Supporting the Elderly with Enhanced Nursing, Social Work and Case Management

Supports with the

“Home First Quick Response Pilot Program”

A Field Practicum Report

Submitted to the Faculty of Graduate Studies and Research

In Partial Fulfilment of the Requirements

For the Degree of

Master of Social Work

University of Regina

By

Daren Nelson Haygarth

Regina, Saskatchewan

July 2015

Copyright 2015: D. N. Haygarth
# Table of Contents

Abstract ......................................................................................................................... 4

Acknowledgements ........................................................................................................ 5

Introduction ...................................................................................................................... 6

Practicum Goals and Objectives ..................................................................................... 7

The Philosophical Shift in Health Care .......................................................................... 9

History of Home Care in Canada ................................................................................... 12

  Legislative Foundations of Home Care ....................................................................... 13

Best Practice in Senior Care .......................................................................................... 15

The Home First Quick Response Program (HFQR) ...................................................... 16

  Data Collection and Assessment Tools ...................................................................... 18

  Problems with Multi-disciplinary Teams .................................................................... 20

  Addressing Interdisciplinary Team Problems ............................................................. 22

Transition Home Team .................................................................................................... 23

  Challenges of the THT Program .................................................................................. 25

Mental Health in Home Care .......................................................................................... 27

Program Evaluation and Satisfaction Survey ................................................................. 29

  Developing the Survey Tool ......................................................................................... 30

  Completing the Survey ................................................................................................ 30

Home Care Funding ........................................................................................................ 33
Value of the HFQR Program................................................................. 35
Privatization of Seniors Care............................................................... 36
Medicalization .................................................................................... 40
Conclusion ......................................................................................... 43
References ......................................................................................... 45
Appendix A: ....................................................................................... 51
Appendix B: ....................................................................................... 53
Appendix C: ....................................................................................... 57
Patient 1: ........................................................................................... 57
Patient 2: ........................................................................................... 59
Abstract

This report discusses the experience of a Master of Social Work (MSW) student from the University of Regina in their field practicum placement based at the social agency, Home First Quick Response Pilot Project with the Regina Qu’Appelle Health Region in Regina, Saskatchewan. The practicum included working with patients as part of a multi-disciplinary assessment team and conducting program evaluation. The program evaluation included developing and conducting patient surveys as well as evaluation interviews. The Home First Quick Response Pilot Program (HFQR) has a mandate to identify seniors (65 +) who are frequent users of the Pasqua and General Hospital Emergency Rooms and implement support services based on a multidisciplinary assessment. The services provided by the HFQR program include assessment, referral to community services, home visits, and case management. This paper will address the needs of seniors with complex medical issues in relation to HFQR program design, historical context of home care, strategies, skills, program recommendations, as well as related ethical issues. It will conclude with a discussion about the impact of the role of social work in providing services within the Home Care field.
Acknowledgements

I would like to thank the University of Regina’s Faculty of Social Work and Faculty of Graduate Studies and Research for their support in this field practicum experience. I would also like to thank Dr. Donalda Halabuza and Dr. Gabriela Novotna for their participation and support in the development of the Field Practicum placement. I would like to thank Karrie Derbyshire for being my professional associate and for her co-ordination of the placement with the Home First Quick Response Pilot Program. I would also like to thank the General Hospital and Pasqua Hospital Emergency room staff for their participation in facilitating the field practicum experience. And a very special thank you to my wife Corrine and my children Sydney, Matthew and Blake for their support in the completion of my MSW.
Introduction

A 450 hour master’s level practicum was completed from September 2014 to December 2014 at the Home First Quick Response (HFQR) Pilot Project with the Regina Qu’Appelle Health Region. The placement provided an opportunity to work primarily with the HFQR as well as several programs that provide care to seniors within a continuum of elder care. It afforded an opportunity to work with several different professionals within the teams including social workers, nurses, case managers, client care aids, occupational therapists, assessor-coordinators, nurse managers and System Wide Admission and Discharge (SWADD) managers.

The primary focus of the field placement was to work within the HFQR Program to understand and evaluate how the program provides services to persons who are aged 65 and over that are repeated users of the Emergency Departments at the General and Pasqua hospitals. HFQR works primarily with seniors who present in the Emergency Department and utilizes a multidisciplinary assessment and care transitioning approach to ensure patients and their families receive the level of supports and services they require to assist the senior to live independently within the community as long as safely possible (Regina Qu’Appelle Health Region, 2014, p. 1). The best way to understand the program was to work within the program itself and also within the programs that are part of the Regina Qu’Appelle Health Districts continuum of care for seniors. My focus was expanded to incorporate participation with other programs within the continuum of elder care including the transition home team (THT) and Community Home Care. Involvement with these programs, HFQR, and the in-hospital services provided an opportunity to understand how the continuum of care currently meets the needs of elderly persons in Regina.
My practicum experience was a sequential learning process that allowed for a successful opportunity to understand the policies and procedures of the HFQR Program. The first week was an orientation to the HFQR Program at the Regina General Hospital Emergency Room. The orientation was provided by the Program Manager and consisted of an orientation to hospital services and the program design of HFQR. Through this orientation I was provided with information on the struggles the program has faced since implementation. The next step was an orientation to the HFQR program at the Pasqua Hospital Emergency Department where the majority of my practicum was completed. This orientation focused on the roles of the interdisciplinary team members (nurses, social workers, and case manager) in completing the assessment, planning, and case management follow up. The next phase of the practicum was to work with the front line staff and participate in contact with diverse clients at the emergency departments and on home visit follow ups with both the HFQR and Transition Home Teams. During this period, I developed and completed a feedback survey with patients who had been involved with the Home First Program. The final phase of the practicum was the preparation of this report. This report includes an overview of the history of Home Care in Canada, best practices that guide the HFQR program, challenges faced by multi-disciplinary teams, and the current social issues that impact the lives of the elderly in Regina.

**Practicum Goals and Objectives**

The HFQR program allowed for an ideal environment to achieve my learning goals. My first goal was to work with a senior population (65 years and over) to better understand the complex needs faced by this population in the health care system. The direct work with seniors, the Transition Home Team (THT) program, community home care and a review of the literature provided a broad learning experience.
My second learning goal was to work with a diverse range of senior populations to gain a higher level of cross-cultural competence. My practicum provided an opportunity to work with seniors from a wide range of ethnic and socio-economic backgrounds to understand the impact of socio-economic status on the quality of care for seniors and how the evolution of the Canadian Health Care system has contributed to the availability of services to seniors. The greatest learning experience of this practicum was an understanding how the lack of universal healthcare coverage affects the care of seniors.

My third learning goal was to gain experience in conducting surveys and compiling the findings to understand the impact of the Home First program. I was able to achieve this learning goal through the development of a client survey and conducting this survey on a sample of HFQR clients. This paper will outline the process of how the survey was developed, how the sample population was identified, how the results were compiled and how the results were utilized. The survey process was discussed with my academic supervisor who, in turn, consulted with the University of Regina Ethics Board who determined that ethics approval would not be required. Conducting this survey was another great learning experience because it allowed for an opportunity to meet with clients of the Home First program and get their perspective on the services provided by the Home First program and the larger health care system.

My fourth goal was to gain skills in working within a multi-disciplinary team. The Home First Quick Response program has not developed a multidisciplinary team to the extent that it was originally intended to. Therefore, being a part of a larger team of multiple professionals did not occur to the extent that was originally planned. The HFQR program was experiencing high levels of conflict between different professions within the team which
became an opportunity to understand the nature of conflict in interdisciplinary teams and the causes of such conflict. My professional associate provided a great deal of insight into how the interprofessional conflict was impacting the program and the barriers that the program was facing in resolving this conflict. This placement did not directly meet my goal of working within a true multidisciplinary team but I did gain a great deal of knowledge about how conflicts develop in multi-disciplinary teams and the layers of challenges in resolving conflict.

My final goal was to complete this paper, which provides an understanding of the learning experience obtained by working with the HFQR program. In addition to describing the experiences of the placement this paper provides background discussion into the evolution of the Canadian Health Care system and how we have come to need programs such as the Home First Quick Response program. I believe that this practicum allowed me to gain a deeper understanding of the complexity of challenges faced by seniors in our community and the current policy shifts that will create additional barriers for seniors in the future.

**The Philosophical Shift in Health Care**

The demographics of Canadian society are changing and with these changes new challenges for the medical system are coming to the forefront. Many policy makers believe that “the percentage of seniors in our society is on the rise and in turn the issues that this presents for those who care and support the elderly has put increased strain on an already strained healthcare system” (Boyle & Welsh, 2011, p. 1). Researchers believe that as the baby boom generation ages that the elderly demographic will increase exponentially in the near future. It is also believed that, even though seniors will be healthier than their predecessors, the progressive growth of the older adult population will lead to dramatic increase in the demands on the health and social services because even though seniors will be healthier than
their predecessors. Many older adults will be faced with at least one chronic condition and an increasing number will be facing multiple chronic conditions (Ploeg et al., 2014, p. 6).

Evolving demographic changes have led many professionals in the healthcare field to believe that elderly care is in crisis. Researchers believe that the crisis in healthcare provides opportunities to rethink and reform health care and social systems that would benefit all (Global Elderly Care in Crisis, 2014, p. 927). There has been an increase in the number of people receiving care in the community and a decrease in the number of seniors requiring in hospital care. Advances in technology and drug therapies are believed to be more cost effective to diagnose and treat a number of health issues without hospital stays. Accordingly, those who are actually admitted to hospital are staying for shorter periods of time than would have been the case just a few years ago. However, some still require home care when they are sent home (Health Canada, 1999, p. 7).

The change in age demographics and the resulting challenges it creates, is not unique to Canada and has become a global reality. “The world’s population is ageing rapidly at an unprecedented rate. The proportion of people aged over 60 years will double from about 11% to 22% between 2000 and 2050” (Global Elderly Care in Crisis, 2014, p. 927). The disease profile of persons who are ill is also changing throughout the world. For example, in developing regions non-communicable diseases such as depression and heart disease are replacing traditional illness, such as infectious diseases and malnutrition as the leading causes of disability and premature death (Murray & Lopez, 1996, p. 2). These changing realities have not only created evolving challenges for health professionals in the world but have also transformed the way that health services are being delivered to the elderly.
The changing needs of the senior population have led to different philosophical approaches being developed. There has been a shift in the way that long-term care is provided to elderly patients who are chronically ill or frail. Goals in long-term care include maximizing quality of life and keeping the level of functioning of the elderly patient at as a high a level as possible for as long as possible. These goals are most easily attained when care is provided in the home for as long as possible (Health Canada, 1999, p. 7). Keeping people in their home for as long as possible meets multiple goals such as allowing the individual to be more comfortable in their home as well as providing care in a lower cost setting than the hospital or long term care facility.

Policy makers who support the home first philosophy, also hold the belief that life-changing decisions are better made in the home. “Home provides a patient with the most comfort for recovery along with lower levels of stress compared to hospitals. As such, it is considered the best environment in which to make potentially life-changing decisions.”(MacCarthy & Hollander, 2014, p.43) These decisions include whether to access private care, long term care or if care will be provided by loved ones. The Home First program has the ability to assist families by facilitating supports to allow for this period of planning and decision making.

The philosophical shift in the delivery of care to the elderly has led to policy and cultural shifts that has added pressure to a health care system that is already having difficulty meeting challenges both in hospitals and in the community. There is pressure to expand and modify home and community care, the demand for care is expected to grow in the future as a result of the shift of care away from hospitals to home and community-based settings.
Other factors that have increased the need for health care in the home and community are demographic changes in the population; changing public expectations; and advancements in medical and information technology (Health Canada, 1999, p. 1). Shifting the location of service delivery to the community makes it possible to provide better care and save money. This has created a shift to programs that quickly re-stabilize clients. Because stable clients cost less, it may also save money (Hollander & Chappell, 2002, p. xi).

**History of Home Care in Canada**

Saskatchewan’s homecare system has not evolved in a vacuum. To understand the current policy, it is imperative that the evolution of Canadian Homecare policy is first clearly understood. From Home Care’s earliest beginnings, it has existed and evolved on the fringes of the primary healthcare system, which has led to a much different evolution than other services. Homecare services are not a guaranteed service under legislation. Therefore there are no consistent models or consistent throughout the country. This is critical in understanding the reasons for challenges in the implementation of the HFQR program.

Home care has been defined by the Canadian Home Care Association as an “array of services for people of all ages, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal caregiver.” (Standing Senate Committee on Social Affairs, Science, and Technology, 2002, p.28) Most provinces share this definition of home care. However, the actual services provided through Home Care vary from province to province because provinces have developed the services with no national standards as guidelines.
The earliest foundations of Home Care are not easy to identify. Prior to 1850, there were few formal healthcare systems in place in North America. Cowles (2003) states that the home was the original location of health care, which was provided by family, friends, and even neighbours with the support of a physician who visited the home occasionally (p. 187). Babies were born at home, mothers typically were homemakers who provided care for ill and elderly family members who often lived with the family. Medical technology along with societal norms shaped the role of caring for the sick and frail as a responsibility of family members, primarily women.

The first establishment of formal homecare programs began in the latter half of the 1800’s when voluntary, non-profit agencies, such as visiting nurse organizations, began to provide formal home care services in the form of maternal and child care (Balinsky, 1994, p. 1). In Canada, Lady Aberdeen established the Victorian Order of Nurses (VON) in 1897. The first Victorian Order of Nurses sites were quickly “organized in the cities of Ottawa, Montreal, Toronto, Halifax, Vancouver, and Kingston. In 1898, a VON ‘‘cottage’ hospital was opened in Regina to provide care to pioneers and early settlers on the prairies.” (Victoria Order of Nurses, 2009) Home support services were established primarily in response to the needs of women and children who were dealing with the harsh realities that accompanied industrialization, urbanization, and immigration to North America (Cowles, 2003, p.188).

**Legislative Foundations of Home Care**

The *British North American Act of 1867* established the foundation of how funding is controlled within Canadian health care. This Act determined that the management of healthcare services in Canada rests with the provincial governments. This decision has had an ongoing impact on the way health care services are designed and delivered in Canada,
especially Home Care. Federal influence over health care has been exerted mainly through the leverage of revenue transfers, and federal/provincial agreements required to establish national standards for programs (Hutchinson, Abelson, & Lavis, 2001, p. 117).

In 1966, the Medical Care Act incorporated the principles of public payment for private medical practice. In Canada, private fee for service practice became the dominant mode of financing health care and physician payment (Hutchinson, Abelson, & Lavis, 2001, p. 118). The political and economic environment of the 1960’s allowed the federal government to establish Medicare. A strong economy allowed provincial governments to bring physicians into the Medicare program by paying generous salaries, including fee for service remuneration, clinical autonomy and control over the location and organization of medical practice (Hutchinson et al., 2001, p. 118). The Medicare agreement between doctors and the government placed physicians at the heart of decision-making system at all levels. This continues to be the model for medical care in Canada.

Since the implementation of the Medical Care Act in 1966, government attempts to reform healthcare from being centralized in hospitals and based on direction from doctors, have been unsuccessful. Governments have had to approach healthcare reforms differently because of these failed attempts. Canadian provinces have undertaken “primary care pilot and demonstration projects, pursuing a variety of innovations in primary care organizations/governance, funding/remuneration, and delivery arrangements, as one approach to dealing with the aftermath of dramatic downsizing and restructuring in the hospital sector since the 1990’s.” (Hutchinson et al., 2001, p. 121) The move to pilot programs is a way that the federal and provincial governments can reform health care without addressing the issues of the centralized role of doctors and how they are remunerated. The Home First Program is one
such pilot program that is aimed at reforming the way that care is provided to the elderly and is at the fringes of the acute care system.

**Best Practice in Senior Care**

The term best practices in seniors care may be misleading because there is no consensus on what constitutes best practice in health care. “High-value care for many decision makers and administrators clearly translates into a reduction in health care utilization.” (Boyle & Welsh, 2011, p. 1) The literature lays out information on how to save costs in health care. Saving money and a reduction in healthcare usage do not always equate to delivering the best service. In Canada the goal of programs such as Home First is to cut wait times in emergency rooms. There is also a focus on discharging patients referred to as alternative level of care patients in an effort to save money. Boyle and Welsh (2011) state that in 2011 almost one in five patients in Ontario hospitals did not need to be there and cost taxpayers $450 a day, compared to as little as $50 a day for home care (p. 1). It is the cost of healthcare that garners most of the attention in reviews of health care delivery to seniors.

There are other important factors to consider when discussing best practices in the care of seniors such as good doctor-patient relationships, good communication and continuity of care, and the long-term interactions that support quality of life and independent living (Tannenbaum, 2014, p. 1126). The HFQR program works to bring these best practice qualities to the Regina Emergency Rooms. The professionals within the program have responsibilities in assisting with communication between families, doctors and community resources to maintain the patient’s independence in the home. The program is essentially attempting to fill the gaps in services which operate in isolation.
Key Canadian researchers have already reviewed the literature on best practices in the field of elder care. One of those researchers is Margaret Mac Adam with the Canadian Policy Research Network (CPRN). Mac Adam (2008) conducted a systematic review of the literature on efforts to provide integrated care for the elderly. The papers reviewed indicated that it is possible to design integrated programmes that redirect care away from institutional services (long-term care homes and hospitals) and achieve improved quality of life and reduced caregiver burden (p.15). MacAdam found that the features of successful models might vary, but typically “include an interprofessional collaborative practice model; use of case management; and access to a wide range of social, health, and community supportive services. The strongest programmes also included active involvement of physicians, specifically geriatricians and general practitioners.” (Ploeg, Markle-Reid, Fisher, Morsy, Dufour, Reimer, Chambers, Kennedy, Bookey-Bassett, 2014, p.14)

The Home First Quick Response Program (HFQR)

The Home First Quick Response Program (HFQR) is attempting to meet the best practice standards in many ways with both some success and some struggles. HFQR is designed as an interdisciplinary collaborative team approach model. The original design of the program had one manager, 5.5 nursing positions, two social worker positions, one pharmacist, one occupational therapist and six critical care aids. The program, unfortunately, never hired the majority of the intended positions for the program leaving a staffing compliment of only one manager position, 5.5 nursing positions, and two social worker positions. The HFQR program did have access to an occupational therapist through a referral process to Community Home Care. However, this process involved long wait times often in the 6 to 8 week range. In addition, there was no direct access to a pharmacist for the program staff.
The professional foundation of the Home First program had obviously been limited and a true multi-disciplinary program was not developed. The reasons for these decisions were not made clear in my practicum experience, but the literature does give some insight into reasons that cost reducing decisions are made and the problems that can result from underfunded implementation. Hollander and Chappell (2002) stated that even “good models, if they are not adequately resourced, can fail because they cannot function optimally if they are under resourced. Thus, failure may come about due to underfunding rather than due to the nature of the model which is implemented.” (p. IX) The Home First Program is a strong model but without the full complement of staffing it is difficult to determine how much better the program could be if it had full staff.

Mac Adam (2010) emphasizes the need for strong engagement of physicians, geriatricians and general practitioners to provide an effective program for seniors. The programs with the strongest results actively included either geriatricians or general practitioners (or both) in the projects (p.3). My practicum experience demonstrated that the HFQR program was not highly valued by the emergency room physicians. The HFQR staff, especially the nursing staff, would make efforts to connect with the doctors, but the doctors were never truly engaged as part of the team. I observed a higher level of co-ordination between physicians to share information on the patients rather than with the HFQR staff. The HFQR staff would assist in catching miscommunication and bridging gaps between different professionals and the family, but physicians do not work as part of the Home First team. It should also be noted that Regina does not have a geriatrician who specializes in the care of the elderly.
Data Collection and Assessment Tools

My practicum experience provided me with an opportunity to utilize the HFQR assessment and data collection tools. The Home First Program uses a data collection tool called the Contact Assessment. The Contact Assessment tool was created to provide information to support the home care intake process (InterRAI, 2013). The Contact Assessment provides a comprehensive assessment of current medical issues as well as psychosocial supports. The Contact Assessment is to be used jointly by both the social worker and nurse in a shared interview with the patient while they are at the emergency department. The social worker is to assess the strengths of key supports through a psychosocial assessment and determine what family and community resources may be available to assist in the ongoing care of the elderly patient. The nurse’s role in the interview process is to assess for ongoing medical issues and determine potential medical interventions and follow up. The value in completing joint assessments is to provide a broad and clear picture from both a medical and psychosocial perspective.

The HFQR team had problems with conducting the Contact Assessment. The reality of the Home First program is that there was a high level of conflict between social workers and nurses who essentially became unable or unwilling to complete a joint assessment together. Most of the assessments were completed by either the nurse or the social worker individually and then followed up with some conversation about what the staff member had decided to do without an interdisciplinary consultation. As a result of this interprofessional conflict, there was minimal collaboration between the social workers and nurses that greatly limited the value and potential of the Contact Assessment tool. Interprofessional conflict was the most obvious problem in the overall functioning of the program. Proper utilization of the Contact
Assessment tool has the potential to identify and address gaps in the provision of care and reduce over utilization of the emergency rooms through a collaborative multi-disciplinary targeting of services. However, the program is struggling with such high levels of conflict, primarily between nurses and social workers, which caused the potential benefits of the Contact Assessment to not been realized.

The Home First program and larger Canadian healthcare system are faced with challenges in how patient information is collected and accessed. Healthcare system in Canada has been slow to embrace the broad advances in information management. Leatt, Pink and Gueriere (2000) report that many providers are currently experimenting with various approaches to increase the accessibility of health records by providers, but these efforts are not coordinated” (p. 26). The Home First Program has some interesting challenges in how information is collected, reviewed, and shared. The program has to access two different computer systems. The medical database of patient records is used by the hospital staff in a program called Procura. Procura is the system that is used by home care for data management. These programs are not integrated, and Home First program staff review the Procura system and pass information on the patient’s involvement in the Home care system to the Emergency room nurses and doctors. This is a slow process that could be eliminated by having an integrated information system.

The most important and challenging aspect of implementing a new program is providing a reliable and effective system for monitoring and evaluating the impact of the service. Systems need to be developed to monitor and evaluate the impact of organizational change. “Although such mechanisms are fraught with methodological difficulties a framework with reliable indicators must be developed to monitor the effects of health reform on access,
quality and affordability of health services.” (Leatt, Pink & Gueriere, 2000, p. 30) The Home First Program does not have mechanisms in place to evaluate its services therefore it is hard to determine its overall impact in achieving the goal of reducing the repeated use of emergency. There is no valid way of assessing if the program was the primary factor in the reduction in utilization of the emergency rooms or if other factors influence the reduction. The program is primarily evaluated by identifying people who are having repeat visits to the emergency room and tracking how many visits they are having. If the number of visits drops, it is assumed that the program is having a positive impact.

**Problems with Multi-disciplinary Teams**

The level of conflict witnessed amongst the staff in the Home First program was very high, and this led to a review of the literature on interdisciplinary teams. The literature was reviewed to understand the reasons conflict occurs and how services address the conflict, which will be addressed later in this report. While it is very difficult to evaluate all the reasons conflict occurs, there were some obvious reasons that the staff identified and areas that I observed in the day-to-day operation of the HFQR program. Based on my observations, the first factor was the way that the nurses and social workers were scheduled. Each Emergency Department has two social workers on each day. The social workers each have a different schedule. The social worker assigned to the HFQR program works an 8-hour shift while the other Emergency room Social Worker works a 12-hour day. Previously, the Home First Social Workers worked independently before being assigned to the HFQR program. The transition from working independently to collaboratively with HFQR nursing staff did not go well and two years into the program the tension was still obvious.
Scheduling problems also existed for the nursing staff. The nurses worked 8-hour shifts (8 am to 4:30 pm) as they are considered to be part of Community Nursing just like the Home Care nurses in the community. The program staff reported that there were frequent gaps in the schedule where no nursing staff was present. Attempts were being made to align the nurse’s schedule with the social workers schedule. That process became highly bureaucratic and involved multiple levels of management approval plus the approval of the Saskatchewan Union of Nurses. The process of a simple schedule change had begun eight months prior to the beginning of my practicum and had not been resolved by the end. Multiple meetings and discussions occurred on a weekly basis regarding the schedule change without resolving the scheduling problems resulting in a great deal of wasted time and money.

Other problems that created conflict were the way that the office and workspaces were set up, which not only created inter-staff conflict but also limited the opportunity for resolving conflict and problems. In both the Pasqua and General Hospitals, the nurses and social workers do not share a workspace. The program staff work in separate offices. At the Pasqua hospital the nurses work on the 4th floor of the building while the social workers have an office just outside of the Emergency Department thus, opportunities to collaborate are not only limited by the interdisciplinary relational challenges, but by the physical separation isolates professionals from each other. To add to the problem, the HFQR Case Manager works out of the Home Care main office in the South End of the city. Opportunity for collaboration, case conferences and relationship building would be greatly enhanced by having the team share one workspace.

Resolution of conflict is the responsibility of the manager. HFQR is saddled with another logistical barrier because there are several managers involved in supervising the staff.
The social workers from the Pasqua Hospital do not report to the same manager, as do the nurses from both hospitals and the social workers from the General Hospital. The Home Care manager supervises the case manager position, not the HFQR manager. Conflict resolution requires the collaborative efforts of at least three managers. During my practicum, I noted many instances where there was potential for conflict resolution to occur but the managers chose to either avoid that opportunity, side with the person they were supervising, or publically discuss individual staffing issues with other staff. In one instance, I asked if I could be excused from the conversation because I believed it was inappropriate, and this conversation was further escalating the conflict between staff. The team would benefit from having only one manager involved who could address conflict, monitor implementation of the program and provide a clear vision for the program.

**Addressing Interdisciplinary Team Problems**

The literature gives some excellent examples of how to address the problems that occur in multi-disciplinary teams. The most progressive countries take a pro-active approach through interdisciplinary education programs. In Denmark, “the demand for interprofessional collaboration has led to a ministerial order of integrating interprofessional elements in the curricula of various educational programmes. An interprofessional element has been integrated in the Danish Bachelor programmes in Education, Social Work, and Health.” (Ploeg et al., 2014, p.25) Denmark believes that having courses in interdisciplinary collaboration at the undergraduate level will lead to effective interdisciplinary teamwork and improved outcomes for patients. Other countries also understand the benefits of pro-active approaches through education. Sweden, which has often been viewed as a world leader in caring for the
elderly, is also demanding changes to the way professionals are educated in interdisciplinary work. In 1996:

Linköping University was the first in Sweden to implement an interprofessional training ward (IPTW) at the department of orthopaedics, to help undergraduate students become proficient in teamwork. Students from medicine, nursing, physiotherapy, and occupational therapy perform the care, treatment, and rehabilitation of patients in the IPTW. Other IPTWs were established in Sweden based on this model. In Orebro, an IPTW was established in municipal care for older adults, including students from occupational therapy, nursing, and social work. Reports on experiences with IPTW at the University of Linköping and other Swedish universities have been published. It has been shown that the placement at the IPTWs had a positive effect on students’ attitudes and views of the other professions (Ploeg, et al., 2014, p.22).

Inter-professional training models may be highly beneficial in proactively addressing the problems that were witnessed throughout this practicum placement and in developing more productive teams throughout the health care field.

**Transition Home Team**

My practicum placement allowed for a high level of engagement with the Transition Home Team (THT). The THT program has the responsibility of providing intensive services to patients that are transitioning out of acute care beds. The client population is very similar to HFQR, but the THT program is much better resourced and maintains a manageable caseload of 20 patients or less. The analogy is that the HFQR program is trying to address issues as they
come in the door of the emergency departments to keep patients out of the Emergency rooms, while THT is getting patients out of expensive acute care beds and back into their homes or lower cost long-term care facilities. Staff positions that were not hired for the Home First Program were reallocated to the THT program. The Critical Care Aides (CCA) were diverted away from the Home First Pilot Project and reallocated to the Transition Home Team (THT). The THT program is made up of nurses, occupational therapists, case managers and CCAs. The program is similar in nature to the Home First Program but plays a much different role. The Home First Quick Response Program’s goal is identifying seniors who are high utilizers of the Pasqua and General Hospital emergency rooms and providing intervention services that will reduce their use of the emergency wards. These interventions have a direct impact on the Emergency Room wait times and utilization, but they do not directly relate to hospital capacity issues and patient wait times, whereas the Transition House services do.

My practicum placement allowed for a week of time within the THT program to attend team meetings and home visits. The meetings allowed for an understanding of the scheduling and decision making process for care and how the team organized service delivery. A great deal of time is dedicated to scheduling CCA appointments and a daily review of the services being delivered. Nurses have the role of reviewing and delivering medications if required. They also complete a contact assessment to determine any ongoing medical needs and any changes in the patients overall condition. The occupational therapists complete in-home assessments to assure that recommendations for home adaptations are put in place that increase the level of independence for the patients in their homes. The CCA’s complete the daily living activities of bathing, bowel care, meal preparation and any other required tasks.
The THT program works with families and community home care to determine placements and care needs.

The THT program exists in a much different funding and political framework than the HFQR program. The creation of the THT program comes with a long history. In 2002, the First Ministers agreed, as part of a ten-year plan, to fund “short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care.” (Standing Senate Committee on Social Affairs, Science and Technology, 2002, p.28) It was also during this period that the high cost of hospital care, for homecare clients, was having a significant financial impact on government resources. Political support for the development of programs, such as the THT program, was present due to the perceived cost savings and improved service delivery.” (Hollander and Chappel, 2007, p. 160) THT had both social and political support that continues.

**Challenges of the THT Program**

One concern about the THT program is that it is a reactive approach to addressing the needs of seniors who are having increased health concerns and requiring higher levels of assistance whereas programs such as Home First are a proactive strategy designed to put services in place to keep seniors out of hospital. The problem is finding a balance between patient flow and continuing with pro-active strategies such as the HFQR program. Money gets drawn away from HFQR and put into THT to address capacity issues in Homecare and Alternative Level of Care beds by increasing patient flow through the hospital. Ontario has also struggled with capacity issues in home care and hospital overcrowding. To increase the capacity in home care, Ontario made similar decisions as were made here in Saskatchewan. Boyle and Welsh (2011) stated that the decision to push funds from the Ontario Aging at
Home strategy to ALC, instead of providing services that would enable seniors to remain in their own homes, is another example of how the province continues to fail seniors (p. 1). The THT program is a highly valuable program but it could be argued that the value is in freeing up hospital space as the primary motivation and more focus on pro-active strategies may be a more cost effective and patient friendly way of addressing health care costs and hospital overcrowding.

My practicum allowed for an opportunity to spend a day working directly with a THT nurse in the community. The experience was valuable but also raised some questions about the gaps that may be occurring in the service delivery of home care and the overall service delivery to seniors in Regina. One of the responsibilities of the shift was to complete a home visit to a gentleman who was receiving short-term Home Care services due to medical problems. It was discussed at a staff meeting that this gentleman was diagnosed with schizophrenia and as such he required two staff be present due to safety concerns. A Continuing Care Assistant (CCA) attended to prepare the patient’s supper and support the visit. The nurse was primarily responsible for reviewing and administering the patient’s medications. I engaged the gentleman in a conversation about what he does to fill his day. He stated that he used to attend the Mental Health Canteen on Albert Street but he rarely attends now because he is scared of some of the other participants. He spoke about doing activities at home such as watching television and listening to music. His day was filled with activities where he was completely isolated from the community. I asked him if he had other supports and he said that he was supposed to be receiving supports from another agency in the city but he rarely had someone stop by. I looked through his medication and noted that he was on several medications that were prescribed by a psychiatrist. I asked him when was the last time
he had seen the psychiatrist and he said it had been a few years. I asked if his medications made him dizzy and he stated that they sometimes did and was worried if this was the reason that he was falling. The conversation was enlightening because the services of the THT may have been unnecessary with proper follow up with his psychiatrist and proper supports being in place from family and the human service agency he was connected to. Medical issues were being addressed but the psychosocial supports were not assessed and connections to community supports were not made.

After this experience, questions around mental health training became a temporary focus of the practicum placement. I initiated a discussion the following day at the THT daily meeting. I inquired as to how many people on the team had received mental health training as part of the requirement for working in the THT program. The shocking answer was that no one on the team received training in mental health conditions. The team discussed the need to implement formal training in mental health issues due to the frequency in which they were working with patients experiencing mental health challenges.

**Mental Health in Home Care**

My practicum experience raised many questions about the awareness of mental health issues amongst the staff of the THT program as well as the nursing staff of the HFQR program. “Among elderly people in primary care, the prevalence of mental disorders can be as high as 33%” (World Health Organization, 2008, p. 26). Assessment and tracking of mental health problems was not even discussed with the THT or HFQR programs. There was also no requirement for training or knowledge about mental health conditions as a requirement of employment in either program. The staff should have support and access to training that
enables them to recognize and address the full range of mental illnesses and differentiate them from the normal stages of aging. (Canadian Mental Health Association, 2010, p. 7)

Under the *Canadian Health Act*, patients are to receive short-term acute community-mental-health home care for two-weeks consisting of case management and crisis-response services (Standing Senate Committee on Social Affairs, Science and Technology, 2012, p. 28).

In Regina, inpatient mental health services are only provided at the Regina General Hospital. Patients presenting with mental health challenges to the Pasqua emergency room are transferred to the General Hospital where psychiatric services are centralized. A crisis response team also works out of the Regina General Hospital as part of mental health services. They have the role of providing crisis care but are currently only able to address patients who are at imminent risk due to the volume of persons that they are attempting to support and the limited resources of mental health. If an elderly person goes into hospital with a serious medical condition, they will receive care and discharge follow up from a well-resourced THT team that maintains a caseload of 20 patients while an elderly person presenting with a mental health condition will be discharged with the support of a two person team that can only respond to major crisis situations. The lack of mental health supports will result in the patient needing to seek supports through the emergency departments.

The *Canada Health Act* outlines a two week period of support for patients who are being discharged from the hospital and have been experiencing mental health issues. Most “jurisdictions provide funding to ministries or other government departments or provide services through established mental-health organizations”(Standing Senate Committee on Social Affairs, Science and Technology, 2002, p.30) instead of directly providing the service through Home Care. In Regina, there is only one social worker who provides psychosocial
supports to the over 5000 patients that home care provides services to a year. There is a significant lack of knowledge and understanding of the mental health needs of elderly patients.

During my practicum placement, I visited the Mental Health Clinic and discussed the services that are currently available in the community to seniors. A nurse from the Pasqua Home First program also attended the meeting with Mental Health to gain an understanding of these services in an effort to better coordinate with community resources. The information shared in that meeting was concerning. The wait times for a new patient to see a psychiatrist through the Mental Health Clinic was approximately eight months at the time of the meeting. Only patients at severe risk of self-harm were being moved to the top of the wait list. It was assumed that this resulted in many people needing to access service through the emergency departments. The meeting provided insight for all attending on the marginal provision of mental health services to those in need and how this lack of support was contributing to the volume of people seeking help support through the emergency rooms.

Program Evaluation and Satisfaction Survey

My practicum placement offered me an opportunity to develop, conduct and follow through on a patient feedback survey. The survey (Appendix A) was developed and then approved by the Program Manager, Karrie Derbyshire. The development of the survey was an interesting process as it created an opportunity to research program evaluation tools that are used both within and outside of the medical field. It also afforded me an opportunity to address the need for program evaluation of the Home First Quick Response Program, which was identified as a part of the program planning but had not been implemented.
Developing the Survey Tool

The process of designing a feedback survey was more challenging than expected. The program goals were not clearly defined with patients who had contact at multiple points in the medical system. For elderly patients it may be a challenge to clearly distinguish and determine which services were provided by the Home First program and which services other health care providers provided. There was also the problem that practicum students are not allowed to meet directly with patients in their homes without the accompaniment of a Regina Health District Employee. Through consultation with the program manager it was decided that the feedback survey would be best delivered with the support of the Home First Case Manager. This meant that the patients surveyed would primarily be those who had received ongoing supports in the community from the case manager. The survey would not capture the services provided within the Regina General and Pasqua Hospital emergency rooms and patients who did not require long-term supports provided through case management. Therefore, it was a biased selection process. This was a much smaller population to work with which created some unforeseen challenges in obtaining a larger sample size.

Completing the Survey

The reality of doing research with an elderly population is that they are a challenging group to survey because many are frail and they have multiple health problems. The survey sample was based on the clients contacted by the case manager. To obtain a sample I consulted with the case manager and HFQR nursing staff. It also included a review of each patient’s current living arrangements, health status, and contact information on the Procura information system. As the process moved forward it became increasingly clear that many of the patients that had been involved in the HFQR program had moved into long term care
homes due to significant health issues or were deceased. Other barriers in obtaining participants were that patients did not have phone numbers that were active or they moved out of Regina.

The initial plan was to complete the feedback survey over the phone. Several attempts were made to complete it in this way. While there was some minimal success (7 of the 18 completed surveys), it was quickly noted that many of the patients were in personal states of confusion or had come to distrust people trying to gather information over the phone. Most patients that were contacted by phone declined to participate. I consulted with the program manager and we decided to have the case manager arrange personal interviews with patients from his current and previous caseloads.

The most educational and enlightening process of my practicum experience was the process of completing the interviews with patients in their homes. The survey was easy for the clients to understand and gave an opportunity to discuss whom they had been in contact with from the HFQR program and how satisfied they were with the services. The process of compiling the data was very simple as it was simply counting the number of answers that were received on each point of a five point Likert scale with possible answers ranging from Strongly Agree to Strongly Disagree. These results were compiled (Appendix B) and were forwarded to the program manager for use in reporting to the Provincial Government.

The interviews with patients were primarily to complete the Patient Satisfaction Survey but also afforded an opportunity to informally evaluate the living conditions of the patients being served by the HFQR program. The patients came from a wide variety of socio-economic backgrounds and a wide variety of living situations. Interviews occurred in a number of senior facilities throughout the city as well as in privately owned homes.
Conversations were about family supports, costs of medications, access and ease of transportation and a greater overall understanding of the barriers elderly face within the health care system. The seniors that we met with were a wealth of information and had a deep understanding of the barriers in healthcare provision and also the ways to navigate the system to have their healthcare needs met.

The interview process revealed that elderly patients are faced with unique challenges in the health care system. The best way to communicate the barriers is through telling a patient's story. An opportunity came up to complete a feedback survey with a patient that I had met through a previous home visit. He was an interesting and well-spoken man in his late 70’s. He lived in a rented apartment with his wife who was also struggling with some ongoing health problems that limited her mobility. He described his income as modest and they lived on a small pension to augment their retirement income. He attended the emergency ward on several occasions for issues related to lung disease, diabetes, and some falls in the home. He was flagged as a high user of the emergency rooms and as such was seen as appropriate for the services of the HFQR program.

The patient’s most recent health issues were as a result of a fall where he had bruised his ribs and again spent time in hospital. When asked why he didn’t go to the walk in clinic he told a story that outlined the barriers to healthcare very clearly. He explained that if he goes to the walk-in clinic he has to get a cab because he no longer feels comfortable driving in the winter. He went on to explain that once he gets to the walk-in clinic he may be waiting an hour, or longer, to see a doctor. Once he sees a doctor he would be sent for x-rays at another location that creates another transportation barrier and cost of another cab fare. After the x-ray is completed he will have to get a cab to get home. He explained that he might then wait a day
or two to hear back from the doctor’s office. He again has to overcome problems with transportation and the related costs to get back to the doctor’s office and again waits hours to be seen. This process presents multiple barriers in transportation, costs, and being physically able to get to and wait at each point in the process because the system is designed to meet the needs of the doctors. The process is not patient centered especially for those living on limited resources. This gentleman explained that he always just goes to the hospital because they have all the services there, and while he may wait several hours to get in, he can have his tests completed, results reviewed, medication delivered, and either be admitted for follow up or be home the same day. The hospital was described, as a one-stop shop for health care.

**Home Care Funding**

Funding home care services is challenging for two reasons. The first is location of where services are delivered and the second is the way doctors are paid. When the location of care moves out of the hospital, non-physician services that would have been covered in the hospital may no longer be covered. “The *Canada Health Act* defines these services in terms of who delivers them (primarily physicians) and where the services are delivered (hospitals). This traditional view of health delivery becomes problematic, as care is delivered in varied locations.” (Canadian Healthcare Association, 2009, p.10) These two foundations of the funding model will continue to drive the status quo within the health care system and be the most significant barrier to change. For home-care to be effective at reducing institutionalization, service provision needs to expand dramatically and be attributed free of charge, in the same way as when services are provided in public nursing homes (Firbank, 2011, p. 39). This is not the trend in Saskatchewan and we are actually moving in the opposite direction with patients needing to acquire private services at a very high cost to the patient.
The second reason that funding home care is challenging is the way doctors are remunerated. The provision of services is dictated by how doctors are paid. “The payment model is siloed. As a result, so is care. We really don’t reward or incentivize continuity of care across providers.” (Deveau, 2013, p.1) In comparison with other developed countries, Canada has a relatively static healthcare system. Doctors are paid in the same ways as when Medicare was implemented in the 1960s. Although regional health authorities have addressed some of the pervasive problems of Canadian healthcare, progress has been slow and is incomplete. Fundamental system problems have not been addressed even with significant money being thrown at the problem. Leatt, Pink & Gueriere, (2000) stated the following:

Unfortunately, fundamental problems are not solved in this way, and the list of problems is long: uncoordinated care, underuse of non-medical practitioners, provider payment methods with perverse financial incentives, emphasis on disease treatment, unexplained variations in service utilization, geographical misdistribution of practitioners, little use of information and information technology, waits and other access problems, retarded dissemination of proven technology, little emphasis on consumer satisfaction, sparse evaluations of quality of care and outcomes, shortages of various health professionals, rigid role definitions that do not allow new models of care, and looming significant cost increases (p. 32).

The HFQR program is also faced with another challenge that was discussed in the survey interviews with the patients. The way that prescription medications are covered has resulted in a shift of the burden of costs for drugs and medical supplies to patients and their families. These costs would have been covered under the Canada Health Act if these patients
remained in hospital. This cost burden for medication has resulted in some patients choosing to remain in the hospital instead; because many drugs and supplies are not covered under existing public drug-insurance plans (Standing Senate Committee on Social Affairs, Science and Technology, 2002, p.29). For many of the patients that I interviewed the additional costs of a $20 prescription would not be manageable based on their fixed income and high costs of living in Regina.

**Value of the HFQR Program**

The value of the Home First program needs to be assessed within the current health care system. It is important to understand how the current health care system is struggling to change, and the policy and structural reasons for those challenges. The Home First program had a dramatic impact in the case of the patient that was previously discussed. A nurse is able to come into his home and provide some physical assessments such as vitals, review medications and listen to any outstanding concerns that the patient and his wife may have. Through this involvement, there was a better understanding of not only the couple’s medical issues but also of the barriers they face and the supports they are able to access. In this situation, referrals were made to case management and other resources such as occupational therapy. The case manager was able to discuss and follow up with services that were put in place, address difficulties with ongoing medical, family and financial concerns. The couple was able to call the case manager as well as book appointments to have him come out to meet with them. The focus was on the client’s needs within their psychosocial context. The program, within many contexts, is succeeding in reducing “premature institutionalization, enhancing the quality of life, increasing health care accessibility to an elderly patient population and their families in the community.” (Ploeg et al., 2014, p.6)
Developing relationships is an important part of the HFQR program. Patients come to trust the professionals that are involved with them, and personal relationships are truly developed. Many of the patients struggle with many health and mental health issues and have long-term involvement with the HFQR staff. They are high users of the medical system overall. The HFQR team knows the people in the community who are most vulnerable, and they make concerted efforts to advocate for the patients as people and not as a commodity that is being consumed by the medical system. The feedback survey confirmed this thinking with very positive responses in how well Home First staff treated their patients.

**Privatization of Seniors Care**

The patient interview process presented a very clear issue. People’s level of care is directly related to their ability to pay for it. Private provision of home care services is growing as a result of the combination of the shift of care into the home and community, and the recent emphasis within the health sector on cost containment in publicly funded care (Health Canada, 1999, p.4). As the medical system looks to shift the location of services, the people being asked to pick up those costs are often the people accessing those services, who are on limited incomes and many of whom are in poverty.

In discussing issues of funding and privatization of services it needs to be understood that there are two subgroups of patients that are accessing home care services in different ways and for different reasons. Hollander and Chappel (2002) state that:

There are two types of home care: short term home care, often provided as a substitute or adjunct to hospital services; and longer term home care for people with ongoing care requirements. Short term home care clients generally receive a greater proportion of professional services such as home
care nursing and, while somewhat older, are more like the general population. Long term home care clients receive mostly supportive services designed to assist them to function at an optimal level for as long as possible, and to reduce the rate of deterioration in their physical and mental functioning. They are generally older and poorer and the typical profile is a low-income woman, living alone who is in her late 70s. Thus, home care is not only a substitute or adjunct to hospital services. (p. xi)

The HFQR program is typically involved with persons who are long term home care patients who are either not able to afford personal home care and do not yet qualify for long term home care supports. Some of the persons served by the HFQR program are also resistant to accept help from home care for a variety of personal reasons such as wanting to remain as independent as possible or preferring the support of loved ones.

The Canadian public may have some misconceptions about how well we do as a country in providing universal healthcare. Madore (2005) states that the delivery of health care in Canada is largely in the hands of the private sector: most medical practitioners are in private practice (small businesses) and hospitals are private, non-profit organizations. Laboratory and diagnostic services paid for by public health care insurance are delivered by private for-profit facilities in most provinces (p.3). The amount of private money spent on health care in Canada is much higher than in many parts of the world. “About 29.8 per cent of Canadian healthcare expenditure comes from private (rather than public) payments. That’s a lot of user fees for those without private insurance.” (Fisk, 2000, p.1) The idea of Canada having free and universal health care is very far from the truth.
Elder care is one of the fastest growing areas of private care delivery. There have been numerous for-profit extended care and rehabilitation centers opened in the province in recent years. “Often their services are not covered by provincial plans—not because they are delivered in for-profit centers but because the service is both non-physician and non-hospital care.” (Fisk, 2000, p. 1) In Regina, there has been a heavy investment in private assisted living facilities as a form of service provision to the elderly. Assisted living facilities are primarily developed by for-profit developers and targeted to upper middle- income and high-income seniors. These facilities offer a range of services on a fee for service basis. Assisted living facilities offer a care model that more closely resembles a hotel in both its appearance and operation. Residents have individual apartments, can lock their doors, and have more say in their own care (Golant, 2001, p.2). These assisted living facilities have been built throughout the province and provide high cost care to those who are able to afford it.

Those who do not see privatization (the move to increasing the number of private for profit care facilities) as a positive policy solution believe it is a selloff of the patients that are the responsibility of the publically funded health care system. “Yet these privatizations are promoted by the cuts and do threaten Medicare's ability to carry out its mission of universality, accessibility, comprehensiveness, portability, and public accountability, as defined in the 1984 Canada Health Act.” (Fisk, 2000, p. 1) The introduction of high cost Assisted Living Facilities may reduce the number of people requiring support of the public medical system but it has not addressed the overall problems with the medical system and the lack of improvements in care for those who cannot afford private care and continue to live in substandard conditions.

There are several companies that are involved in the operation of assisted living facilities in Regina, across Canada and throughout North America. These facilities often have
a reputation of high profile concerns such as mistreatment of patients, delivery of substandard meals, poor staffing ratios, and overall concerns about the care provided to seniors in their care. Some of these concerns have resulted in the death of patients for reasons other than natural causes. For example, a 2013 “ground-breaking W5 investigation into resident-on-resident abuse in long-term care homes found more than 10,000 "incidents" across Canada in one year.” (Rinaldo & Sourtzis, 2013, p. 1)

On the surface, concerns about assisted living and private long-term care are very overwhelming, and the concerns seem to be increasing with the move towards privatization. Parkview Place in Winnipeg is owned by Revera; a for-profit chain that manages more than 200 senior facilities across North America with several large properties in Regina. The problem is that Revera itself is not just a private company that operates as a typical business. According to the Federal Government’s Public Treasury Board (Treasury Board of Canada Secretariat, 2013) Revera is a subsidiary of the Public Sector Investment Board. The Public Sector Pension Investment Board (PSP Investments) is one of Canada’s largest pension investment managers, with $93.7 billion of assets under management at March 31, 2014. They invest funds for the pension plans of the Public Service, the Canadian Forces, the Royal Canadian Mounted Police and the Canadian Forces Reserve Force. There is a potential conflict of interest when the RCMP are asked to investigate the wrong doing of a Revera facility because the income generated by that facility is being put towards assuring RCMP officers pensions. This conflict of interest is both obvious and very concerning. Revera’s own website (www.reveraliving.com) makes no mention to the connection to the Public Sector Investment Board or the potential conflicts of interests that could arise from this association.
The connection between the federal government and for-profit services delivery of care to seniors raises additional concerns that are difficult to quantify and raises questions that need to be addressed. The government may not be motivated to address the problems plaguing the healthcare system if it is also profiting from the current system failures. This ethical question needs to be brought to the forefront by making the public aware of the fact that the government is profiting from the for-profit services that they are responsible for overseeing.

**Medicalization**

A key factor in the development of the Home First Program is the widely held belief that there is a need to address the care of seniors due to the impending crisis in the health care. In other words, there is concern about whether the health care has the ability to meet the needs of an aging population. This perceived crisis may actually not be the real driver of healthcare costs. The real cost increases in health care are due to availability of costly new medical technology and staffing costs. “These factors will be the dominant drivers of health spending in the future as well. Blaming Medicare’s future economic pressures on demographic factors beyond policymakers’ control are an evasion of more important challenges.” (Reinhardt, 2003, p.31)

The current political climate has created a level of fear associated with the aging of the baby boomer generation. Fear of this change rests partly in the stereotype that elders are parasites expensive to maintain (Cruikshank, 2009, p. 26). This stereotyping is constructed through the language associated with aging. Stereotypical terms such as:

- Epidemic, tsunami and time bomb denigrate old women and men. Instead of being seen in multiple roles or as having diverse economic needs, they are caricatured as
parasites, living too long, consuming too many societal resources, and robbing the young (Schermer & Pinxten, 2014, p. 30).

Many see this language as having a motive and the purpose of creating a fear of the aging population. The development of an irrational fear of an aging population is a weapon that has also been “used against women, people of color, and workers. Today elderly people are scapegoated for problems they did not cause: deficits due to tax cuts, wars, bank bailouts, and stimulus spending in 2008 and 2009.” (Schermer & Pinxten, 2014, p. 27) The motivation for the use of this language may be to cut social programs to the elderly and to continue the shift towards more privatized care to the elderly.

We are being swayed to view aging as a disease in need of a cure. Elderly persons are increasingly seen in terms of a privatized market in which interventions are based on cost-effectiveness. The process of receiving care becomes “centered on the individual, irrespective of the social factors responsible for the presumed deficiency being treated. Even when there is no pathology, simply failing to adhere to the demands of this reality can warrant pharmacological intervention.” (Esposito and Perez, 2014, p. 430) In essence, being elderly has been equated with being diseased.

Medicalizing the process of aging was already experienced in the mental health field. Mental health conditions are often treated in isolation from other psychosocial factors. The visit that occurred with the gentleman diagnosed with schizophrenia is an excellent example of how we have long viewed mental health conditions as a medical problem for an individual without understanding the larger psychosocial context or contributors of health conditions. Conrad (1979) notes that the development of early phenothiazine medications in the early 1950s, which was developed for the treatment and control of mental disorders was the
beginning of an explosion of the development for large numbers of psychotropic medications that are easily administered. The use of medication was also much cheaper that having patients spend long periods of time admitted to hospital. This has meant that the accepted use of psychotropic medications has resulted in “the successful articulation of mental distress as a thing you treat individually, despite a cultural understanding that emotional suffering can be due to larger social forces.” (Esposito and Perez, 2014, p. 432) Mental illness is now considered a disease of the individual and not a condition that evolved both within and due to a psychosocial context.

It is important to understand the concept of medicalization to have a deeper understanding of the reforms that are occurring in health care and how the Home First Program fits into the bigger picture. The Home First Program is focused on providing care to those most in need. Is the motivation to assure that those people’s health care needs are met? Or is the focus of the program is to identify high users of the Pasqua and General Hospital emergency departments and put strategies in place that will reduce or re-direct their use of emergency departments. Home First Quick Response is part of an effort to reduce the volume of seniors filling high cost hospital beds and reduce long wait times at the Emergency Rooms themselves. While the Home First Quick Response staff provide a personal approach to the patients, the program itself exists as an attempt to reduce the perceived health care costs associated with an aging population and the burden that the perception that elderly are putting additional strain on an already overburdened healthcare system. As much as the program can be perceived as a proactive approach to meeting the needs of high-risk seniors it can also be negatively portrayed as another expensive investment on a population that is already consuming expensive medical services at an alarming rate.
Conclusion

My field practicum placement for the completion of a Master of Social Work from the University of Regina with the Home First Quick Response Program provided me with an excellent learning opportunity. This opportunity expanded my skills and knowledge of working with an elderly population within a health care setting. This practicum allowed for a program survey and evaluation component that included interviewing persons who had been served by the Home First program. This interviewing process provided me with a wealth of information on how the elderly themselves see the challenges in the medical system and their opinions on what need to be done to fix the issues. Affordability, access to care, and improved standards of care were common concerns throughout the interviews. The practicum placement provided an encompassing understanding of the Home First Quick Response Program as well as an opportunity to work with the staff and patients of the Transition Home Team and Community Home Care. This experience gave me a broad understanding of the services provided to the elderly with our community.

Completing a practicum placement with the Home First Quick Response Program allowed me to apply theoretical knowledge at the micro, mezzo and macro level of social work practice. Working with elderly persons who are experiencing health and personal difficulties allowed me to enhance my skills of working within a multi-disciplinary team to advocate for the needs of the elderly within a complex health care system. The field practicum also allowed an opportunity to network with professionals throughout the healthcare system to gain an understanding of the services available within our community to a growing elderly population.
Overall my experiences with the Home First Quick Response Program met all of my learning goals and have greatly increased my understanding of issues faced by the elderly. I have developed a deeper understanding of the challenges faced by seniors in an evolving health care system. I was also able to work with seniors from a variety of ethnic and socio-economic backgrounds to gain a better understanding of the different challenges faced by people who have financial resources and those who live in poverty. I was also able to gain valuable experience by developing and conducting a feedback survey of patients who had received services from the Home First Program. This process was an opportunity to speak with seniors and hear their perspective on the health care system, which proved to be an excellent learning opportunity. My experiences with the Home First staff, Transition Home Team and the patients themselves will assist me in approaching my social work practice with a more critical and higher level of understanding and empathy for the elderly and their families. The review of the literature provided a much deeper understanding of the issues that continue to shape the medical system and how those contextual issues have led for the need to develop programs such as the Home First Quick Response Program.
References


Feedback Survey
The Home First Program

If you have any questions about this survey please contact:

[Contact information]

The Regina Qu'Appelle Health District would like to thank you for completing the survey. Your feedback is greatly appreciated and important. Feedback surveys like this will be used to improve the services provided by the Home First Program. The Home First Program is a year plan project to support and enhance the services and patient satisfaction for those served by the Home First Program. We would like to thank you for taking the time to complete this survey.

Please provide any additional comments about your experience with the Home First Program.
<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

52

Other:

-搬到了长期护理
-搬到了私人疗养院
-搬到了家庭疗养院
-搬到了家庭
-参加了紧急房间

如果你们不能与正在发生的健康问题一起生活，你们将如何处理？

-支持
-在家庭中继续
-家庭健康工作者
-社工
-营养师
-物理治疗师
-职业治疗师
-心理健康

哪个程序提供的服务最好？你的总体印象是：

- 65 岁以上
- 75-84
- 65-74

你们年龄是？
Appendix B: Results of the Feedback Survey Provided to Karrie Derbyshire, Manager of the Home First Quick Response Program

A client feedback survey was developed and conducted by a graduate student from the Masters of Social Work program, University of Regina. The surveys were conducted by phone and by in home visits. The target population of clients were primarily those who had received both HFQR nursing and enhanced Case Management supports. A total of 52 potential clients were identified as appropriate for follow up.

One hundred and two (102) patients had received support through enhanced case management since October 2013. This original list was reduced to 43 appropriate patients for follow up due to a number of patients who had passed away, were in Long Term Care Homes or had dementia or other health problems that rendered their ability to complete the feedback survey was very impacted.

In total 18 surveys were completed. 11 were completed by in home visit and 7 by phone. Two (2) additional visits were attempted to patients that were in a state of confusion. Attempting to complete the survey with them was upsetting to them and it was quickly determined that the individuals were in distress and it was not appropriate to conduct the survey. It was determined that phone calls were not an effective way to conduct the survey with this population. An additional 14 surveys were attempted by phone with the patients refusing to participate.

The reality is that the HFQR program serves a vulnerable and fragile population who are typically attending to the emergency room due to complex medical and social issues. In the surveys that were completed several of the participants were somewhat confused about the
purpose of the survey and even forgot whom they were speaking with while the survey was being conducted.
Survey Findings:

Age

Services Received by Those Who Completed the Survey
Question 1: If you did not have the support of the Home First Quick Response Program how would you cope with ongoing health issues?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend to Emergency Room</td>
<td>14</td>
</tr>
<tr>
<td>Move in with family</td>
<td>2</td>
</tr>
<tr>
<td>Move into an Assisted Living Facility</td>
<td>4</td>
</tr>
<tr>
<td>Move to a Private Care Home</td>
<td>6</td>
</tr>
<tr>
<td>Move to Long Term Care</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>

Question 2: The Staff was courteous and Respectful?

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>0</td>
</tr>
<tr>
<td>Agree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>16</td>
</tr>
</tbody>
</table>


Question 3: The staff was knowledgeable of your needs?

Question 4: The staff spoke to me in a way that was easy to understand?
Question 5: Appointments were booked quickly and at a time that was convenient for me?

Question 6: The Support I received will help me be more independent in my home?
Question 7: The support I received will allow me to stay in my home long term?

Question 8: The support I received reduced my need to attend to the Emergency Room?
Question 9: I was provided information that useful in managing my own care?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Question 10: Staff followed up with you when they said they would?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Question 11: I had a choice about the services and decisions made about my care?

Question 12: I know who to contact if I have a concern or question about the services I received?
Appendix C: Stories provided for Inclusion in the Annual Report to the Ministry of Health

Patient 1: Completed an interview in the home with Patient #1 and his wife;

When asked the question “If you did not have the support of the Home First Program how would you cope with ongoing health issues?” Patient #1 had a profound answer that sums up the value of the Home First Program.

Patient #1 replied “I would go to the Emergency Room every time.” Patient #1 told a story about attending to his family physician after experiencing chest pain over a few days. His family doctor assessed him at the clinic and prescribed him antibiotics for bronchitis as he had experienced lung problems in the past due to a lifetime of working in a bakery. Patient #1 returned home but the pain continued and became more intense until he decided to attend to the General Hospital Emergency Room three days later. Patient #1 was brought in and after some tests he was told that he was being admitted because he had a heart attack sometime in the previous week.

Patient #1 stated that he “will always go to the emergency room if he is sick. The hospital has all the equipment and tests all in one place and I get results faster.” Patient #1 explained that if he goes to his doctor and gets a requisition for an x-ray and blood work that he will need to go to 2 different places where he will have to wait about an hour at each place. He has mobility problems and is anxious about getting around town when the streets and sidewalks are icy. He went onto explain that even after he completes all of the trips he still has to sit at home and wait for several days for the results and then make a forth trip back to the doctor to get his results. He can go to the emergency room and get all of this done in a few hours. One trip to emergency
limits his anxiety about travel, fewer hours spent waiting, and all the tests and x-rays can be completed in one place over a couple hours and the results and treatment are discussed on the same day.

Enhanced case management dramatically reduced the need for Patient #1 to return to the emergency room. Weekly home visits, by the case manager provided an opportunity for education about managing his care. A referral for Occupational Therapy allowed for an assessment of the home and minor modifications to be made to reduce the chance of falls and allow a greater level of his independence while remaining in his own home. The home visits have also allowed Patient #1 and his wife to discuss their personal circumstances with someone who has the time to listen. These meetings alleviate the anxiety they have been feeling while addressing some serious and ongoing health issues.
Patient #2: Completed an interview in the home with Patient #2 and his wife;

Patient #2 is facing several severe health issues including diabetes, congestive heart failure, Chronic Obstructive Pulmonary Disease has a pacemaker and cancer. He has been given a limited amount of time to live and requires daily care that is provided by his wife. Patient #2 has a very difficult time getting out of bed due to weakness and very low endurance. He is constantly on oxygen. Patient #2 reported that he has been very happy with the provision of enhanced case management.

Patient #2 requires weekly blood work as part of his treatment. He was initially attending to a lab but his wife stated that he would need to sleep for 2 to 3 days after his blood work appointment because it was so physically draining for him. They spoke with the case manager about advocating on their behalf for in home lab work to be completed in their home. The case manager was able to advocate on their behalf highlighting the issue of significant stress that these appointments had on Patient #2’s health as well as on his wife who is caring for him. In home lab was approved and the family has noticed an improvement in Patient #2 overall health and anxiety as he no longer has to attend these very taxing appointments. There has been a reduction in caregiver burn out, as his wife does not have to assist in negotiating the outings and coping with Patient #2’s health after each outing. His daily struggles due to medical problems are severe enough without adding additional stress on the couple.

Patient #2 and his wife also talked about how nice it was to have someone who had the time to listen and understand their concerns and then help them follow through. They spoke about how this has really helped with their anxiety in an already stressful situation.