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# **“My home is not my home anymore:” Improving Continuity of Care in Homecare**

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# **“My home is not my home anymore:” Improving Continuity of Care in Homecare**

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## **Key Implications for Decision Makers**

- In the mid-1990s, Ontario's homecare sector underwent dramatic changes in the way services are organized and paid for, as a system of managed competition was introduced.
- The main barriers to continuity of homecare lie in problems with staff and a lack of information.
- Problems with continuity of care can occur when care plans are being designed and evaluated and when services are being delivered by homecare workers.
- The systems for monitoring service contracts and service delivery are inadequate, resulting in duplication and poor continuity.
- There is a high turnover rate in the homecare sector, due to lower wages and benefits than the institutional sector.
- Homecare clients should have consistent service providers to maximize efficiency and improve care continuity – when service providers know how the home is organized, they can work more quickly and efficiently.
- Service providers must consistently have the appropriate knowledge and skills to effectively do their jobs.
- Co-ordination of services to meet the care plan for homecare recipients is necessary for continuity of care.
- The competitive bidding process means Community Care Access Centres and service providers cannot work collaboratively, which hinders continuity of care.
- Better communication among stakeholders is required. Communication – especially during transition periods – is inadequate between case managers and service providers, resulting in poor continuity of care.

## **Executive Summary**

### **Context**

The management of homecare services changed following the 1995 election of a new provincial government in Ontario. Forty-three not-for-profit transfer agencies called Community Care Access Centres (CCACs) were created to manage homecare and act as purchasers of services for homecare clients. CCACs were directed by volunteer community boards overseeing the introduction of competitive contracting for homecare service provision. At the same time, hospital downsizing led to patients being discharged sooner, sicker, and more likely to need homecare during their recovery at home.

In this environment, we examined what continuity in homecare means for different stakeholders, including longer-term clients, case managers, service providers, and community physicians. We also examined the problems with care continuity that clients experienced, the implementation of the competitive contracting model, and the impact of competitive contracting on continuity of care and the consistency of homecare personnel for clients in one Ontario community.

### **The Implications**

There are many implications of our findings for policy makers, case managers, and service providers. Policy makers must think of the homecare sector in terms of the broader healthcare system, and they need to pay greater attention to the factors that promote continuity of care.

Requests for proposals process should be changed so that CCACs can better compare information from service providers, and better mechanisms are needed to monitor how well the service providers follow contract terms, including guarantees regarding communication strategies and consistency of personnel. As well, longer contracts would provide greater stability for both clients and the homecare workforce.

Case managers and service providers should consider lengthening the contract overlap period to ensure knowledge about clients is passed on to new workers. More effective, active communication between service providers and case managers is necessary, and case managers should have lighter case loads to allow sufficient time for case planning and review. As well, monitoring systems should be developed to ensure high consistency of care. One possible way to alleviate problems would be to use primary provider teams and backup teams to reduce the number of workers visiting a client. Another would be to stop using short appointments for homemaking services, as fewer, longer appointments are a more efficient use of time.

### **The Approach**

Over the two years of the study, we used a variety of research approaches to develop an understanding of continuity of homecare and the issues surrounding it. In particular we:

- conducted key stakeholder interviews;
- surveyed clients;
- examined client care provision records;
- studied sections of agencies' service delivery proposals; and
- discussed our findings and implications with our advisory group.

### **The Results**

Continuity of care in homecare has two dimensions that interact with each other to promote continuity: case management and service provision. Case management includes negotiating a care plan with clients and their families, and then monitoring and re-evaluating the plan to ensure efficiency. It also involves co-ordinating services to effectively meet the care plan. Service provision includes ongoing service delivery by providers who consistently have appropriate knowledge and skills to meet the clients' needs. There must be ongoing, accurate observations of the clients' conditions. Most importantly, clients and their caregivers must develop trusting relationships, and the various members of the care team must communicate well with each other. Clients also believe consistent timing in their care appointments facilitates continuity of care.

There are several problems with both case management and service provision that interfere with continuity, however, and there are aspects of the competitive bidding process used in the Ontario homecare sector that exacerbate the difficulties in achieving continuity of care. Some of the barriers to continuity include human resource problems, inadequate communication among stakeholders (particularly during transition periods), differing client needs (which make it impossible to have a “one size fits all” care plan), the diversity of the community care sector, and inadequate systems for monitoring service contracts and delivery.

Two strategies facilitate and support homecare continuity: *effective communication* among all stakeholders and *consistent personnel*. Current communication strategies are primarily passive, except when working directly with the client, and clients who require multiple visits per week generally have less consistency in personnel.

The home as a setting for care also presents novel challenges to care delivery that contribute to the need for greater care continuity and/or make it more difficult to deliver care continuity. These include a different idea of what is acceptable to clients regarding service provision than if they were in an institution, and the need for knowledge about how the home is organized to deliver services effectively. An additional difficulty is that the healthcare team is not in one setting where they can meet regularly, and most communication among team members is likely to be passive.