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Organizational home care models across Europe: A cross sectional study

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ABSTRACT

Background: Decision makers are searching for models to redesign home care and to organize health care in a more sustainable way.
Objectives: The aim of this study is to identify and characterize home care models within and across European countries by means of structural characteristics and care processes at the policy and the organization level.
Data sources: At the policy level, variables that reflected variation in health care policy were included based on a literature review on the home care policy for older persons in six European countries: Belgium, Finland, Germany, Iceland, Italy, and the Netherlands. At the organizational level, data on the structural characteristics and the care processes were collected from 36 home care organizations by means of a survey. Data were collected between 2013 and 2015 during the IBenC project.
Study design: An observational, cross sectional, quantitative design was used. The analyses consisted of a principal component analysis followed by a hierarchical cluster analysis.
Results: Fifteen variables at the organizational level, spread across three components, explained 75.4% of the total variance. The three components made it possible to distribute home care organizations into six care models that differ on the level of patient-centered care delivery, the availability of specialized care professionals, and the level of monitoring care performance. Policy level variables did not contribute to distinguishing between home care models.
Conclusions: Six home care models were identified and characterized. These models can be used to describe best practices.

What is already known about the topic?

- Principals of innovative models of care development are described.
- Innovative models of HOME care delivery to meet the challenges of future health services are described.
- Based on a service delivery integration index of home care, several models of services delivery integration have been identified such as a medico-social model, a medical model and a fragmented model.

What this paper adds

- An evidenced based approach to identify and characterize organizational care models across Europe, based on structural characteristics and care processes of home care organizations.
- Home care models differed on three core elements: level of patient-centered care delivery, availability of specialized care professionals, and the level of monitoring care performance.

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1. Introduction

Both in Europe and the U.S., decision makers are searching for models to redesign home care and to organize health care in a more sustainable way (European Commission, 2013; Kringos et al., 2015; Landers et al., 2016). There is a sense of urgency since growing numbers of care dependent older persons with chronic conditions are served in the community, along with a shortage in the primary care workforce, and reductions or changes in public health care expenditures (Bienkowska-Gibbs et al., 2015; Kringos et al., 2015; Landers et al., 2016; Rodrigues et al., 2012).

American as well as European literature indicate that the home health care of the future needs to be more patient and person centered; more integrated and coordinated across settings, services and care professionals; providing high quality care for example by offering specialized care; and technology supported (Bienkowska-Gibbs et al., 2015; Kringos et al., 2015; Landers et al., 2016). There however is no 'one size fits all' model (Bienkowska-Gibbs et al., 2015; Kringos et al., 2015; Landers et al., 2016). The economic situation, the national political landscape, the structure of the health care system, and prevailing attitudes and beliefs among the populations force each country to put different accents while improving health and home care in their country (Kringos et al., 2015). However, in order to improve the efficiency of health and home care, policymakers need information on which type of home care delivery or which home care model provides the best outcomes in their country.

The Queensland Health (2000) defines a care model as a multifaceted concept, which broadly describes the way health services are delivered. The World Health Organization Chronic Care Framework (World Health Organization, 2002) illustrates that new care models have to include both organizational-level and policy-level building blocks. At the home care policy or macro level, overall values, principles, and strategies for home care delivery are developed, and decisions concerning resource allocation are taken (World Health Organization, 2002). At the organizational level or meso level, home care organizations manage and coordinate care delivery (World Health Organization, 2002).

Donabedian's framework for assessing the quality of care suggests that structural characteristics, care processes, and outcomes are related with one another (Donabedian, 1997). Structural characteristics are defined as the physical and organizational characteristics of the settings in which care occurs. This includes aspects of material resources (such as facilities, equipment and money), of human resources (such as the number and qualification of staff), and of organizational structures (such as involvement of medical staff, methods of quality monitoring, and system of reimbursement). The care processes denote what is actually done while giving and receiving care (Donabedian, 1997).

The aim of this study is to benchmark home care models within and across European countries by identifying and characterizing structural characteristics and care processes of home care at the policy and the organization level.

2. Methods

This study was part of the IBenC project (Identifying best practices for care-dependent elderly by Benchmarking Costs and outcomes of community care, EU FP7, grant no. 305912), which was conducted between January 2013 and December 2016. Since the IBenC project aims to collect data of European community-dwelling older people by means of the interRAI instruments, European countries with care organizations where the interRAI Home Care (HC) instrument is known to be implemented were asked to participate. The six countries participating were Belgium (Flanders), Finland, Germany, Iceland, Italy, and the Netherlands. Medical ethical clearance for the study was provided by appropriate legal Ethical Boards in each of the participating countries.

2.1. Sample selection

The study focused on home care, defined as 'care provided at home by social and health care professionals' (www.ibenc.euwww.ibenc.eu). A home care organization was defined as a professional care organization that offers nursing care (activities of nurses that are of technical, supportive, or rehabilitative nature), personal care (assistance with activities of daily living (ADL) such as dressing upper and lower body, eating, personal hygiene, toilet use, and bed mobility), and/or domestic care (help with instrumental activities of daily living (IADL), such as shopping, meal preparation, ordinary housework, transportation, managing medications, and managing money) in the community (www.ibenc.euwww.ibenc.eu).

Home care organizations were invited to participate in the study. For the purpose of the IBenC project, care organizations preferably used the interRAI HC instruments in routine care practice. In order to fulfil the required number of clients per organization (n = 153), each participating country was asked to include a maximum of three home care organizations (www.ibenc.euwww.ibenc.eu; Van Eenoo et al., 2016). However, since it was not feasible in all countries to include large size organizations, smaller home care organizations could be included as well. To benchmark home care models, data heterogeneity was required and therefore organizations were not selected based on representativeness, but on variation in organizational structures and practices.

In Belgium, home care organizations from the Dutch speaking part of Belgium, Flanders, were selected. Typical for Flanders is that home nursing and other home care services such as social care are provided by different organizations (Van Eenoo et al., 2015). In 2013, 193 nursing home care organizations and 116 social care organizations operated in Flanders (Agency Care and Health Flanders, 2016). For this study, a large umbrella care organization providing mainly nursing care, was contacted and 18 home care agencies, spread over the five Flemish provinces, were selected.

Finland consists of 320 municipalities and has 641 home care provider units and 356 home care organizations (in 2013). All these units and organizations provide mixed social and nursing care. For this study, three care organizations were selected in two regions of Finland: one organization in a small town and two organizations in a region with two small municipalities.

Germany consists of 16 federal states and has 12.700 predominantly small home care organizations. Most of the organizations are private (63%), 36% are run by welfare services, and 1% belongs to a public body (Van Eenoo et al., 2015). For this study, 11 private organizations in three states were selected: five in Saxony, four in Berlin and two in Baden Württemberg. All selected organizations provide mixed social and nursing care.

In Iceland, one care organization was recruited in Reykjavik. Reykjavik is the capital city of Iceland and covers half of the Icelandic population. Reykjavik only has one home care organization with integrated social and nursing care. This organization contributed participants to the IBenC study. The included organization is thus fully representative for Reykjavik.

Italy consists of 20 regions and had 145 home care organizations in 2013. For this study, four mixed social and nursing home care organizations were invited in Umbria, a central region of Italy. Two of these however refused to participate because they were not allowed to share data due to privacy issues.

In the Netherlands, 418 home care organizations were active in 2013. For this study, four care organizations were invited and all agreed to participate. One smaller organization in a provincial city dropped out because of their low client influx during the recruitment period. The other organizations operated in: 1) the city of Amsterdam, 2) the predominantly rural area of West Friesland and 3) in the city of Utrecht and surrounding region. Two organizations provide mainly nursing care and one mixed social and nursing care. The organization in West Friesland was affiliated with general medical practices.