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About this paper

This discussion paper is a joint project with many partners. It draws on the ideas and research of Michael M. Rachlis, MD, MSc, FRCPC. A strong advocate for community health and primary health care reform, Michael Rachlis has coauthored, with Carol Kushner, two major books on the subject: *Second Opinion* (1989) and *Strong Medicine* (1994).

Blended Care is a fusion of different perspectives. To develop the initial concepts, Michael Rachlis met with front-line care providers from the BCNU, HEU and the Health Sciences Association. As a group, they shared wide-ranging expertise and knowledge of a variety of institutional workplaces. The initial draft of the paper was revised and significantly expanded; a second version was then reviewed by representatives from community organizations, consumer groups, BCNU and HEU. The BC Government and Service Employees Union also provided insights and comments which were incorporated into the final draft.

Marcy Cohen, HEU Research Policy Planner, coordinated the project. Rewriting and editing was by Nancy Pollak.

Executive Summary

The key message of B.C.'s Royal Commission on Health Care and Costs was delivered in the report's title, *Closer to Home.* Like other inquiries into Canada's health care system, the 1991 Seaton Commission recognized that more and more Canadians needed care for chronic ailments that could be well managed at home or in supportive, non-acute care facilities. With this in mind, *Closer to Home* proposed that resources be transferred from hospitals to the community, for the sake of improving care and reducing costs.

As the decade ends, it is clear that many governments pursued a lopsided version of "closer to home." British Columbia's complement of acute care beds has fallen by approximately 40 percent since the early 1990s, and there is continuing pressure on Health Authorities to cut even more institutional beds and staff. Yet as hospital care became scarcer, there was no parallel transfer of resources to the community. Today, our system has not only downsized acute care beyond an acceptable limit, it also faces a serious shortfall in community care and a reduction in personal care services. Not surprisingly, anticipated cost savings have not been realized.

The fact remains: People who are defined as "inappropriately" hospitalized still require some sort of care – care that is currently lacking due to the gaps between hospital and community-based services. Hospital staff and health care unions are increasingly concerned about the plight of people who are discharged earlier and earlier into communities that cannot meet their needs due to a lack of resources. Stated simply, the problem has two dimensions:

1) non-existent programs (missing levels of care), and
2) lack of coordination/links between hospital and community.

On the political front, the federal government partially acknowledged the need to inject more money into health care in the 1999 budget. Some influential Canadians are promoting a two-tiered privatized system as the marketplace solution to problems of access, choice and availability. Yet money alone will not cure the health care system any more than a dismantling of Medicare will.

What is needed instead is a genuine commitment to community-based health care and an innovative vision of "closer to home."

blended care

The historical context

Today, relatively few persons treated in hospitals are previously healthy young people with life-threatening medical emergencies. Most patients are elderly people with pre-existing chronic conditions.

Caring for people with ongoing conditions requires advanced levels of planning, coordinating, monitoring and participation by a range of care providers, individuals and communities. The current system is not designed to do this; rather, it is best suited to provide episodic crisis intervention.

The same issue confronts the system's ability to fulfill its preventive and health promotion roles. Effective preventive and promotion strategies also call for a high degree of multidisciplinary teamwork and coordination. The current primary care structure, which tends to isolate physicians and to disempower consumers and other care providers, delivers neither the health benefits nor fiscal efficiencies that are possible.

It is these realities that make a new conception of health care organization both essential and inevitable.

Blended Care

There will always be people who require acute care within hospitals, and we must therefore ensure the availability of high-quality institutional care. Yet as a society, we must also give people broad access to excellent programs outside the traditional hospital. To do this, we need to learn how to better integrate the services provided by institutions with the services provided by communities.

This innovative approach is called "Blended Care": *an integrated public system that merges the best features of institutional and community care, fully utilizes the skills of all health personnel, and builds in community and consumer participation.*

What is new about Blended Care?

Blended Care represents a cultural critique of the current health care system and its division into two organizational solitudes: acute care and community care. Blended Care is more than the oft-discussed "seamless delivery of service" model insofar as it envisions fundamentally different roles

for hospitals and care providers.

For example, transitions are a critical element of health care: every time a person transfers from one practitioner to another, there is a risk of serious setback. Today, patient transitions from hospitals are often mismanaged or not managed at all, despite the best efforts of under-resourced health workers. In a Blended Care system, planning and executing transitions between institutions and community services would become a built-in practice – because both parties would have an ongoing and mutual interest in the patient's future well-being.

Blended Care respects the unique strengths of institutions and seeks to tap their assets for the population as a whole, not just for acutely ill patients. What are some of those strengths? Hospitals provide 24-hour care, employ a broad range of personnel, and ensure reasonably clear responsibilities for physicians through a privileging process. Hospitals also have procedures and policies to maintain communication among different care providers.

Blended Care also draws on the strengths of community services. Such programs tend towards a more holistic and preventive approach, offering a melange of health and social services to individuals, families and groups. Community services may also permit greater input into management and planning by a multidisciplinary team of care providers; and democratic governance structures may offer local citizens a means of setting policies, programs and community development goals.

Principles of a Blended Care system

Blended Care is rooted in three related principles:

1. The system would recognize that social and economic factors are among the key health determinants of Canadians. For example, a Blended Care approach acknowledges the role of poverty, isolation, homelessness, discrimination and social supports in shaping population health status and function. Although a Blended Care system cannot in itself resolve problems like poverty and homelessness, it can avoid the artificial boundary between "health services" and "social services." Similarly, the system would work to strengthen the resources and capacities of communities and to build local support networks.

2. The system would foster direct public accountability and be structured to enhance

community involvement, democratic governance and shared decision-making by communities and care providers. Engaged citizens and consumers would have real authority to ensure that programs and services were focused on and responsive to community needs.

3. The system would embrace universal coverage and public provision in order to deliver equal, high-quality services to Canadians of all income levels and social status. The Canada Health Act, which currently funds hospital and physician services only, would be extended to cover community/home care. This would promote fair access, efficient administration, integrated services and innovation in program development. Research shows that this mode of health care provision not only improves health status, it can help to control costs.

Values and features of Blended Care programs

Blended Care programs would incorporate the following values and features:

Services would be provided in a context of:

- 24-hour availability
- high-quality holistic care delivered with a psychosocial focus
- non-hierarchical, multidisciplinary teamwork by a broad range of care providers and health workers
- integration of physicians, including alternatives to fee-for-service funding and a clear delineation of physician responsibilities within the team

Recognition would be given to the expertise of front-line workers and the role of health care unions in promoting change and innovation within the health care system.

Community representatives and health care users would be intrinsically involved in the planning, developing, evaluating and governance of health care services and programs

What needs to change?

Blended Care calls for fundamental changes to organizational structures and practices. One key change would be the delivery of care via *multidisciplinary teams within a context of blended*

institutional/community services. In other words, Blended Care involves reshaping the roles of both care providers and institutions. These are some key points:

Research shows that multidisciplinary, proactive interventions can dramatically reduce deaths from chronic illnesses. Prevention, regular monitoring, counselling and telephone contact (recall) programs would be built-in features of a Blended Care system.

Physicians and other care providers need to work in multidisciplinary teams, sharing decisions about care practice. It is important to give physicians a role beyond that of fee-for-service practitioners, but more than their payment structure needs to change. There is strong evidence that RNs, LPNs, mental health workers, care aides, home support workers, physiotherapists etc., can effectively and efficiently provide many services, including preventive and monitoring programs.

Blended Care poses two broad questions for hospitals: How can their resources, strengths and stability be harnessed for population health goals, not simply for the treatment of acutely ill individuals? And how can their skilled work force be better coordinated to assist in the delivery of care to people living in the community?

In a Blended Care system, hospitals would play a much more active role in coordinating services with the community sector and managing transitions with community agencies. For example, hospitals could:

- help coordinate post-discharge patient care;
- supply additional skilled workers and professionals to act as specialist consultants to front-line care providers (e.g., as members of community care teams, resource consultants to community clinics, and educators of home care providers);
- be one of the vehicles for launching programs, finding people in need, and monitoring patients with similar problems (e.g., diabetes, problem births and heart disease); and
- establish more community care liaison positions.

Blended Care challenges the organizational culture of hospitals. The undue power vested in administrators and physicians comes at the expense of other personnel – RNs, LPNs,

clerical and technical staff – whose skills, contributions and knowledge are often undervalued and underutilized. Studies of organizational culture show that patient care actually improves when hospitals promote flexibility, nursing leadership, job satisfaction, constructive approaches to communication and collaboration, and open styles of problem solving. A Blended Care approach would empower all workers throughout the system.

Recommendations to the Ministry of Health and Regional Health Authorities

The following broad recommendations were developed by the B.C. Nurses' Union and the Hospital Employees' Union:

Health Authorities should work with unions, management, communities, consumers and the public to build a health care system based on these Blended Care principles and values:

- Social and economic factors would be acknowledged as key health determinants of Canadians.
- Universal coverage and public provision would be cornerstones of the system, in order to deliver equal, high-quality services to Canadians of all income levels.
- Community representatives and health care consumers would be intrinsically involved in the planning, developing, evaluating and governance of services and programs.
- Recognition would be given to the expertise of front-line workers and the role of health care unions in promoting change.
- Service would be provided in a context of 1) high-quality holistic care delivered with a psychosocial focus; and 2) non-hierarchical, multidisciplinary teamwork by a range of care providers.

This new approach calls for transformation *and* innovation. Existing institutions and

services, as well as professionals and other workers within hospitals and community services, must be encouraged to change and grow.

- Equally important, Health Authorities should work with care providers to educate the public about the merits of a Blended Care system: the proven value of multidisciplinary teams; the benefits of fully utilizing staff; the impact of health determinants, etc.

As Blended Care programs are developed and implemented, bridging funds will be required to maintain existing services. It would be shortsighted and counterproductive to plan Blended Care services on the basis of immediate cost savings.

A new management culture is needed, one that respects front-line workers and collective agreements, and fully utilizes their knowledge and experience. Managers, health professionals and workers will need to be provided with orientation/training to develop skills to work in new ways.

The province should ensure a level playing field in which health workers receive comparable wages and benefits whether they deliver care in institutions or in other community settings.

Funding must be made available for physicians to provide care on a non-fee-for-service basis, within settings that promote the benefits of a multidisciplinary, teamwork approach.

Blended Care

Introduction

The key message of B.C.'s Royal Commission on Health Care and Costs was delivered in the report's title, *Closer to Home*. Like other inquiries into Canada's health care system, the 1991 Seaton Commission recognized that more and more Canadians were needing care for chronic ailments that could be well managed at home or in supportive non-acute care facilities. With this in mind, *Closer to Home* proposed that resources be transferred from hospitals to the community, for the sake of improving care and reducing costs.

As the decade comes to an end, it is clear that many governments pursued a lopsided version of "closer to home." British Columbia's complement of acute care beds has fallen by approximately 40 percent since the early 1990s, and there is continuing pressure on Health Authorities to cut even more institutional beds and staff. Yet as hospital care became scarcer, there was no parallel transfer of resources to the community. Today, our system has not only downsized acute care beyond an acceptable limit, it also faces a serious shortage of services in the community. At the same time, anticipated cost savings have not been realized.

The fact remains: People who are defined as "inappropriately hospitalized" still require some sort of care – care that is lacking due to the gaps between hospital and community services. Stated simply, the problem has two dimensions:

1) non-existent programs (missing levels of care), and
2) lack of coordination/links between hospital and community.

Health care workers and their unions recognize that, with clearly defined community links, appropriate care/discharge planning in hospitals and adequate local resources, some people can do well at home or in community settings. A program such as the Quick Response Team in Victoria, B.C., demonstrates that hospital admissions can even be averted entirely when strong community resources are available.

Yet we are increasingly concerned about the plight of patients who are discharged earlier and earlier into communities that cannot meet their needs due to a lack of resources. When services are unavailable and when discharges are not well planned, then early discharge and averted

admission programs are not only unsafe, they put patients, families and health care providers in extremely difficult situations.

Early maternal discharge programs provide a case in point. A study from the Hospital for Sick Children in Toronto showed that as Ontario's length of stay for newborns and mothers fell by 40 percent, the infant readmission rate within the first two weeks increased by 60 percent.[1] Some U.S. studies also show that newborn readmissions rise when lengths of stay fall.

Equally important, overviews of studies conclude that early maternal/newborn discharge can be safe, but only when patients give their consent, are carefully selected and *have access to adequate services outside the hospital*.[2]

Unfortunately, health services across Canada are usually playing catch-up when it comes to publicly funded community services. British Columbia, for example, has taken valuable steps to develop non-institutional services around home care and mental health, but programs are still insufficient to meet the population's needs. Similarly, mental health services in this province are recognized as among the best in North America, yet there are still many people not receiving the treatment they need.[3]

On the political front, different views about how to "cure" our health care system continue to circulate. The federal government partially acknowledged the need to inject more money into health care with its 1999 budget. At the same time, some influential Canadians are promoting a two-tiered privatized system as the marketplace solution to problems of access, choice and availability.

Yet money alone will not cure the health care system any more than a dismantling of Medicare will. What is needed instead is a genuine commitment to community-based health care and an innovative vision of closer to home.

How did we get here?

When Medicare was first debated in the 1940s and 1950s, acute injuries and infectious diseases in the young were the country's major health problems. Medicine had little to offer people with chronic illnesses such as heart disease and cancer. Hospitals were the most expensive part of the

system, and people who lacked good insurance feared serious acute illness as much for the cost as the suffering: a significant hospitalization could lead to bankruptcy. It was understandable that as provinces developed their health care systems in the 1950s and 1960s, the focus was on insuring hospital costs and then medical care. There was little consideration of creating an integrated system of care.

Yet the original framers of Medicare had a much larger vision than simply providing insurance for hospital and physician services. Tommy Douglas and his first government, elected in Saskatchewan in 1944, proposed a comprehensive health program in which all necessary health services would be available without charge through multidisciplinary teams, with physicians as equal (and salaried) members. Unfortunately this proposal was derailed, primarily by opposition from the medical profession and insurance companies.[4]

New realities

Today, relatively few persons treated in hospitals are previously healthy young people with life-threatening medical emergencies. Most patients are elderly people with pre-existing chronic conditions.

Illnesses such as cardiovascular disease and cancer are among the dominant health problems facing Canadians; diabetes, a disease that requires regular monitoring and early intervention to avoid grave complications, is a permanent condition for 5 percent of the population.[5] Further, chronic ailments are the chief cause of death and morbidity: 80 percent and 90 percent respectively.[6]

Chronic care is also the most expensive component of the health care system. Extrapolating from the U.S. experience, where "70 percent of all medical costs relate to people with chronic conditions,"[7] British Columbia is spending $1.3 billion in physician costs alone (based on the province's Medical Services Plan budget of $1.87 billion in 1999-2000). It can be assumed that the majority of provincial expenditures on pharmaceuticals and community care are for persons with chronic conditions.

Caring for people with ongoing conditions requires advanced levels of planning, coordinating, monitoring and participation – by care providers, community helpers, individuals and families.

The current system, however, is not designed to do this; rather, it is best suited to provide episodic crisis intervention. As a result, our inability to effectively manage chronic care has become costly to individuals and communities by limiting people's quality of life and function; it is also literally costly to the health care system.

A similar issues arises with the system's ability to fulfill its preventive and health promotion roles. At its best, primary care should be focused on helping people maintain/maximize their own health and avoid unnecessary illnesses, both chronic and acute. Effective

preventive and promotion strategies also call for a high degree of multidisciplinary teamwork and planning, including the participation of individuals and communities. Our current primary care structure, which tends both to isolate physicians in a fee-for-service environment and to disempower consumers and other care providers, delivers neither the health benefits nor fiscal efficiences that are possible.

It is these realities that make a new conception of health care organization both essential and inevitable.

Blended Care

There will always be people who require acute care within hospitals, and we must therefore ensure the availability of high-quality institutional care. Yet as a society, we must also give people broad access to excellent programs outside the traditional hospital. To do this, we need to learn how to better integrate the services provided by institutions with the services provided by communities.

This innovative approach is called "Blended Care": *an integrated public system that* ***incorporates*** *the best features of institutional and community care, fully utilizes the skills of all health personnel, and builds in community and consumer participation.*

What is new about Blended Care?

Blended Care represents a cultural critique of the current health care system and its division into two organizational solitudes: acute care and community care. Blended Care is more than the oft-discussed "seamless delivery of service" model insofar as it envisions fundamentally different roles

for hospitals and care providers.

Blended Care creatively addresses some of the defects in the divided system. Consider one such problem area: transitions. In the world of sports, players understand that when a ball or puck changes hands, the speed with which the team in possession moves into offence, as the other moves into defence, often determines the outcome of the game. Transitions are equally important in health care: every time a person transfers from one practitioner to another, there is a risk of serious setback.

Today, patient transitions from hospitals are often mismanaged or not managed at all, despite the best efforts of under-resourced care providers. In a Blended Care system, planning and executing transitions between institutions and community services would become a built-in practice – because both parties would have an ongoing and mutual interest in the patient's future well-being.

Blended Care is an approach that is both fundamentally new and somewhat tried and tested. In the last few years, several hospitals have pioneered programs that reflect Blended Care elements, such as Healthy Heart programs, quick response teams and support programs for new mothers and babies. These programs break down the separation of hospital and community – and they work. They are proof that the Blended Care approach is valuable and viable, and they are a beginning from which to build.

Combining the best of both worlds

Blended Care respects the unique strengths of institutions and seeks to tap their assets for the population as a whole, not just for acutely ill patients. What are some of those strengths? Hospitals provide 24-hour care, employ a broad range of personnel, and ensure reasonably clear responsibilities for physicians through a privileging process. Hospitals also have procedures and policies to maintain communication among different care providers.

Of course, institutions also have weaknesses. Hospitals usually take a limited bio-physical approach to patient care. They are typically very hierarchical, with managers and physicians passing orders to other staff without allowing their full participation in care planning and decision making. People in the community have little power too, either to influence their local hospital's programming or to hold it accountable to their needs.

Blended Care also draws on the strengths of community services. Such programs tend towards a more holistic and preventive approach, offering a melange of health and social services to individuals, families and groups. Community services may also permit greater input into management and planning by a multidisciplinary team of care providers; and democratic goverance structures may offer local citizens a genuine means of setting policies, programs and community development goals.

On the other hand, community programs are often fragmented and unable to employ a full complement of personnel. Services are not always available 24 hours a day, and communication difficulties may arise because different care providers are employed by different agencies; further, there are limited links between community/home care services and physicians. Finally, services are not fully covered under Medicare.

Principles of a Blended Care system

Blended Care is rooted in three related principles:

1. The system would recognize that social and economic factors are among the key health determinants of Canadians. For example, Blended Care acknowledges the role of poverty, isolation, homelessness, discrimination and social supports in shaping population health status and function. Although a Blended Care system cannot in itself resolve problems like poverty and homelessness, it can provide care in a manner that avoids the artificial boundary between "health services "and "social services." Similarly, the system would work to strengthen the resources and capacities of communities and to build local support networks.

2. The system would foster direct public accountability and be structured to enhance community involvement, democratic governance and shared decision-making by communities and care providers. Engaged citizens and consumers would have real authority to ensure that programs and services were focused on and responsive to community needs.

3. The system would embrace universal coverage and public provision in order to deliver equal, high-quality services to Canadians of all income levels and social status. The Canada Health Act, which currently funds hospital and physician services only, would be extended to cover community/home care. This would promote fair access, efficient administration, integrated services and innovation in program development. Research shows that this mode of health care provision not only improves health status, it can help to control costs.

Values and features of Blended Care programs

Blended Care programs would incorporate the following values and features:

Services would be provided in a context of:

- 24-hour availability
- high-quality holistic care delivered with a psychosocial focus
- non-hierarchical, multidisciplinary teamwork by a broad range of care providers and health workers
- integration of physicians, including alternatives to fee-for-service funding and a clear delineation of physician responsibilities within the team

Recognition would be given to the expertise of front-line workers and the role of health care unions in promoting change and innovation within the health care system.

Community representatives and health care users would be intrinsically involved in the planning, developing, evaluating and governance of health care services and programs

Why the Existing System Isn't Working

The following section looks at some fundamental problems with today's health care system.

Traditional structures, traditional funding:

Disincentives to the sound management of chronic care

Report after report has called for a so-called seamless spectrum of services in which patients move effortlessly through the system and their care is managed according to published clinical guidelines. Yet recent Canadian studies find that our health care system is far from seamless and, in fact, does a poor job of managing patients with chronic illnesses.

For example, only one-sixth of Canadians with high blood pressure are being adequately treated;[8] as a result, thousands of preventable heart attacks and strokes occur every year. Reports criticize the management of asthma[9] and other chronic illnesses. These documented problems are merely the tip of the iceberg. Given the fragmented and inaccessible state of health care organization, how could we expect patients to actually find, let alone receive, comprehensive care?

Nevertheless, we do know what constitutes a cost-effective approach to managing chronic illnesses. The steps are:

1) identifying patients with specific chronic illnesses;
2) systematic monitoring and regular interactions with care givers, including mechanisms for recall if patients do not attend;
3) focussing on health promotion/function and on activities that prevent complications;
4) educating patients on self and family care;
5) using medications appropriately, including the integration of patient preferences;
6) coordinating and integrating care, including medical specialists, institutions and social service agencies;
7) quickly responding when a patient de-stabilizes; and
8) linking these interactions, over time, with clinically relevant information systems.[10]

We also know this: Traditional funding and organizational structures pose serious disincentives to such an inclusive approach. For example, monitoring and telephone contact (recall) systems require significant expenditures yet offer no financial benefits to a physician's practice. Is it any wonder, then, that only 13-39 percent of fee-for-service practices have any kind of patient recall system?[11],[12] Patient and family education, health promotion and disease prevention are usually not reimbursed by Medicare or are paid very poorly on a fee-for-time basis. In one survey, 50

percent of fee-for-service doctors reported that they believed the payment system limited their ability to deliver preventive care.[13]

From her research on home care patients, Professor Carol McWilliam of the University of Western Ontario concludes that:

> ... family physicians need better incentives for hospital and home visits, for telephone management of care, and for interdisciplinary conferences to plan care. With the exception of home visits (which are reimbursed at a low rate in comparison to similar time in office visits), the fee-for-service structure for physician reimbursement in Ontario provides no remuneration for these essential components of well coordinated care.[14]

Family physicians support the idea that the system must become less fragmented; according to a 1998 survey by the College of Family Physicians of Canada, 87 percent say that home care should be treated as an integral part of the nation's publicly funded health care system.[15]

Organizational structures that overlook the benefits of flexible, round-the-clock service are another stumbling block. Today, home care programs are looking after unstable patients who would have been institutionalized in the past. It is crucial to respond quickly when these patients start to deteriorate. Consider the practice of the Community Medical Alliance, a primary care program in Boston that manages about 400 patients with either severe disabilities or end-stage AIDS.[16] The Alliance does a meticulous job of ensuring that patients comply with therapeutic regimens and health promotion programs. As well, the nurse practitioners who do direct patient care keep half their time unscheduled to ensure they can respond to urgent situations. And the doctors who consult to the nurses are available 24 hours a day.

In contrast, Canadian home care nurses typically have little unbooked time and often cannot immediately reach a doctor when they face an acute problem. This points to the weakness of time-limited home care services, and to another systemic problem: the need to encourage – and enable – nurses and other appropriately trained health care workers to do more monitoring and supporting of patients with chronic ailments.

Lack of universal, publicly funded services

Many patients plunge into the gap between what is and what isn't available under Medicare after they are discharged from hospital. Hospital and physician services are covered under the Canada Health Act, but most preventive, home-based and continuing care services are not. User fees and fragmented/limited coverage are the prevailing conditions for community care, with hazardous consequences for individuals, families, workers and the public health care system as a whole.

For example, drugs that are available for free in hospital must be paid for by patients at home. Across Canada, 3.6 million people are without coverage under a drug benefit plan.[17] In British Columbia, the pharmacare program's $800 deductible is prohibitive for many elderly women who live alone (almost half of whom, past the age of 75, have incomes under $20,000). Similarly, many people simply cannot afford essential medical equipment; this includes hearing and walking aids, and the monthly $40 fee for the Lifeline program, which assists frail people who live alone and are at risk of falling or otherwise hurting themselves.

The funding vacuum in our public system has enabled the for-profit sector to steadily gain ground. In 1977, 23 percent of health care expenditures were paid for privately – either by individual Canadians or by their private insurance plans; by 1997, the figure had risen to 32 percent. The pharmaceutical industry is a prime area of for-profit growth. For years, drug companies have targeted physicians with high-powered advertising, free samples and other product promotions. Today, these transnational corporations are creating a brave new world of opportunity – for themselves – via "disease management," an approach to care that often uses *their* drug products in health promotion and disability prevention schemes.[18] Pharmaceutical companies continue to enjoy enormous profits while, not surprisingly, prescription drug costs steadily increase: in the mid-1990s, 12.7 percent of Canada's health care budget was spent on drugs, "the only area of spending that remains out of control."[19]

Commercial interests are a strong presence in nursing homes and other residential care facilities. In Saskatchewan, only 6 of the province's 256 personal care homes are owned by non-profit corporations.[20] In 1997 British Columbia adopted a policy to fund new care facilities for seniors as public-private partnerships (P3). This means that private companies bear the capital costs of constructing facilities and retain ownership of the buildings and land, in exchange for provincial mortgage subsidies and operating funds.[21] In effect, P3 is just another name for private long-term care. The new policy created fears that the majority of the province's long-term beds could end

up in the hands of private companies and individuals over the next few years (in 1999, only about 25 percent were in the private sector).

If allowed to proceed, the P3 arrangement would intensify existing threats to quality health care. Based on their past experience, front-line care providers and regional managers know that standards of service suffer when private firms use government per diem funds to pay down their mortgages, rather than for direct patient care. As well, some Regional Health Authorities see P3s as an obstacle to well coordinated and fiscally responsible care; the Central Vancouver Island Health Authority is concerned that privately constructed and operated facilities do not allow "full integration of services or administrative economies of scale."[22] Finally, private sector financing is more expensive than public financing – private borrowing costs are higher, and those costs are passed on to the taxpayer.

At the same time, a serious shortage of facilities means that elderly people with mild disabilities or impairments cannot find space in appropriate publicly funded care homes. One consequence of this shortfall is a growing reliance on family caregivers, a situation that can exacerbate health problems for both the original patient and their over-extended relatives. In B.C., the only other option for such individuals has been non-licensed, private care homes, for which they must pay out of their own pockets – a financial demand that is too onerous for many people.

Rather than P3s and exploitation of informal caregivers, a better approach to the long-term care shortage would be to foster a range of publicly subsidized supportive housing and long-term care options along with increased access to home support. (Supportive housing is defined as shelter for moderately disabled seniors that provides "a supportive and social environment that balances autonomy with security,"[23] thus enabling individuals to remain in their own homes.)

The holes in our public system affect more than individual families. Some patients remain in hospital because they are unable to pay for the home care and drugs that they need. Low income individuals are over-represented in long-term care homes, again because they cannot pay for the services that would enable them to live independently. These are unnecessary drains on the public system and actually thwart efforts to reform the system: Medicare's own limitations lead to limited possibilities for "closer to home" measures.

Two-tier health care is increasingly a reality in Canada. It is for these and other reasons that the National Forum on Health, a blue-ribbon panel appointed by the federal Liberals in 1995, endorsed the idea of bringing pharmacare and home care programs under the public funding umbrella.

Lack of continuity and coordination

With the existing system oriented towards acute care, people with chronic conditions often end up being admitted to hospital in crisis. Many of these emergency admissions could be averted through a Blended Care network of prevention, early intervention and home support services. Such a system would also ensure coordination and continuity of care, both of which are seriously lacking today.

For example, people usually show up at emergency with little documentation. Emergency staff take a history and provide care, frequently without any background on the person's medical or social circumstances. Problems also develop when a patient leaves; although discharge planning should begin upon admission, this is often more theory than practice.

With patients now leaving hospitals `sicker and quicker,' it is crucial that their family and community care providers be well prepared. Yet many people are sent home without any contact with their family doctor and before home support services can be mobilized. In their 1998 survey, 59 percent of family doctors say they are never or only occasionally notified when one of their patients is referred to home care services by another care provider; further, almost 50 percent say that they are infrequently or never consulted about their patient's home care plan.[24] Moreover, a critical shortage of community resources often means there is no home care plan, or an inadequate one at best.

Lack of integrated, 24-hour care

Twenty-four-hour coverage by an integrated team of care providers (e.g., physicians, RNs, LPNs, home support workers, etc.) is essential for patients and their families facing conditions such as terminal cancer, serious mental illness or dementia, or severe frailty. Families are simply unable to cope with complicated illnesses without the assurance of 24-hour care. To quote a patient from Dr. McWilliam's research, "The only alternative I seem to have if I really think things are that serious is to call 911. And then you end up in emergency again!"

The key is not just full-time coverage, but integrated coverage. At present, home support workers are isolated and often have no means of contributing their knowledge and insights to a patient's overall care plan. Such isolation is hard on workers, unhelpful to patients and other caregivers – and costly. A 1995 article in the *New England Journal of Medicine* showed that home care services do not automatically improve patient function and reduce costs; the active ingredient for such outcomes was the integration of a broad range of skilled staff.[25]

Built-in hazards of prescription drug programs

Besides the encroachment of pharmaceutical companies into the disease management field, Canada's prescription drug programs have problems that are at least partly due to how primary health care is organized.

The majority of Canadian family doctors are paid on a fee-for-service basis, which means they have a raw incentive to see large numbers of patients. And the easiest way to end a patient visit is to write a prescription. Research in New Brunswick indicates that physicians who see more patients also prescribe more drugs, which in turn may lead to more drug-induced illnesses and higher costs.[26] A study from Montreal showed that elderly patients were much more likely to be prescribed an unnecessary and potentially dangerous drug if their doctor scheduled short visits.[27]

Canadian studies have revealed other serious problems with inappropriate prescribing and drug-related illnesses, especially for elderly patients. One review concluded that at least 5 percent and perhaps as many as 20 percent of admissions to hospital for seniors are caused by drug-related illnesses.[28] A Quebec study found that over half of all seniors in the province had a potentially dangerous prescription in 1990, especially for benzodiazepines (valium/serax) and anti-arthritics.[29] This same research group found that patients were less likely to receive a potentially dangerous prescription if they had one primary care physician coordinating their care.[30] An Alberta study also found very high rates of prescribing anti-arthritic drugs to seniors – along with higher rates of ulcer disease (a well-recognized complication of anti-arthritics).[31]

Not only do these studies expose avoidable human suffering, they point to an overtaxing of our limited health care resources.

What Needs to Change?

blended care

Blended Care calls for fundamental changes to organizational assumptions, structures and practices. One key change would be the delivery of care via *multidisciplinary teams within a context of integrated institutional/community services.* In other words, Blended Care involves reshaping the roles of both care providers and institutions. (For examples of Blended Care in action, please see the Appendix.)

Physicians: More than a fee-for-service issue

Discussions about health care reform often focus on the limitations created by paying physicians on a fee-for-service basis. Yet research shows that altering the way doctors are paid without altering other aspects of health care organization will make little difference to the overall system. In 1991, the B.C. Royal Commission on Health Care and Costs surveyed the available evidence and concluded that

> relative to conventional fee-for-service medical practice by self-employed private practitioners, alternative forms of care organization can lead to both better outreach to underserviced groups and lower overall costs of care. But simply substituting budgets or capitation contracts for fee-for-service is no guarantee of improvement.[32]

A recent study by Dr. Brian Hutchison of McMaster University found that when Ontario fee-for-service group practices converted to capitation funding through the Health Service Organization (HSO) program, there was no decrease in hospitalization rates – despite a bonus incentive to reduce admissions.[33] (Capitation is a funding formula based on the size and characteristics of the population served.)

Another study showed that community health centres (CHCs) were much more likely to improve patient care than were physician-run HSO practices.[34] (CHCs employ a salaried multidisciplinary team and incorporate community participation and community development in their planning and activities.) The authors found that CHCs were more likely to have an organized approach to care, "including more counselling and education for its patients and other community residents who need such wide-ranging care." In CHCs, other personnel were able to more fully utilize their skills, leaving physicians the time to do what physicians do best: diagnose, and treat complicated medical cases. As the authors concluded:

> It appears that CHCs are much more committed than HSOs ... to the use of nurses, nurse practitioners and other nonphysician staff to carry out their activities ... It appears that few HSOs are, in fact, using other health care professionals in their practices.[35]

The primary problem in this area appears to be physician knowledge and attitudes. Ten years ago, researchers at the American Kaiser Permanente Health Maintenance Organization (HMO) surveyed their physicians and found that they greatly underestimated the proportion of patient visits that could be delegated to nurse practitioners and physicians' assistants.[36] (Physicians' assistants are ex-U.S. armed forces medics who have been given additional training to enable them to operate as independent practitioners. Canada has no equivalent profession.) To make matters worse, the HMO physicians would only delegate about half of the patient visits that they themselves believed could be delegated. The actual number of delegated visits was even lower, because physicians claim to be more willing to delegate in surveys than they are in practice.

The implications of this research are profound. There is strong evidence that RNs and other care providers could effectively and efficiently deliver many services currently performed by doctors.[37], [38], [39], [40], [41] There is also very strong evidence that multidisciplinary proactive interventions could dramatically reduce deaths from chronic illness.

Increasingly, provincial legislation pertaining to health professionals supports this model of a broad multidisciplinary team of care providers. Yet if decisions about the utilization of RNs, LPNs, mental health workers, home support workers, social workers, etc., are left completely to doctors, these other providers will never achieve their full potential to add value to the system.

Integrating physicians, enhancing care

There are well-documented benefits to integrating doctors into a linked system of Blended Care. Health care providers in the continuing and community care fields have long recognized that one-time interventions by physicians are unlikely to change a patient's behaviour. What is needed, they say, are *multiple* interventions by a coordinated team of care providers.

Such integrated services employ a variety of personnel to screen, monitor or counsel patients with chronic illness. Consider the evidence of one study, conducted in New Westminster, B.C., by Dr. Nancy Hall.[42] Patients applying for long-term care were randomly assigned either to receive

private health promotion from a visiting nurse or to join a control group. After 36 months, the patients who received individual attention were 39 percent less likely to have died or be placed in a long-term care institution than those in the control group.

Studies from other jurisdictions show similar impacts.[43],[44],[45],[46],[47] Some of this research focuses on health promotion/education for patient and family on self care. Other studies focus on active case management or integration of care: primary care with social services, or primary care with secondary and tertiary health care. Overall, the literature is quite clear that providing better organized and integrated care can lead to improvements in both health and cost-effectiveness.

A landmark study of hypertension provides some of the best evidence. The Hypertension Detection and Follow-up Study was designed by the U.S. National Institutes for Health to determine if an organized approach to the treatment of hypertension would lead to decreased deaths from cardiovascular disease.[48] The experimental subjects were cared for by special centres while the control subjects were cared for by their regular doctors. As expected, many more of the experimental subjects had their blood pressure properly controlled, and they were 18 percent less likely to die from cardiovascular disease. However, they were also 15 percent less likely to die of noncardiovascular diseases even though improved treatment of hypertension had no direct effect on these other conditions.

The only explanation seems to be that integrating physicians into a system of continuing and community care can have big payoffs, regardless of the specific condition being treated.

A new role for hospitals

Just as physicians and other care providers must move beyond their traditional roles, hospitals too are in need of an expanded vision. Blended Care proposes that coordinating care delivery with community health agencies become central to the mandate of hospitals.

Traditionally, hospitals disconnect from their patients at the point of discharge or transfer. This disconnection is problematic on many levels. For individual patients and care providers, it means the loss of continuity in care, medical information and planning; in turn, this leads to increased vulnerability for patients, and inefficiency and waste throughout the system. For the population as a whole, disconnection means that the considerable resources of the hospital are unavailable

for preventive care, education, monitoring and follow-up. In other words, the isolated position of the hospital shortchanges both individuals and communities, and rebounds on the hospital in the form of avoidable readmissions and preventable illnesses.

Blended Care envisions hospitals playing a much more active role in coordinating services and managing transitions with the community. This could be done in many different ways. For example, hospitals could:

help coordinate post-discharge patient care;
supply additional skilled workers and professionals to act as specialist consultants to front-line care providers (e.g., as members of community care teams, resource consultants to community clinics, and educators of home care providers);
be one of the vehicles for launching programs, finding people in need and monitoring patients with similar problems (e.g., diabetes, problem births and heart disease); and
establish more community and home care liaison positions.

Essentially, Blended Care poses two broad questions for hospitals: How can their resources, strengths and stability be harnessed for population health goals, not simply for the treatment of acutely ill individuals? And how can their skilled work force be integrated into caring for people at home and in the community?

And a new workplace culture, too

Blended Care also challenges the organizational culture of hospitals. As mentioned earlier, the strengths of institutions are often offset by their weaknesses. These historical flaws must be addressed, not only to benefit patients and communities, but to transform hospitals into supportive partners within an undivided system. The two goals are compatible: changes in organizational culture that improve patient care will also make the institution more flexible, tuned-in and responsive to the larger community.

Perhaps the biggest weakness is the hospital's hierarchical structure. The undue power vested in managers and physicians comes at the expense of other personnel – nurses, health professionals,

clerical and technical staff – whose skills, contributions and knowledge are often undervalued and underutilized. This hierarchical culture leads to disregard for the actual work that people do (or could do), which in turn is harmful to patient care, stressful to morale and interpersonal relations, and wasteful of hospital resources.

Consider the situation of nurses, the backbone of patient care in hospitals. Recent studies have examined how patient outcomes are affected by nurses' level of workplace autonomy, status and control over care. A significant U.S. study in 1994 found that hospitals with a reputation for good nursing practice – referred to as "magnet hospitals," whose organizational culture gives nurses significant control and autonomy around clinical decisions, among other things – were also good places for patients: the 39 magnet hospitals had around a 5 percent lower mortality rate than other hospitals.[49] Linda Aiken, the report's author, says that the "research suggests the better control that people close to patients have, the better the [patient] outcomes."[50]

Other studies of organizational culture show similar results. People are well-served by hospitals that promote flexibility, nursing leadership, job satisfaction, constructive approaches to communication and collaboration, and open styles of problem solving.[51]

Just as nurses are more effective when they have greater control over their care practice, empowering workers throughout the health care system – clerical, technical, para-medical professionals and home support workers – can also improve patient services. The opposite is certainly true: a case in point is Vancouver General Hospital, where the medical records department was restructured.

The administration at VGH approached the 1998 restructuring using a traditional methodology: clerical staff were not asked directly about their work practices, and clerical perspectives/knowledge were not *embedded* into planning, implementing and evaluating stages. Without this input, the hospital failed to understand the intricate work processes of the clerical and technical staff who, in fact, played a central role in maintaining quality assurance of medical records. As a result, the restructured Health Records Department at VGH went from being well managed to being overwhelmed by backlogs, high error rates, frustrated users within and outside the hospital, and a stressed-out, overworked staff – all of which posed threats to patient care and safety.[52] Health Records Administrators, technicians and clerks, along with Unit Clerks on the

wards, repeatedly raised the alarm about deteriorating health records standards until management agreed to deal with the problems.

In contrast, Vancouver Hospital's G.F. Strong Rehab/George Pearson Centres introduced a new patient care information system by incorporating the knowledge and skills of clerical workers from the beginning. The result? A relatively painless transition, with smooth operations thereafter.

Restructuring projects can expose the worst of traditional hospital culture. And when top-down, bureaucratic values are married to narrow cost-savings goals, the results are especially destructive. According to the authors of *The Re-engineering Revolution*, there is

> a 70% failure rate for re-engineering initiatives because the approach predominantly focused on cost-saving and de-emphasized the human skills needed to achieve the outcomes embodied in an organization's mission ... Separating the design of work from its execution turned out to be a major flaw. Expert-driven re-engineering methodologies also usually resulted in long and painful implementation phases characterized by resistance, low morale and deteriorating quality. [53]

An over-emphasis on cost savings and steamlining may produce more than an inefficient workplace and a disenchanted staff; it can also impede patient care. Various studies have explored how the ability of health workers to give caring attention to patients – by simply talking with them, expressing interest, and offering basic information and emotional support, however briefly – is a factor in improving health outcomes.[54] "Caring effects," as this measurable phenomenon is called, involves many personnel, from cleaners and clerks, to nurses and physicians, as well as many modes of human contacts, from chatting by a bedside to follow-up telephone calls and regular clinic visits.

Institutions are practising a false economy when they prioritize the measurement of technical and clinical data over the provision of human needs. As authors Hart and Dieppe state:

> The risk is that as all staff in ... hospital and community units get squeezed tighter in the

> drive to achieve maximum output of processes at minimum labour costs, human relations may be increasingly ignored; [managers] should provide enough time for staff to work in human rather than mechanical ways. *Without caring, real health outputs fall, despite increased and more efficient output of process*.[55] (emphasis added)

For all the above reasons, critiques of workplace culture must make visible the work, skills and capacities of all health personnel, whether clerical, technical, service or professional; and any proposals for a new organizational culture must include their perspectives on good work processes and good care.

Community control and direct public accountability

Just as Blended Care calls for a richer utilization of care providers, it also acknowledges that individuals and communities must play a substantial role. Indeed, a Blended Care approach considers community involvement and direct public accountability to be not only appropriate in a public health system, but a core strength of the system.

Today, Canadians are no longer willing to allow experts alone to make decisions about their personal health and their health care system. Individuals and families expect to ask questions, explore options and take part in determining care plans and treatments; they also want the means to address problems and complaints that may arise. The same can be said of communities, whether they be geographic communities or communities of interest.

There are significant advantages to building consumers and communities into decision-making and governance structures. The community health centre movement has long recognized that because citizens have a tangible stake in the quality and usefulness of health services, they are both valuable resources (e.g., in identifying needs) and helpful participants (e.g., in developing programs). Community control can also enhance the system's ability to innovate at the local level, adapt to local needs, and develop programs that integrate health and social services.

Other advantages flow from participation itself. It is well documented that people's health suffers when they are isolated or have little power over their circumstances. A governance model that includes representatives from neighbourhoods and user groups can promote well-being by addressing the health determinants of control and connection. Such a model will also open up the

issues of support and community development (e.g., how to involve/acknowledge the caring role of people other than paid personnel; how to help each other get better and stay well; and how to change the conditions that make people unhealthy, isolated or poor in the first place).

Democratic governance structures are essential to a Blended Care system. Regional Health Authorities can provide leadership and resources, but the transformation of our health care system will also depend on genuine power sharing among boards, consumers, family care givers, community representatives and front-line staff.[56] Shared governance means more than allowing communities to "have input": it means giving communities the actual power to design programs and develop services. How this will be achieved in a Blended Care system will have to be hammered out. For example, community health centres/clinics will require locally accountable boards; the role of hospital boards will need to be reassessed to make institutions more responsive and accountable; and Regional Health Authorities will need to take up the challenge of educating/encouraging the public to get involved.

Building a Blended Care Network in British Columbia

British Columbia has several programs that could provide templates for a Blended Care system, including:

the Quick Response Team in Victoria (see the Appendix for details);
community health centres, such as James Bay in Victoria, the REACH clinic in East Vancouver, and the health centre in Vancouver's Downtown South established by St. Paul's Hospital;
hospital and community-based early maternal discharge programs in Kamloops, Vancouver and other locales (these programs screen mothers and newborns who are suitable for early discharge and offer them home visits by nurses and a 24-hour telephone line);
New Vista's adult day care program, tied to the society's intermediate care facility; other supportive housing projects that are linked to long-term care homes; and
Healthy Heart, asthma, AIDS and numerous other community support programs.

There are other well-established B.C. programs that seek to bridge the gap between institutional and community care. The Vancouver Home Hospice Program, administered by the region's continuing care program, attempts to deliver a level of care normally associated with institutions to palliative care patients at home. Some mental health services in the Lower Mainland are trying to link the expertise of hospital-based personnel with patients, families and care providers in the community.

The establishment of health regions in B.C. should ease the way to developing Blended Care programs. Prior to decentralization, separate funding for different parts of the system presented insurmountable barriers to the free flow of personnel and resources into innovative programs. The regions now have the managerial control and mandate to develop new services. A key issue will be whether, and *how,* home care is integrated under regional authorities. A Blended Care approach would deploy a coordinated team of workers – RNs, LPNs, physicians, home support workers, OTs, nutritionists, etc. – within a locally organized, publicly funded network. Among other things, this means that health regions must be willing to integrate services, currently provided by private home care agencies, directly under their authority. This approach would foster continuity of care, efficiency of operation and, equally important, a sense of ownership and willingness to innovate.

Workers in B.C.'s health system are keen to develop Blended Care approaches. However, the province and health regions need to implement certain policies before the vision can become a reality. The B.C. Health Labour Accord facilitated some reforms, but without comparable wages and benefits for all workers regardless of their work site, it will be very difficult to encourage the development of innovative services.

Saskatchewan, Québec and B.C. are each moving towards eliminating differences in wages and working conditions between workers in acute and community care. It is not surprising that these three provinces are also making headway with Blended Care-style reforms: eliminating the labour barrier opens the way to greater integration of services, with all the related advantages and flexibility. Ontario has taken quite a different route. Queen's Park is focusing on cutting costs via a strategy that increases privatization and awards contracts to the lowest bidder. This direction creates further fragmentation of health services and new obstacles to innovation and coordination; it also exacerbates the wage gap between public sector and for-profit operators. Today, Ontario

could be said to embody a two-tiered, marketplace approach to health care, while Saskatchewan, Québec and B.C. are following a tack with a more social democratic flavour.

Where does the general public fit into this picture? Many Canadians focus their concerns on shortcomings in traditional services rather than on demands for new kinds of care. Although they are clearly unhappy about deficiencies in our health care system, as individuals they don't necessarily see how *access* problems are related to *organizational* problems. And they are not being well informed about how demographics – delivering care to increasing numbers of people with chronic illnesses – has lead to misuse and overcrowding in institutions.

Regional Health Authorities have a role in educating the public about such matters, as well as actively seeking the public's views on, and involvement with, programs and policies. To work properly, a Blended Care system must be as much about community development as it is about delivering health care services. For example, a supportive housing project could cultivate links with a neighbourhood senior's organization. Community representatives and health care consumers need to be intrinsically involved in the planning, developing, evaluating and governance of Blended Care programs. And health care practitioners need to learn how to work with other social supports, whether they be cultural, self-help, recreational or advocacy in nature.

Recommendations to the Ministry of Health and Regional Health Authorities

The following broad recommendations were developed by the B.C. Nurses' Union and the Hospital Employees' Union:

> Health Authorities should work with unions, management, communities, consumers and the public to build a health care system based on Blended Care principles and values:
>
> - Social and economic factors would be acknowledged as key health determinants of Canadians.
>
> - Universal coverage and public provision would be cornerstones of the system, in order to deliver equal, high-quality services to Canadians of all income levels.

- Community representatives and health care consumers would be intrinsically involved in the planning, developing, evaluating and governance of services and programs.

- Recognition would be given to the expertise of front-line workers and the role of health care unions in promoting change and innovation.

- Service would be provided in a context of 1) high-quality holistic care delivered with a psychosocial focus; and 2) non-hierarchical, multidisciplinary teamwork by a range of care providers.

This new approach calls for transformation *and* innovation. Existing institutions and services, as well as professionals and other health care workers within hospitals and community services, must be encouraged to change and grow.

- Equally important, Health Authorities should work with care providers to educate the public about the merits of a Blended Care system: the proven value of multidisciplinary teams; the benefits of fully utilizing staff; the impact of health determinants, etc.

As Blended Care programs are developed and implemented, bridging funds will be required to maintain existing services. It would be shortsighted and counterproductive to plan Blended Care services on the basis of immediate cost savings.

A new management culture is needed, one that respects front-line workers and collective agreements, and fully utilizes their knowledge and experience. Managers, health professionals and workers will need to be provided with orientation/training to develop skills to work in new ways.

The province should ensure a level playing field in which health workers receive comparable wages and benefits whether they deliver care in institutions or in other community settings.

Funding must be made available for physicians to provide care on a non-fee-for-

service basis, within settings that promote the benefits of a multidisciplinary, teamwork approach.

APPENDIX

BLENDED CARE IN ACTION

Victoria's Quick Response Team

British Columbia already has some of the building blocks for implementing a Blended Care system. An excellent example is the Quick Response Team (QRT), developed 10 years ago as part of the Victoria Health Care Project.

The program's goal is to reduce the pressure on emergency departments and to prevent unnecessary hospitalizations. For example, consider a frail elder who lives by herself and suffers a fall. Even if the patient has no fractures or other reasons for acute care, she might well be hospitalized if she is too bruised to manage her own care. However, if there were home nursing care and homemaking assistance available, she could convalesce at home.

In Victoria, most QRT referrals initially came from hospital emergency departments, but now half come from community agencies, family doctors, neighbours and relatives. Patients are assessed promptly, and whatever services required are instituted immediately, including short-term 24-hour care. If services are still needed after three days, patients are referred to the regional home care program.

The Quick Response Team is available 15 hours per day. They assess approximately 3,000 patients per year and are credited with preventing many hospital admissions. The staff working for the QRT express great satisfaction with their work. The team also brings some relief to staff within institutions, who are often uneasy about the lack of supports available to their patients once they are discharged.

The QRT concept has spread to many other provinces. In some Saskatchewan regions, the service is now available 24 hours per day.

San Francisco's On Lok or PACE

(Program for All-Inclusive Care for the Elderly)

San Francisco is the home of a highly innovative health program called On Lok Senior Health Services. On Lok has become the inspiration for new approaches to the care of the frail elderly, in the U.S. and Canada. The federal government's Health Transition Fund recently selected a Québec proposal for a demonstration project based on On Lok's principles, to be applied in a manner compatible with Medicare.[57]

The Cantonese words *on lok geui* (abode of peace and happiness) were chosen to reflect the philosophy of the program. On Lok Senior Health Services opened its nonprofit operation in 1973 with a day health centre, located in a renovated nightclub in downtown San Francisco. Today there are three such centres serving 560 high-risk seniors whose average age is 84.

Clients of the program are very frail. Three-quarters of On Lok's participants are incontinent and over 60 percent have some type of chronic mental disturbance, including Alzheimer's Disease. In addition, many are at special risk because of poverty and isolation. Sixty percent of participants live alone and 40 percent are poor enough to qualify for SSI (Supplemental Security Income). Located in San Francisco Chinatown, many of On Lok's enrollees are Chinese (75 percent), though Filipinos, Italians, other Caucasians and Blacks also use its services.

To participate, applicants must be over 55 and be assessed by a state representative as needing nursing home care. The California government pays On Lok 94 percent of what it would have paid a nursing home for their care through the U.S. Medicare and Medicaid programs.

Health promotion is the cornerstone of On Lok's programming at the day health centres. To stay healthy, everyone needs proper nutrition, exercise and socialization, and these are even more important for the frail elderly. The frequent monitoring of clients allows for the treatment of acute flare-ups of chronic conditions before they have become serious. On Lok brings people to its services, rather than only bringing services to people's houses. Participants must come to one of these centres at least once a week; most come at least three times. At the day centres clients receive many services, from rehabilitation to dentistry, but the accent is on health promotion.

A distinguishing characteristic of On Lok is the multidisciplinary team of doctors, nurse practitioners, nurses, health care aides, social workers, audiologists, podiatrists, physiotherapists

and speech therapists. Care aides play an especially prominent role within the team: On Lok employs 30.8 aides per 100 patients. The program has two salaried, full-time doctors as well as two half-time physicians for night call. On Lok's founder, Mary Louise Ansak, notes that it is frequently the program's drivers who have the opportunity to talk to the participants about their wishes for care should they fall acutely ill. Just as a stranger may confide her or his innermost thoughts to a taxi driver, On Lok's clients sometimes choose their driver to engage in such weighty discussions. The drivers have become key team members in discussions around a participant's desire for acute care.

On Lok uses only 16 percent of its budget for institutional services, including acute hospital care, and over half of its budget for home care and day programming. It is not easy to make quick comparisons with a similar population of Canadian elders, but certainly the vast majority of their health care expenses are spent on institutional, pharmaceutical and medical services, not on community supports. The lesson of On Lok is clear: by spending relatively more money on personnel, the program actually saves money by reducing acute care admissions.

On Lok's wages are much higher than those of other San Francisco home care workers. The lowest wages are 50 percent higher than minimum wage and all workers have generous benefits which include full health care coverage (worth about $4 CAN per hour). Staff turnover is less than 5 percent per year.

On Lok's record speaks for itself. Their elderly, poor and extremely frail population has an overall institutional rate of only 6 percent, with about 5 percent of the daily census in a nursing home and only 1 percent in an acute care hospital. On Lok is at full financial risk for all persons and cannot arbitrarily cut them off from coverage. On Lok has managed to nearly eliminate hospitalizations due to flare-ups from chronic conditions. Comparing On Lok's 6 percent institutionalization rate for such frail elderly people to Canada's record, where at least 7 percent of all people over 65 and 16 percent of all people over 75 are in institutions, the scope for improvement in Canada is very large indeed.[58]

On Lok became the prototype for PACE programs (Program for All-Inclusive Care for the Elderly) and during the past 10 years the U.S. Congress has issued special waivers under the U.S. Medicare and Medicaid programs to authorize 15 replicate sites. In 1997, Congress made PACE a mainstream provider and authorized the establishment of 40 new PACE sites per year.

Edmonton's CHOICE (Comprehensive Home Option of Integrated Care for the Elderly)

The first PACE replicate came to Canada in 1996, when the Edmonton Regional Health Authority opened the Comprehensive Home Option of Integrated Care for the Elderly (CHOICE). The program is directed towards seniors who used to frequently be admitted to hospital for acute care or who normally would be candidates for continuing care homes. CHOICE provides 24-hour care through multidisciplinary teams at three day centres; in February 1998, the program served approximately 230 participants.

CHOICE manages patients at a slightly lower level of acuity than On Lok. Participants have an average age of 79; almost half are eventually discharged to long-term care facilities, while the other half dies while in the program. The three Day Health Centres and clinics offer a range of services: personal care and grooming, individual and family support, recreational activities, medical and pharmaceutical care, rehabilitation, health promotion and meals. Home support comes in the form of personal care and health aids that enable participants to live at home. Drivers take participants in wheelchairs to and from the centres and to other appointments; this service is contracted out by CHOICE. An on-call nurse responds to problems that arise when the health centre is closed on nights and weekends. Two centres have a six-bed subacute unit where minor episodic problems can be managed.

CHOICE staff are unionized (HSA, UNA and CUPE) in the two centres administered by the region, but not in the centre run by the Good Samaritans, a nonprofit society; wages and benefits, however, are comparable. Most staff originally worked in the institutional system; they were given an approximately one-month 'reorientation' to community care. Home care workers work both in patients' homes and in the day centres. The first shift spends the morning in the community and the afternoon in a day centre, while the second shift starts the afternoon in the day centre (where they receive the 'hand off' from the first shift) and then finishes in the evening in patients' homes.

CHOICE has three FTE physicians. There was some friction with local doctors when the program insisted that the community doctors 'give up' their patients to CHOICE. (This is also the philosophy of On Lok and other PACE programs.) Recently CHOICE became more flexible and doesn't exclude community doctors from continuing to provide services to their patients as part

of the program.

A 1998 evaluation of CHOICE revealed a high degree of satisfaction with the program among participants and their informal caregivers. Patients reported either that their general health was being maintained or that the decline in their health status had slowed down. Moreover, while their use of care providers had increased by 12.5 percent, the CHOICE program repeated the On Lok experience by reducing "the utilization of ambulatory care services ..., in-patient services ... , ambulance ..., and pharmaceuticals (86%) ... by participants."[69]

The major frustrations of seniors and their informal caregivers were the inadequacy of CHOICE's home support and transportation services. For example, house cleaning services were needed to allow seniors to remain living at home. Regarding transportation, it is worth noting that On Lok integrates drivers into their program with valuable results, whereas CHOICE contracts out this job.

Québec's Community Health Centres (CLSCs)

All provinces have community health centres (CHCs) but only Québec has a full network. There are approximately 160 CLSCs (Centre local services communautaire) in the province. The first were initiated by community groups, often with federal government grants, in the late 1960s and early 1970s. However, as Québec implemented its Medicare program after 1970, the CLSCs gradually became the focal point for community-based services. The centres receive approximately 9 percent of the provincial health budget, a percentage that continues to increase.

In the mid-1980s, the CLSCs took on the home care mandate and gradually have become 'one-stop shopping' facilities for health and social services. Today they are the exclusive providers of home care, public health and certain specialized services for individuals (for example, programs for children's mental health). Most CLSCs are open evenings and during some weekend hours, providing a meaningful alternative to so-called walk-in clinics.

Québec has also implemented a province-wide telephone advice system (Info-Santé) run by the CLSCs. The program was piloted in the Hull region and now each CLSC provides the service to their catchment area. Info-Santé uses registered nurses from the CLSCs from 8 a.m. until 8

to 12 p.m. (depending on the region), after which the service is folded into regional offices overnight. The phone service was recently evaluated;[60] approximately 90 percent of users found the call useful and claimed it was all they needed to deal with their problem. Ninety percent also claimed that they could handle the problem themselves if it reoccurred. Seventy-five percent claimed that they would have visited a doctor or emergency department if they had not been able to call Info-Santé.

The CLSCs provide an essential public health infrastructure in local communities for either natural disasters or communicable disease control. During the devastating 1998 ice storm in Québec, CLSCs and their Info-Santé service in particular enabled people who did not have electricity to communicate. As the main providers of home care services, the CLSCs knew the most vulnerable people in their areas and were able to facilitate enhanced home care services or evacuation.

During the hospital downsizing of the 1990s, Québec relied on the CLSCs as the centrepiece of its *virage ambulatoire* (move to the community). Budgets and personnel were literally moved from the hospital system to the CLSCs. Transferred employees retained their union membership, seniority, and wages and benefits. According to some reports, it took time to reorient new staff to community care, and some managers paired new staff with existing staff to facilitate the transition.

All staff in CLSCs are unionized. They employ high number of RNs, health care aides, social workers and LPNs; an average centre employs only around seven or eight physicians. In all CLSCs, doctors provide support for specific programs (e.g., occupational health, home care). In all but a few CLSCs, physicians also act as family doctors to anyone in the community.

During 1997-98, Québec merged the boards of about 65 CLSCs in rural areas with the boards of small hospitals; unfortunately, the province did not also transfer resources from rural hospitals to CLSCs to enable them to fulfill this larger mandate. There are concerns that the mergers could undermine health promotion and community development, which are already under attack due to increased demands for home care services. However, Québec still leads the country in the development of community care.

Toronto's Hospital-Community Health Centre Mental Health Program

In Toronto in the early 1990s, six community health centres (CHCs) worked in cooperation with the Psychiatric Department of Doctors Hospital to manage over 500 persons with severe mental illness.[61] The program was an example of "shared care," where specialists from the hospital worked as consultants to front-line care providers, such as family physicians, social workers, psychologists and nurses. This was multidisciplinary teamwork in action.

A psychiatrist and psychiatric nurse from Doctors Hospital visited the CHCs on a regular basis, discussed patients with CHC staff, provided ongoing continuing education based on actual cases, and saw some patients directly. Within the CHCs, staff worked together to ensure complete patient care, including assistance with employment and housing. The hospital-based staff were also available by telephone to provide timely advice to CHC personnel.

This Blended Care approach to mental health services has been proven to improve health and function and to reduce the use of institutions and medical care.[62],[63],[64],[65] Without such a coordinated and integrated program, many of the Toronto patients would have been destitute and on the streets.

In 1997 the Canadian Psychiatric Association and the Canadian College of Family Physicians issued a position paper on shared mental health care, praising its ability to ensure that psychiatric expertise is available for those who really need it.[66] However, it notes that new funding mechanisms were required to implement such novel approaches, especially a move away from fee-for-service payment.

Burnaby's New Vista Society

New Vista provides a wide array of housing, community and care services for seniors, families and individuals in Burnaby, British Columbia. The facilities are spread over four sites and include two 14-storey apartment buildings for seniors; a 236-bed intermediate care facility; two seniors' housing projects (another is currently under construction); and a large social housing project with designated units for seniors. Most of the buildings lie within walking distance of each other and will eventually link over 750 seniors in a two-block radius.[67]

The society was founded in 1943 to provide shelter and care for women discharged from psychiatric institutions. To this day, New Vista shows a strong commitment to community development and client-focused continuity of care; a key goal is to enable seniors to participate in their environment and live independently for as long as possible.

Care and services are provided by about 250 unionized staff. Residents contribute by volunteering among their fellow tenants and within the nursing home; indeed, the Seniors-for-Seniors program is an important presence in the intermediate facility.

The apartment towers are an example of supportive housing with some services linked to an intermediate care facility – and vice versa. Most apartment tenants are between 55 and 100 years old, with low to medium incomes. The majority are widowed or single women, and about 40 percent need some help with daily activities. They have access to: Resident Caretakers, on call 24 hours a day; light lunches prepared by the nursing home staff and delivered by volunteers; telephone contact with a security firm, which coordinates responses; English language classes; and a Wellness Clinic in each tower (for blood pressure tests, etc.). A Tenant's Association organizes social events and maintains a volunteer program that monitors the safety and well-being of each resident. The care home also runs social programs, including tai chi and gardening, some of which are open to other New Vista tenants.

The services available from the care facility are somewhat limited, so residents of the housing projects also make use of services from other agencies: home care, nursing, Meals on Wheels, etc. New Vista would like to be able to deliver their own bundled package of services in order to improve continuity and efficiency.

At New Vista Society, the commitment to a continuum of care includes

> the concept of aging in place; community involvement; affordable accommodation; wellness and
>
> healthy community; barrier free housing; homemaker services; day support for seniors/adults with special needs; and multilevel care for the frail elderly adults (both physical and mental) with a specialized focus ... [including] convalescent

care, palliative care, and dementia care.[68]

To advance this vision of seamless care, New Vista is considering setting up a CHOICE-style program.

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