POLICY BRIEF

CROSS SECTOR COLLABORATION IN HOME CARE

KEY MESSAGE

THE SAFETY AT HOME STUDY DETERMINED THAT THE RATE OF ADVERSE EVENTS (AE) IN CANADIAN HOME CARE CLIENTS WAS 10 – 13%, OVER A PERIOD OF ONE YEAR. OF THESE ADVERSE EVENTS, OVER HALF WERE DEEMED PREVENTABLE. IT WAS DETERMINED THAT HARMFUL INCIDENTS IN HOME CARE HAPPEN BECAUSE OF: INCONSISTENCIES IN THE WAY CARE IS PLANNED AND DELIVERED, LACK OF INTEGRATION WITHIN THE HOMECARE TEAM AND ACROSS SECTORS, AND POOR STANDARDIZATION OF PROCESSES, PACKAGING OF MEDICATION AND EQUIPMENT.

THERE IS A NEED TO DEVELOP FUNDING AND SERVICE MODELS THAT SUPPORT OPPORTUNITIES FOR COLLABORATION BETWEEN HOME CARE AND INSTITUTIONAL CARE AND THEIR CLIENTS.

BACKGROUND

Within institutional care, there can be ambiguity about the role and capacity of home care and unrealistic promises can be made to patients about what to expect.

At the same time, despite in-roads in some jurisdictions, physician willingness to meet the unique needs of HC patients (house calls, after-hours consultation or communication) has been in decline.[1]

A recent US study reported that 42% of seniors discharged from hospital experienced a post-discharge "problem" such as needing re-evaluation, problems getting treatments or difficulty obtaining follow-up.[2]

A recent Canadian study found that within 30 days of hospital discharge, 12.6% of medical patients had been re-admitted and 20.9% had been re-admitted at 90 days. Length of stay for re-admissions was found to be longer for patients who were re-admitted compared to those who were not and 14% of re-admitted patients died.[3] In another recent Canadian study, 16% of urgent re-admissions were found to be avoidable.[4]

THE EVIDENCE

Several overarching systemic weaknesses were identified in the Safety at Home Study as contributing factors to adverse events in home care.

Lack of continuity of service providers, together with poor documentation processes in the home contributed to inconsistent and inaccurate communication and ultimately harm to clients.

While paid providers had responsibility for specific aspects of client care, often no one person had a complete overview.

Frequently there was ambiguity regarding which of the healthcare workers had the responsibility and authority to act. When compounded by poor documentation of a client's status, the appropriate intervention was less likely and the potential for client harm increased.

The absence of reliable communication processes at transition points, frequently between acute care, home care, primary care providers and the community pharmacist lead to the loss of information required for consistent care delivery and an increase in the potential for harm to the client.

RECOMMENDATIONS FOR CREATING MECHANISMS TO SUPPORT CROSS-SECTOR COLLABORATION

1   *Assign to home care clients a single cross-sector case manager with the authority and responsibility required to ensure the planning and delivery of a consistent quality of care.*

The requirement for a cross-sector case manager should be identified early and based on standardized and evidence based criteria.

The role of the cross-sector case manager should be highly visible, include responsibility for clinical service coordination, and have clearly defined and standardized role functions.

The cross-sector case manager should have the authority to act as "quarterback" within the health care system. They should be responsible for interdisciplinary and inter-sector liaising and ensure that all new information at the interface of care is delivered to the appropriate decision-makers involved in the client's care.

The cross-sector case manager should be accountable for monitoring care, continuity and establishing reliable communication pathways including expanded mobile access 24/7, and could facilitate frank and open dialogue between clients, families and their cross-sector care providers to determine and clarify care expectations.

2   *Caregivers/families should receive cross-sector support in their care giving roles.*

Support of caregivers and families should include training and ongoing continuing education to enable them to understand new equipment and therapies and support their health literacy. Caregivers need access to psychosocial counseling, and assessment and ongoing re-assessment of their needs.

3   *Fund pilots and create incentives for collaboration between home care and institutional care (e.g. Partnering for Patients, Virtual Ward, National Partnership Project, and PRISMA Program).[5] Establish integrated, interdisciplinary healthcare teams, which include clients and caregivers as integral parts of the team.*

Policymakers should examine safe and high-quality care from a system perspective rather than an organizational one. Adverse events that result from system weaknesses such as inadequate discharge procedures or inadequate home care resources need to be addressed at a policy level.

Regional or local community-based clinics could provide an opportunity to build formal bridges between home care and acute care.

4   *Implement a common electronic chart or integrated communication systems accessible to all caregivers from all sectors to standardize communication among disciplines and across sectors and expand the use of electronic screening, reporting and communication tools.*

Electronic health records and closed-loop communication processes should be rapidly expanded in home care. The current system too often relies on clients and families to share and relay vital health information among providers.

Electronic health platforms or smart technology can be used to trigger requirements for risk assessments (e.g. transition checklists) and interventions tailored to local requirements. Having a common, electronically accessible chart, available to all health care providers in all settings would enhance communication of important information and promote information continuity.

REFERENCES

1   Schneider, C. (2010). Chronic disease: Access to health care and barriers to self-management. Summary version of a report to the community advisory councils. Winnipeg Regional Health Authority. Retrieved from http://www.wrha.mb.ca/about/chac/files/CHAC_Summary_Jan10.pdf

2   Arora, V. M., Prochaska, M. L., Farnan, J. M., D'Arcy, M. J., Schwanz, K. J…Johnson, J. K. (2010). Problems after discharge and understanding of communication with their primary care physicians among hospitalized seniors: A mixed methods study. *Journal of Hospital Medicine*, 5(7), 385-391. doi 10.1002/jhm.668

3   Gruneir, A., Dhalla, I. A., van Walraven, C., Fischer, H. D., Camacho, X…Anderson, G. M. (2011). Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm. *Open Medicine*, 5(2), E104-E108.

4   Van Walraven, C., Jennings, A., Taljaard, M., Dhalla, I., English, S…Forster, A. J. (2011). Incidence of potentially avoidable urgent readmissions and their relation to all-cause urgent readmissions. *Canadian Medical Association Journal*, 183(14), E1067-E1072.

5   Health Council of Canada. (2012). Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada? Toronto: Health Council of Canada. Retrieved from http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348