of complex health care systems. Our work will be guided by a Panel of Experts, a group of individuals from across Canada who are involved and interested in the transfer of patients from hospitals to in home care. The Panel will provide input and advice to the project.

Framework

CPRN is working on the development of a framework for improving the understanding of health care organizations and systems. One aspect of this framework considers the coordination of services across the many boundaries in health care. These boundaries mark such things as professional interests, institutional budgets, levels of care and so on. Building on this preliminary framework, it is our assumption that there are many boundaries between acute care and in home care that can complicate patient transfer.

In particular, the framework considers the nature of the dynamic relationships between four key worlds of health care – the hospital which focuses on cures, acute care facilities which focus on care, the community, represented by elected officials and advocacy groups, and the system controllers, the regulatory agencies, public health authorities and managers. The framework also articulates three forces which draw these different worlds together. These are commitment to purpose, desire to advance knowledge, and urgency. It is expected that use of this framework will help promote an understanding of the various relationships and dynamics in the case studies and encourage the consideration of a broader range of responses to the difficulties that arise from boundary issues.

Experts

We have begun to assemble a Panel of Experts who represent a range of professions, organizations and interests across both sides of the acute/home care boundary. They include medical, nursing, service and administrative experts from acute and in home care organizations and researchers who are knowledgeable about the issues. The Panel will actively contribute to the research exercise by participating in the development of the systems framework, contributing their knowledge of the field, identifying sites for detailed study and issues for investigation, providing input and comment to the project report, and acting as a resource throughout the research project. The Expert Panel will contribute early in the project to the framework development, they will shape the research and they will play a central role in developing the conclusions and recommendation contained in the final report.

Experiences Across Canada

Policies and practices respecting the transfer of patients from hospitals to the care in the home differ from province to province, within provinces and from institution to institution. The diversity of experience suggests that there will be much to learn from the variety of approaches across the country and from academic and professional studies and research on the issue.

Substudy 15 will include a focussed literature search on transfer issues and practices. Based on input from the Expert Panel a selective telephone survey will be conducted with key

informants. These telephone interviews will contribute to a broad understanding of the range of hospital to home care transfer arrangements across Canada. A minimum of 10 key informant interviews will be undertaken. The standard survey questions will be shared with interview subjects prior to the interview and detailed notes will be taken of the responses. The goal of this part of the research is to provide an overview of the range of transfer arrangements across Canada and to articulate the key challenges faced by organizations involved in the processes. Common issues and themes will be highlighted. Jurisdictions will be selected which represent a broad range of communities and organizational arrangements across the country.

There are some individual sites where innovative work is being done on the transfer of patients from the acute sector to in home care. Short case studies will be prepared for three such sites. These case studies will describe the service environment and the relationship between the hospitals and in home service providers, the policy context, the model of patient transfer and its successes and challenges. Learnings from the case studies will be summarized, compared and contrasted. Common elements in the transfer process will be highlighted as well as elements unique to one jurisdiction.

Case studies will be prepared on the following jurisdictions:

- P.E.I. – This province of approximately 150,000 people is divided into 5 Home Care regions. Each region directly provides service to eligible clients. P.E.I. Home Care does not provide acute care substitution. They do not provide 24-hour care or services 7 days of the week, except in particular situations. It was estimated that 75% of clients are seniors, persons with disabilities or persons receiving palliative care. While each region shares the common Home Care program parameters, they have unique situational and organizational challenges. For example, Charlottetown, the largest of the five regions, has the major provincial hospital and consequently must coordinate its hospital discharge processes with all five Home Care regions.
- Ontario – There has been significant reform in the separately managed hospital and home care sectors in Ontario. The Ontario situation will examine a Community Care Access Centre and its discharge relationship with hospitals in its region. A jurisdiction has not yet been selected for detailed study. Because the direct provision of service has been contracted to community providers, this case study will include the perspectives of community providers and detail the role they play in the discharge process. As health reform continues in Ontario, this case study will document the situation at this particular point in the reform process. This study may also highlight conclusions which relate specifically to the ongoing transfer of clients during periods of major system(s) change.
- British Columbia – In British Columbia, hospitals and home care are under the same jurisdiction, the Health Region. As in other provinces, there are some interesting reforms underway in B.C. The Simon Fraser Health Region, for example, is involved in a major process redesign between the region's hospitals and its home care program. \$2 Million is being shifted from acute care to community care to support the transfer of individuals from hospitals. Client Coordinators, staff of the Continuing Care program, have been placed in hospitals, 24 hours a day, 7 days a week, to navigate the transfer process and

coordinate successful community care arrangements. The Care Link program is relatively new – it is in its 10th week of implementation.

Following a review of relevant material including reports, program descriptions, etc., site visits will be made to each of the case study jurisdictions. Individual interviews will be held with key informants in the jurisdiction. Focus groups may also be organized in situations where there are informants from a range of organizations with similar roles in the transfer system or where there are multiple interviews within the same organization and it would be beneficial to the process to organize a group discussion of the issues. Decisions on whether to hold individual or group interviews will be made on a site by site basis. The interviews will follow a standard interview format to ensure that all areas for investigation are consistently covered. The common questions will allow for individual variability in response and for probing unique areas of expertise or interest. Detailed notes will be taken during all interviews – they will be used by the researcher and will not be transcribed or recorded.

Most of the data collected will be qualitative. It will reflect individual, system and organizational perspectives on what works and what doesn't work in selected jurisdictions' discharge processes. Common themes will be highlighted, as will unique individual perspectives on the issues. Some basic quantitative budget, program and demographic data will be included in the case studies to describe the current scope and scale of service provision. Standard measures will be used to ensure that this descriptive information is comparable as much as possible.

Because of the variations in the organization of the services in each of the regions, it is not possible to identify organizations and individuals to be contacted. The following groups of interview subjects can, however, be identified:

- individuals involved in the discharge process from the hospital(s) in the region
- other individuals within the hospital system – administrators, physicians, discharge planners, practitioners, etc., as appropriate
- individuals involved in the management, planning and delivery of the regional Home Care program
- contracted service providers (if appropriate)
- district health council or other health planning organizations
- health planners – provincial and/or municipal
- academics and/or others interested and involved in the transfer process
- others – as identified through research and pre-visit discussions with the key informants in the jurisdictions

It is anticipated that at least 8 individuals will be interviewed at each case study site. This is a minimum number as case study jurisdictions involving multiple hospitals and service providers, for example, would require additional interviews and/or focus groups and the number of individuals contacted/interviewed would be greater.

Final Report

The final report will be reviewed and approved by the Expert Panel prior to its release. The report will:

- clearly identify the key issues and challenges relating to the effective transfer of clients from hospitals to home care
- describe case studies where obstacles to patient discharge have been reduced and transfers improved. It will identify and clarify the boundary issues that create obstacles to smooth patient transfer. It will indicate key characteristics of optimal discharge procedures and identify common challenges in developing successful transfer processes.
- highlight the policy and practical implications of the research.

The report will provide a clear description of methods used. Background material including lists of individuals and organizations contacted and/or interviewed, interview questions, listing of background material by jurisdiction as well as a detailed bibliography will be included in an Appendix to the report.

Principal Investigator

Sholom Glouberman, Ph.D., is Director of the Health think tank at the Canadian Policy Research Networks, Philosopher in Residence at Baycrest Centre for Geriatric Care, Adjunct Professor at the University of Toronto and a Visiting Fellow at the King's Fund in London England.

Sholom has worked with and spoken before a wide variety of health professionals, managers and policy makers in many European and North American countries. He has written extensively. He edited *Beyond Restructuring*, a collection of papers from a King's Fund international seminar and wrote *Keepers*, a study of workers in total institutions. He has recently completed a series of papers with Henry Mintzberg on the structure and dynamics of health care systems and organizations.

Senior Researcher

Caryl Arundel, M.Sc., has a strong background in municipal government, having held senior operational, policy and support positions in Metro Toronto and the City of York. She also worked in London, England in the local government and community sectors. Caryl has particular expertise in social policy and in the human services and health sectors. She is a past member of the System Planning Committee and the Coordination of Psychogeriatric Services Work Group of the Toronto District Health Council.

APPENDIX 3: Expert Panel Members

Denise Alcock, Ph.D., is Dean of the Faculty of Health Sciences at the University of Ottawa. Dr. Alcock is a member of the Medical Research Council, a board member of the Ottawa Hospital and the Sisters of Charity, Health Services Inc. She sits on the University of Ottawa Senate Committee and is a member of the University of Ottawa Faculty of Graduate and Post Doctoral Studies. Dr. Alcock's areas of specialization and research include health system research, home care, competencies of health service providers and pediatrics. She has published in numerous refereed journals including *The Canadian Journal of Public Health* and *The Canadian Journal of Nursing Administration*.

Margaret Macadam, Ph.D., came to Baycrest Centre for Geriatric Care as Vice-President, Social Services with extensive experience managing, developing and researching services for elderly people. Born and raised in Nova Scotia, she attended Ottawa University, Boston University and Brandeis University. Her doctorate from the Florence Heller School at Brandeis University in the United States is in the area of health policy and aging. Before joining Baycrest Centre for Geriatric Care, she was Associate Research Professor at the Health Policy Institute at Brandeis University.

At Baycrest, Dr. Macadam is responsible for directing and evaluating the delivery of social services to elders served throughout the Centre. Dr. Macadam is also the Senior Vice-President at Baycrest Centre and is responsible for policy development and implementation of certain Centre-wide projects.

During the past year, Dr. Macadam has worked part-time for the Home Care Development Branch, Health Canada.

She is Associate Professor in the Faculty of Social Work and Health Administration, Faculty of Medicine, University of Toronto.

Howard Bergman, MD, is Associate Professor in the Departments of Family Medicine and Medicine and Director of the Division of Geriatric Medicine of the Department of Medicine at McGill University. He is Adjunct Professor in the Département d'administration de la santé at the Université de Montréal. Dr. Bergman is also Director of the Division of Geriatric Medicine at the Jewish General Hospital in Montreal. His research interests focus on health care systems for the elderly as well as on dementia and Alzheimer's disease.

In the area of health care systems for the elderly, Dr. Bergman, with François Béland, leads a joint McGill/University of Montreal Research group on Integrated Care for the Elderly (SIPA). The Montreal Regional Health Board, in collaboration with the research group, recently received a major grant from the Health Transition Fund to implement and evaluate a demonstration project based on the SIPA model. He is a member of a working group in the Quebec Ministry of Health studying integrated delivery systems. He was also co-investigator with a group which received a grant from the Fonds d'innovation of the Quebec Ministry of Health to develop and evaluate a project on joint hospital/CLSC case management for frail elderly. He has been involved as a consultant on the organization of care for the elderly in other provinces across Canada.

Dr. Bergman is the founder and Director of the Jewish General Hospital/McGill University Memory Clinic and he is a co-investigator in the Canadian study on Health and Aging. Dr. Bergman is a member of the Executive Committee of the Geriatrics/Gerontology network funded by the Fonds de la Recherche en Santé du Québec (FRSQ). He is particularly interested in early diagnosis of dementia and is a member of a research team funded by the FRSQ on the epidemiology of dementia. He is involved in multicentre trials in dementia and is a member of the executive of the Consortium of Canadian Centres for Clinical Cognitive Research (C5R).

Céline Bureau, M.Sc. (Nursing), is the regional coordinator for the SIPA project in Montreal since April 1998.

Before joining this project, she was Coordinator of the Home Care Program at CLSC Metro in downtown Montreal for 10 years.

Ms. Bureau received her Master's degree in Nursing from the University of Montreal in 1981.

Since 1976, she has held various positions in nursing. Among those, she was staff nurse at Hotel-Dieu Hospital in Sherbrooke, in a nursing home and in home care between 1976 and 1980. She also taught nursing in Switzerland, was a team leader for nurses in a home care program and worked for the Provincial Association of Nurses in Quebec between 1980 and 1988.

Carol McWilliam, M.Sc.N., Ed.D., is an Associate Professor, Faculty of Health Sciences, at the University of Western Ontario. Over the past 9 years, both as a Career Scientist of the Ontario Ministry of Health and as a member of the Centre for Studies in Family Medicine, she has developed a program of research focussing on issues of seniors: independence in the pursuit of health care, including investigation of the management of their transition from hospital to care at home, health promotion for chronically ill older persons, and approaches to in-home, medical, and public health care which foster seniors' independence. Her interests include health promotion, health services delivery, care management, living with chronic illness, and innovation in research methodologies, including the application of qualitative research methodologies and new approaches to knowledge transfer from research.

Julie Foley, M.S.W., is the Executive Director of the Scarborough Community Care Access Centre in Toronto. She previously worked as the Director of the Placement Co-ordination Service of the Family Services Association of Metro Toronto and as the Executive Director of the Family Counselling Centre in Sarnia. Ms. Foley also has worked in the social work department in hospitals and with a Children's Aid Society.

Ms. Foley has extensive experience in the community. She is Past President of the Canadian Association of Social Workers and participates in the Ontario Association of Social Workers. She is Chair of the Montreal 2000 World Conference of the International Federation of Social Workers. She has been active in the past as a Board Member of the Sarnia General Hospital Commission and on a number of other voluntary organizations including an AIDS Support Committee, the Canadian Mental Health Association (Sarnia) and the Policy Research Centre.

APPENDIX 4: Hospital to Home Care Discharge Interface – Synthesis of Relevant Literature

This paper summarizes the key issues contained in recent literature regarding the relationship between hospitals and home care and the discharge of patients from acute care to home care. It begins with some definitions and descriptions of the different perspectives from which one can consider the interface. It identifies barriers and challenges to a more effective relationship and the range of best practices cited as promoting an enhanced discharge interface. And finally, it concludes with some discussion of the need for systemic change in the relationship.

The paper is organized to focus attention on key elements of the hospital to home care discharge interface and to provoke discussion of the issues.

Definitions

A 1990 Working Group on Home Care, established under the Federal/Provincial/Territorial Sub-Committee on Long Term Care, stated that “...there is no precise and universally accepted definition.... Home care has different meanings in different places.” The report noted that there were three distinct models of home care: (22, p. 13)

1. Acute care substitution
2. Long term care substitution
3. Maintenance and prevention model

While acknowledging that there is variation in the definition of home care, for the purposes of this study, it has been defined as acute care substitution.

Home care is usually discussed in the context of a system of continuing care. Continuing care is seen as containing two complementary concepts: first, that care may continue over a longer period of time, and second, that an integrated program of care continues across service components; that is, that there is a continuum of care. It is a complex system of service delivery which includes all the services provided by long term care, home support and home care. (22, p. v)

Different Perspectives on the Interface

Most studies focus on home care to hospital discharge relationships within a specific environment. Some consider the interface from the perspective of home care and its policy and organizational environment. This environment has been described as emphasizing patient rights and holistic and personalized care.(21) Home care has been described as “undergoing an industrial metamorphosis” (34) based on the rise of the patient as consumer, the introduction of innovative technology and a new breed of more entrepreneurial managers. In some environments home care is characterized by multiple smaller service deliverers, contracts with

larger profit and not for profit organizations, single, government-based service delivery, or other delivery arrangements. Accountability within the home care environment also varies across Canada. Some home care organizations report to a regional health care authority and others to a non-profit Board accountable to the Province.

Other studies use the patient care environment as the basis for a review of the relationship between hospitals and home care. This environment is complex; it reflects the multidisciplinary nature of patient care and the broad socio-cultural and demographic patient backgrounds.(22) It focuses on the discharge process and interface between the hospital, home care and patient from the perspective of patient satisfaction and outcomes. Patient confusion regarding the discharge process, anxiety about discharge and lack of communication are issues that are frequently raised.

Much research is based in the discharge planning environment. This includes the hospital and its multilayered and multidimensional environment and some elements of the home care and the patient care environments. It is not usually comprehensive in encompassing all the diversity and complexity of these other two environments. The discharge planning environment has been described as representing a “clashing and bashing of competing interests.” (27) It is complex; it contains shared and/or dispersed authority for decision making. It includes both acute and continuing care players. Frequently research attention is focussed on the roles and interrelationship of specific professionals in the discharge process, i.e., physicians, nurses, case managers, social workers, and discharge planners as well as on the tools they use, i.e., assessment criteria, case management protocols and coordination mechanisms. It considers internal boundary issues, managerial and cultural, that affect the discharge process.

Finally, the relationship between hospitals and home care can be considered from an organizational perspective. This tends to occur more in management and organizational theory literature than in research grounded in the health professions. This approach considers the relationship between the two different health care systems in the dynamic and changing health care environment. It focuses on external boundary issues, which tend to increase and become more important as the number of organizations involved expands and the level of contact increases.(18) This environment is further complicated by the inclusion of both community and institutionally based and profit and non-profit organizations.(24)

Challenges/Barriers to Effective Hospital to Home Care Discharge Interface

A wide range of barriers to the effective interface between hospitals and home care is discussed in the literature. It is summarized below.

Interprofessional Relationship Barriers

- Specialization in the health care sector – it is estimated that there are 53 types of health care professionals in Canada and many more paraprofessionals. While this can have a positive effect of raising the educational and experience standard for each profession, growing specialization and professionalization have also resulted in narrower professional perspectives and a more fragmented and professionalized care system. (24,22)

- Physician authority – physicians have ultimate authority and responsibility for patient care. The concentration of power in physicians reduces the scope for collaboration and interface relationships.(21)
- Perceptions and attitudes – limited perspectives of professionals in home care and hospital settings undermine effective discharge processes. Negative perceptions as well as lack of information and understanding affected referrals, communication and coordination.(21)
- Degree of specialization and bureaucratization – Rural settings demonstrate a greater capacity to coordinate and collaborate on discharge planning. This is partly because individuals involved in the health care system know each other and are required to work together on an ongoing basis and also because there is less specialization and bureaucratization in the smaller health care settings.
- Lack of common system priorities – poor understanding of the new health care environment and resistance to move away from current hospital paradigm will impact on the development of common and shared system priorities. In addition, individuals’ perceptions of their goals, whether the goals are cooperative, competitive or independent, will affect the dynamics of the relationships within a system and the outcomes of interaction.(31)

Organizational and Cultural Barriers

- Entrenchment/traditional way of doing things – research consistently identifies entrenchment as a barrier to integration and more effective systems and relationships. The existing power structure or “negotiated order” and the established patterns of practice were seen as significant barriers to change and to a more effective discharge relationship.(24,19,23,2)
- Overemphasis on acute care – the overemphasis and dominance of acute care in the health care system and the discharge process in particular is seen as a barrier to the development of more effective and responsive discharge relationships and processes. (8) The development of a relationship between the hospital and home care sectors has been described as “putting an underfed mouse (home care) with a well-fed elephant (hospital and acute care sectors).”(10)
- Entrepreneurial interests of hospitals – hospitals are seen to be successful if they garner research grants, have state-of-the-art technological equipment, upgrade their facilities and attract renowned researchers and practitioners. It is suggested that pursuit of these “entrepreneurial” and “bricks and mortar” interests overshadows the institutions’ attention on some of its less visible internal and interface issues.(8,2,29)
- Lack of incentives – A number of studies noted that the lack of incentives to change existing practices and negotiate new relationships and interfaces was a significant barrier.(8)

- Information – lack of information, inadequate formal information systems, misinformation and the challenges of educating and informing everyone within a large hospital/institution were seen as barriers to a better interface.(6)
- Organizational independence – hospitals and home care are separate and independent organizations.(21) Maintenance of this independence was seen as limiting the possible interface options. In addition, hospitals and home care organizations have limited relationships at defined service points in their service continuum. While increasingly important, these relationships have not been seen as critical to the effective functioning of the institutions. Size, complexity, structure and nature of health care systems undermine access, coordination, continuity, comprehensiveness, patient centredness and effective care.(21)
- Restructuring activities – both the hospital and home care sectors are involved in significant restructuring and consolidations of organizations, structures and processes. This restructuring tends to be occurring within each sector, rather than based on a comprehensive view of the total health care system.(6,10)
- Organizational philosophy and culture – it has been suggested that the hospital environment emphasizes efficiency, rules and authority. It has been subject to a number of years of fiscal restraint. In contrast, the home care environment has an increasing emphasis on patient rights and more holistic and personalized care and its budgets have grown over the past few years. The contrasts in operating cultures have an impact on the development of an interface between the organizations.(21)

Best Practices

The literature identifies a wide range of interface and discharge best practices. These practices range from tools and relationships, which lead to more effective discharge practices, to best practices, based on more comprehensive system reform. The literature recognizes that there has been a great deal of project improvement – ad hoc, fragmented, separate responses which address specific problems or inefficiencies. Increasingly this is seen to be tinkering with the discharge relationships and processes and not tackling the nature of the problem.(23,24) This includes the application of tools such as pathways, eligibility criteria and screening forms as well as mechanisms to coordinate the discharge process or various interests involved in the process. This could include discharge planner roles, multidisciplinary teams, social work and home care coordinator functions.

This observation is consistent with the perspective that the health care sector separates issues and actions into segments or increments. It is also consistent with the perspective that most of the discharge literature is discipline specific.(27) Both serve to restrict and narrow the focus within the discharge planning process and will naturally result in tool and service focussed relationship changes.

While many argue for more integrated health systems, few best practice examples of comprehensive systems change were identified in the discharge interface literature. When vertical integration has been discussed it has been with the caution that it may lead to integration of home care into the medical model of care rather than the development of a new, integrated, more holistic model.(24) Nonetheless, there is wide support for systemic and transformative change and for the development of a new model.(23)

The following is a list of best practices identified in the literature review. It is important to note that best practices occur when a practice has been both successfully developed/designed and successfully implemented. The practice, by itself, will not change the discharge process or interface. It must be accompanied by successful implementation and follow-through.

The list is intended to illustrate the broad range of best practice elements contained in recent literature and to stimulate reflection on an appropriate package of practice elements to promote better discharge relationships between hospitals and home care.

Patient Transfer Tools

Clinical pathways (4)
Care pathways
Quality planning (9)
Systematic approaches to written correspondence (21)
Application/eligibility criteria
Screening
Active patient management system (24)
Care level classification system (11)
Complete, understandable, documented and communicated discharge plan (33)

Interprofessional Relationship Best Practices

Discharge planner (27)
Home care coordinator (27)
Multidisciplinary teams (21)
Team meeting (21)
Team work/team leadership (24,25)
Face to face communication (21)
Committee structures (25)
Social work (26)
Informal, interpersonal relationships
Interdisciplinary approaches to professional education (21)
Consistent RN presence in acute care (3)
Coordinated case management (35,11)
Coordinated assessment and placement (11)
Single point of entry (10,11)

Elements of System and Organizational Best Practice

Incentives/rewards (24, 17)
Congruent goals
Integrated management and operations (17)
Budget integration (1)
Aligned funding (26,17)
Integrated policies
Single administration (11)
Shared goals (19)
Leadership (24,25)
Communications (25)
Overcoming resistance
Changing attitudes, perceptions and traditions
Feedback and monitoring (8,17)
New management culture – managing across boundaries (24)

Elements of Patient Focussed Best Practices

Patients frame of mind, philosophy of life (20,19)
Patient and family preparedness (21,3)
Patient and family involvement in discharge process (6,21)
Timely identification of needs (33)
Options/alternatives (33)

Hospital and Home Care Integration and Organizational Models

The 1997 National Forum on Health Report called home care one of three areas for action to move towards a more integrated health care system.(32) A 1998 National Conference on Home Care defined five elements of a national home care program. One of the five elements was integration – a coordinated system of home and community related service, embracing a broad (holistic) definition and including a wide range of services. It was described as being seamless, comprehensive, well-planned, integrated with other health care services and having a single entry point.(10)

Organizational change in the health care sector is usually described in terms of integration. Lateral integration is seen as addressing internal coordination and focus issues. However, as health care organizations expand, and the number and type of organizations they interact with expand, external boundary issues become more important. This often leads to an interest in horizontal integration.(18)

The literature identifies three main forms or levels of integration that are possible within the health care system. They include functional, clinical, and physician integration. It notes that integration can be done through contractual arrangements, strategic alliances and partnerships, or single ownership. Functional integration refers to the coordination of management and administrative functions within the health care system (i.e., information systems, human resources, finance, etc.).(24, 8) Clinical integration is the coordination of care to a patient across

professions, sites, processes and activities. (24, 8, 32) Physician integration describes the shared vision and system values among physicians and the presence of economic motivations to participate in the system.

The development of a single point of entry has resulted in some coordination in the discharge process and relationship between hospitals and home care. Further integration, a paradigm shift (17), transformative change or systemic change is identified as needed. There are different opinions about the ultimate form of an integrated hospital and home care system. It has been argued that home care should not become an independent program – focus instead should be on its integration with other parts of the health care system. Another perspective recognizes the integrity of the home care system and cautions that it should not be merged into the hospital model but rather a new model, building on the strengths of both systems, be developed.

Parallel to the discussion of integration is increasing attention on organizational form and function. Again, while it is recognized that the current organizational forms do not adequately respond to the changing environment and the need for increasing integration, there is little consensus on the solution or organizational approach.

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APPENDIX 5: Interview Templates

Hospital Interview Questions:

The specific focus of the interviews/focus groups will vary depending on the individual's involvement in the process; however, the following represents a broad overview of the areas that will be discussed during the sessions.

Describe your discharge process:

- Is there a formal discharge plan/process?
- When does it begin?
- Who is involved?
- What roles do they play?
- Level of integration of professionals within the hospital?
- Level of integration with home care services?
- Post discharge – roles and responsibilities. Who has ongoing clinical responsibility for the patient when he/she leaves the hospital?

How are complex cases handled?

What about chronic patients, who return for different reasons to the hospital for treatment?

Is information shared between the hospital and home care programs?

- What is shared?
- How is it shared?

Do you have any service standards/performance measures that relate to discharge process/planning?

How do you measure how successful you are regarding patient discharge?

Are these measures/indicators common across your organization – do different professionals in your hospital have different measures?

Does your hospital have common or different measures/indicators than home care?

Do you assess patient satisfaction with the process? How?

Do you obtain other performance input regarding the discharge process? From whom?

What kinds of problems arise in the discharge process most often?

How are they resolved?

Describe an unusual situation – how are unusual problems resolved?

Is discharge a priority within your organization?

Why or why not?

How is this communicated within the hospital?

What is the impact on the discharge process?

Are there any incentives within your system to facilitate patient discharge?

What are your hospital's discharge best practices?

How is best practice defined in your hospital?

What factors need to be in place and what helps them to work?

Lessons learned from your experience with patient discharge and the hospital to home care interface?

Based on your experience, what are the barriers to effective and efficient patient discharge?

These could include:

- Process barriers
- System barriers
- Resource barriers
- Patient barriers to discharge
- Role barriers
- Other

Other comments/input?

Home Care Interview Questions:

The specific focus of the interviews/focus groups will vary depending on the individual's involvement in the process; however, the following represents a broad overview of the areas that will be discussed during the sessions.

Describe the hospital to home care discharge process:

- Is there a formal discharge plan/process?
- When does it begin – at what point does home care become involved?
- Who is involved from home care?
- What roles do they play?
- Level of integration of professionals within your organization regarding discharge?
- Level of integration with the hospital?
- Post discharge – roles and responsibilities?

How are complex cases handled?

What about chronic patients, who return for different reasons to the hospital for treatment?

Is information shared between the hospital and home care programs?

- What is shared?
- How is it shared?

Do you have any service standards/performance measures that relate to discharge process/planning?

How do you measure how successful you are regarding patient discharge?

Are these measures/indicators common across your organization – do different professionals have different measures?

Does your hospital have common or different measures/indicators than the other hospital(s)?

Do you assess patient satisfaction with the process? How?

Do you obtain other performance input regarding the discharge process? From whom?

What kind of problems arise in the discharge process most often?

How are they resolved?

Describe an unusual situation – how are unusual problems resolved?

Is effective and efficient patient discharge a priority within your organization?

Why or why not?

How is this communicated within the organization?

What is the impact on the discharge process?

Are there any incentives within your system to facilitate patient discharge?

What are your organization's discharge best practices?

How is best practice defined ?

What factors need to be in place and what helps them to work?

Lessons learned from your experience with patient discharge and the hospital to home care interface.

Based on your experience, what are the barriers to effective and efficient patient discharge?

These could include:

- Process barriers
- System barriers
- Resource barriers
- Patient barriers to discharge
- Role barriers
- Other

Other comments/input?

Discharged Patient Interview Questions:

How would you describe your discharge from hospital?

Was it smooth? Was it well-coordinated?

Was your discharge delayed? If so, why?

Did you understand what was happening, or going to happen, and why?

Were you involved in the decision that you would be discharged from hospital? Were you involved in deciding what kinds of service you would be receiving from home care?

When did someone at the hospital first mention your discharge and the need to make arrangements for home care for you?

Who first talked to you about discharge?

Was it always the same person who talked to you about discharge or were there different people?

Who were they? Nurses, doctors, social workers, home care workers, etc.

Was anyone from your family or community involved in the discharge arrangements that were made for you? Who? What was their role?

Did you talk to anyone from home care while you were in the hospital?

When you got home from the hospital, was the home care service delivered to you as you understood it would be?

Did you get the services you thought you would get, when you thought you would get them?

Did anyone follow up with you to make sure you received the right services after your discharge from hospital? Who? When? What type of follow-up? (phone call, home visit, etc.)

What worked well in your hospital discharge? What do you feel worked well and why?

What didn't work well – what can be improved for future hospital discharges?

Basic Information (encouraged, but optional)

Age:

Length of time in hospital:

Reason for hospitalization:

Type of services received: nursing, homemaking, therapy (occupational therapy, physiotherapy), social work, other

APPENDIX 6: Bibliography

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