McMaster University | Health Forum

Rapid evidence profile

Examining the features and impacts of approaches to extend at-home living for Veterans

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Context

- Provincial and territorial health systems (and parts of social systems that intersect with home care) in Canada are responsible for ensuring that Veterans, like other members of the general population, can remain healthy and at home for as long as possible.
- However, provincial and territorial home-care sectors are under increasing amounts of pressure from an aging population, health workforce challenges, and increasing complexity of care.
- While Veterans Affairs Canada operates 'top-up' programs such as the Veterans Independence Program, an increasing number of Veterans are relying entirely on these programs when provincial and territorial care do not provide what's needed.
- In addition, many Veterans report challenges with the coordination between home-care supports and services provided by provincial and territorial systems and those funded by Veterans Affairs Canada.
- This rapid evidence profile examines the features and impacts of approaches to extend at-home living for Veterans that could be pursued in either provincial and territorial health systems or as part of 'top-up' programs specific to Veterans.

Box 1: Evidence and other types of information

+ Global evidence drawn upon

Evidence syntheses selected based on relevance, quality, and recency of search

+ Forms of domestic evidence used (🍁 = Canadian)

Evaluation

+ Other types of information used

Jurisdictional scan (five countries: AU, CA, NZ, UK, US)

*** Additional notable features**

Prepared in the equivalent of three-business days using an 'all hands-on deck' approach

Questions

- What are the features and impacts of approaches to extend at-home living for Veterans?
- What recent innovations to extend at-home living are being pursued in general at the federal level and in Canadian provinces and territories and for Veterans at the national level in each of the 'Five Eyes' countries?

High-level summary of key findings

- We identified 33 documents relevant to the research questions, of which we determined 11 to be highly relevant, including three evidence syntheses and eight single studies.
- The included evidence provided insights into how at-home living innovations for Veterans are organized and delivered and how home-care funding is currently allocated.

- We identified evidence documents that support the use of home modifications, home-based primary care supports, assessments from a broader range of healthcare professionals, participation in activities that aim to increase socialization, and remote monitoring technologies to help older adults stay at home longer.
- We also identified evidence documents that examined financial arrangements, including the use of individualized budgets, which helped promote agency and independence but sometimes resulted in challenges coordinating services.
- From the jurisdictional scan, we identified a range of innovative approaches specific to Veterans including to delivery arrangements such as supporting changes to the home environment and providing additional support services, as well as to financial arrangements such as introducing new or revised funding approaches and providing individualized care budgets.

Framework to organize what we looked for

- Innovations that can help extend at-home living for Veterans
  - Innovations in how home care is organized and delivered
    - Supporting changes to the home environment that allow the Veteran and/or their family to stay at home longer
    - Providing home-care interventions earlier (i.e., adjusting eligibility to work with Veterans who face rising risk, not just those with already highly elevated risks)
    - Providing assessments from a broader array of providers (e.g., occupational therapists)
    - Introducing disease-management approaches specific to Veterans' needs
    - Building connections and/or teams to coordinate care within the home-care sector and other sectors (e.g., primary care)
    - Providing Veterans with case managers or care coordinators who can use a population-health management approach that builds services around people with similar levels of need and barriers to accessing care
    - Providing 24/7 remote monitoring and rapid coordination with urgent care through community paramedics
    - Providing additional support services, including for caregivers (e.g., Meals on Wheels, transportation, adult day programs, friendly visiting services)
    - Providing social integration opportunities for Veterans in their communities
    - Providing respite to caregivers
    - Using trauma-informed approaches
    - Providing culturally appropriate care (including training for health and social service providers)
  - Innovations in how funds for home care get allocated

Box 1: Approach and supporting materials

We identified evidence addressing the question by searching Health Systems Evidence and PubMed. All searches were conducted on 7 May 2024. The search strategies used are included in Appendix 1. In contrast to synthesis methods that provide an in-depth understanding of the evidence, this profile focuses on providing an overview and key insights from relevant documents.

We searched for full evidence syntheses (or synthesis-derived products such as overviews of evidence syntheses) and protocols for evidence syntheses.

We appraised the methodological quality of evidence syntheses that were deemed to be highly relevant using AMSTAR. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality. The AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to evidence syntheses pertaining to delivery, financial, or governance arrangements within health systems or to broader social systems.

A separate appendix document includes:
1) methodological details (Appendix 1)
2) details about each identified synthesis (Appendix 2)
3) details about each identified single study (Appendix 3)
4) details from jurisdictional scan (Appendix 4)
5) documents that were excluded in the final stages of review (Appendix 5).

This rapid evidence profile was prepared in the equivalent of three-days of a 'full court press' by all involved staff.

        - Introducing new or revised funding approaches to support Veterans to invest in home retrofits
        - Introducing new or revised funding approaches to cover a broader range of services
        - Introducing new or revised funding approaches to support Veterans to invest in at-home medical devices, medical technologies, and medical supplies
        - Providing Veterans with individualized home-care budgets
        - Working towards pooled budgets across levels of governments, systems, organizations and teams
        - Reducing threshold to eligibility through enhanced financial coverage (e.g., first-dollar coverage)
    - Innovations in how decisions are made about home care
        - Improving coordination between provincial and territorial home-care services and Veteran-specific home-care services (i.e., those funded by Veterans Affairs Canada)
        - Engaging with existing provincial and territorial and community services to ensure they are meeting Veterans' needs
- Outcomes
    - Health outcomes
        - Quality of life
        - Functional status
        - Hospital admission
        - Long-term care admission
        - Other
    - Care experience
        - Wait-time for approval of home-care services
        - Wait-time between approval of home-care services and receipt of home-care services
        - Care satisfaction (including family, friend, or caregiver satisfaction)
        - Other
    - Provider experience
    - Costs

What we found

We identified 33 documents relevant to the research questions, of which we determined eleven to be highly relevant, including three evidence syntheses and eight single studies. In addition to the highly relevant documents, we summarized key findings from nine medium-relevance documents in the section below. This is followed by a summary of key findings from our jurisdictional scan of the 'Five Eyes' countries and all Canadian provinces and territories and a high-level assessment of gaps in evidence and next steps.

Coverage by and gaps in existing evidence syntheses and domestic evidence

The included evidence provided insights into how at-home living innovations for Veterans are organized and delivered and how home-care funding is currently allocated. Innovations primarily focused on care coordination between multidisciplinary care providers in the home-care system, remote monitoring technologies to support independent living, and social integration opportunities. A critical gap that was identified in the included evidence is a lack of findings on the use of trauma-informed approaches and culturally appropriate care.

In terms of funding allocation for home care, existing evidence described increases in funding to expand access to home- and community-based services for Veterans and to offer individualized budgets, but research is still needed on funding approaches to support Veterans in investing in at-home retrofits, supplies, and technologies and to explore ways to reduce thresholds for eligibility to funding. Finally, evidence is lacking in how decisions about home-care services for Veterans are made at the federal, provincial, and territorial levels to ensure that Veterans have access to the services they need.

Key findings from included evidence documents

Innovations in how home care is organized and delivered

One older high-quality evidence syntheses reported that home modifications, alongside other interventions targeting physical activity, reduced frailty levels among community-dwelling older adults.(1) Home-based primary care interventions delivered by interprofessional care coordination teams can also have positive impacts on Veterans.(2) Six single studies we identified evaluated the effects of the U.S. Department of Veterans Affairs (VA) Home-Based Primary Care (HBPC) program, which promotes the routine collaboration of multidisciplinary health teams to provide home-based care to Veterans. One recent single study found home-based primary care involving flexibility in supports, addressing isolation and complex health needs, and coordinating individualized supports improved Veterans' quality of life and functional independence.(3) After completing individual problem-solving training with licensed psychologists and social workers, one study highlighted that Veterans participating in the home-based primary care program reported significant reductions in depressive symptoms, difficulty functioning, and fewer thoughts of death.(4) While Veterans were found to be more functionally independent with activities of daily living than their civilian counterparts, Veterans participating in the home-based primary care program were found to have increased burden from chronic diseases and poorer overall health status.(5) At times, home-based primary care team members may go beyond their roles as healthcare providers to ensure that individuals gain access to community-based services, and may also collaborate with VA Mental Health Intensive Case Management teams that help to provide outpatient community care for Veterans with complex mental health issues.(6; 7) Although there may be highly variable trajectories of care for patients enrolled in the home-based primary care program, with enrollment time ranging from as little as three months to over two years, a recent single study reported a reduction in hospitalization rates, nursing home use, and emergency department use after six months of enrollment.(8)

The included evidence also explored how assessments from a broad array of providers can facilitate access to a diverse mix of services for Veterans living at home. One high-quality evidence synthesis from 2015 found that low-intensity occupation-focused and occupation-based interventions employing cognitive, behavioural, and environmental strategies with the support of occupational therapists can significantly improve the performance of home-dwelling adults with physical health issues.(9) Similar findings were identified in two single studies that assessed occupational therapy interventions – restorative occupational therapy and Advancing Better Living for Elders (ABLE) – that featured therapy sessions, adaptive equipment, and home modifications. Participants in these programs experienced improved home safety and health-related quality of life and reductions in functional difficulties.(10; 11) Another study found that Veterans and their caregivers benefited from having a psychologist as a core member of the VA's HBPC team to provide education and counselling, crisis/suicide assessments, and medication management. The study also highlighted that the availability of a psychiatrist also proved to be beneficial for Veterans with complex mental health issues.(7)

An older high-quality evidence synthesis identified several interventions that may impact social isolation and depression in older adults, including group-based reminiscence therapy, gender-based social clubs, an indoor gardening program, a radio program, and playing a Wii game.(12) The evidence synthesis concluded that only group-based reminiscence therapy successfully reduce both social isolation and depression, and that there is a need to identify interventions that are transferable to rural areas.(12) Another 2016 high-quality evidence synthesis suggested that self-management support programs that feature a multi-component structure containing disease-specific information, education of knowledge and skills, and individually tailored coaching may also improve daily living activities in older adults.(13)

Four identified evidence syntheses focused on exploring remote monitoring interventions for independent older adults using telephone-based and internet-based technologies. One older high-quality evidence synthesis highlighted that while telecare systems in home-care settings can promote safety and security for older adults aging in place, there is no one-size-fits-all approach for telecare and systems must be tailored to older adults' individual needs.(14) Further, one older low-quality evidence synthesis found in-home telehealth delivered through mobile applications, smart technologies, teleconferencing systems, internet-based therapies, and videoconferencing (e.g., Skype) significantly reduced emergency visits, hospital admissions, and depressive symptoms and improved cognitive functioning in older adults.(15)

One older medium-quality evidence synthesis found smart homes and home-health monitoring technologies can support older adults with complex needs, cognitive decline, and mental health and heart conditions. (16) Internet-based health monitoring systems were used to develop a falls management framework for independent older adults that included assessments by health practitioners, real-time monitoring using sensor-based systems, falls detection and response strategies, and ongoing support after a fall risk was detected. An older medium-quality evidence synthesis explored the development of this framework; the most common response strategy identified involved sending alerts and messages to family members or caregivers when there was a high probability of an emergency being detected.(17)

Innovations in how funds for home care get allocated

We identified three U.S.-based single studies that addressed efforts to increase Veterans' access to home- and community-based services through changes to financial arrangements. A recent study found that while the Veterans Health Administration (VHA) expected that the 2001 Millennium Act's expansion of home- and community-based services would have decreased the use of its substitutes (e.g., institutional care), after the expansion of services, there were no significant differences observed between VHA users and non-users in long-term care admissions or in participation in activities of daily living.(18) Participants in a Veteran-directed home and community-based services program that offered individual budgets described a greater sense of self-agency, independence, and participation with daily activities from the program.(19) However, participants experienced challenges with the limited ability to transfer services under the program across regions, managing budgets and accessing additional supports for caregivers. When the cost and impact of continuity of care of community-dwelling older Veterans living with dementia were evaluated, researchers found that continuity of care was effective at reducing costs associated with hospitalization and long-term care.(20)

Innovations in how home-care decisions are made

There were no innovations identified from the evidence in how home-care decisions are made.

Key findings from the jurisdictional scan

For the jurisdictional scan, we looked at the federal level in each of the 'Five Eyes' countries (Australia, Canada, New Zealand, U.K., and U.S.) for information about extending at-home living for Veterans. We broadened the search for Canadian provinces and territories to include approaches for civilians and Veterans. Identified innovations are organized by how home care is organized and delivered, how funds for home care get allocated, and how decisions about home care are made. Additional details about each of the approaches is available in Appendix 4.

Approaches to extend at-home living for Veterans in each of the 'Five Eyes' countries

Innovations in how home care is organized and delivered

Innovations at the federal level in each of the ' Five Eyes' countries included seven innovations noted in the framework. These include:

- supporting changes to the home environment to allow the Veteran and/or their family to stay at home longer (NZ)
- providing assessments from a broader array of providers (e.g., occupational therapists) (NZ, U.S.)
- building connections and/or teams to coordinate care within the home-care sector and other sectors (AU, U.K., U.S.)
- providing 24/7 remote monitoring and rapid coordination with urgent care through community paramedics (NZ,U.K.)
- providing additional support services, including for caregivers (AU, CA, NZ, U.S.)
- providing social integration opportunities for Veterans in their communities (NZ, U.S.)
- providing respite to caregivers (AU, NZ, U.S.).

Specific examples of innovations include:

- in New Zealand, assessments for the Veterans' Independence Program included multiple perspectives such as occupational therapists and social workers who can help identify challenges with living arrangements, access to services, and services that could be provided by other organizations
- the United States VA HBPC program follows a similar model, connecting home care to primary care and allied health services (e.g., social work, psychology, nutrition, speech therapy, psychological supports, and pharmacy) either in person or through telehealth services
- in Australia, Canada, New Zealand, and the U.S., national Veteran programs offer household management supports, meal preparation, and personal care services
- New Zealand offers a home modification program for Veterans with service related impairments for Veterans who are unable to work full time to meet unique accessibility needs
- Australia offers funds to purchase medical equipment to support independent living
- The United States offers an Adult Day Health Care program that allows Veterans a place to socialize and also practice activities of daily living (e.g., dressing), while providing respite to caregivers
- The United States provides the most comprehensive caregiver support program, offering supports for caregivers based on a tier-level rating. If Veterans are assessed with a service-related disability rating of 70% and have challenges performing daily activities, their primary caregiver may apply for the program. The program offers access to healthcare insurance, mental health counselling, travel benefits for appointments, and 30 days of respite care per year
- Australia's Department of Veterans' Affairs provides up to 196 hours of in-home respite care, 28 days of residential respite care, and up to 216 hours of emergency short-term home relief.

The U.S. provides the most comprehensive home and community care services specific for Veterans, but this may be a result of a separate health system dedicated to Veterans, whereas Veterans in the remaining 'Five Eyes' countries receive home and community care services from both Veteran-specific programs as well as civilian health systems.

Overall, there are gaps in the organization and delivery of supports to extend at home living for older adults. For example, New Zealand and the United States were the only countries to offer innovations for social integration, providing changes to the home environment, and providing assessments from a broader array of providers. New Zealand's assessment involving multidisciplinary professionals (e.g., occupational therapists and physiotherapists) may explain their inclusion of broader supports.

Innovations in how funds for home care get allocated

Innovations at the federal level in each of the 'Five Eyes' countries included three innovations noted in the framework. These include:

- introducing new or revised funding approaches to support Veterans to invest in home retrofits (CA, NZ)
- providing Veterans with individualized home-care budgets (US)
- working towards pooled budgets across levels of governments, systems, organizations, and teams (AU).

Specific examples of innovations include:

- the U.S. VA home services provides co-payments for approved health services
- the United States also provides eligible Veterans with individualized budgets through their Aid and Attendance fund in the form of a monthly payment.
- in Canada, Veterans can apply for the Veterans Independence Program as a top-up support if they have already qualified for disability benefits, War Veterans Allowance, or Prisoner of War compensation

Overall, it appears that the United States is the only country to provide individualized funding, at the federal level, with the remaining countries utilizing subsidized or publicly covered services.

Innovations in how decisions are made about home care

No innovations at the federal level were identified in any of the 'Five Eyes' countries.

Approaches to extend at-home living in Canadian provinces and territories

Innovations in how home care is organized and delivered

Innovations at the provincial and territorial levels included eight innovations noted in the framework. These include:

- supporting changes to the home environment that allow the Veteran and/or their family to stay at home longer (BC)
- providing home-care interventions earlier (i.e., adjusting eligibility to work with Veterans who face rising risk, not just those with already highly elevated risks) (BC, AB)
- building connections and/or teams to coordinate care within the home-care sector and other sectors (AB, SA, ON, NB, PEI, NWT)
- providing Veterans with case managers or care coordinators who can use a population-health management approach that builds services around people with similar levels of need and barriers to accessing care (SA, AB, ON, NB, PEI)
- providing 24/7 remote monitoring and rapid coordination with urgent care through community paramedics (BC, MB NS, NB)
- providing additional support services, including for caregivers (BC, AB, SK, PEI, NWT)
- providing social integration opportunities for Veterans in their communities (BC, ON, SK, QC)
- providing respite to caregivers (AB, ON, QC, NL, NS, NWT).

Specific examples of innovations include:

- British Columbia was the only province identified to have innovations supporting changes in the home environment
- Alberta's Health Services Home Care program includes prevention and screening measures through their case coordination program, using assessments from a broader array of providers
- Prince Edward Island offers a specialized service, Caring for Older Adults in the Community and at Home (COACH), which connects older adults with care from three partner programs: Home Care, Primary Care, and the provincial Geriatric Program
- Alberta, Ontario, and New Brunswick's Home and Community Care Programs may connect with dieticians, occupational therapists, physical therapists, speech language pathologists, respiratory therapists, and social workers
- British Columbia, Saskatchewan, and Prince Edward Island also provides services for homemaking, meal services, and transportation to medical appointments
- universities in British Colombia and Manitoba have begun research programs exploring initiatives to support independent living through digital technology monitoring health and movement
- Saskatchewan, Ontario, and Prince Edward Island all provide a case coordinator to collaborate with older adults to develop a personalized home-care plan and identify appropriate personal, health, and community supports.

Across Canada, there is a wide range of supports. The least common supports were to the home environment and for providing 24/7 monitoring.

Innovations in how funds for home care get allocated

Innovations at the provincial and territorial levels included four innovations noted in the framework. These include:

- introducing new or revised funding approaches to cover a broader range of services (BC, MB ON, NL)
- introducing new or revised funding approaches to support Veterans to invest in at-home medical devices, medical technologies, and medical supplies (SK, NL)
- providing Veterans with individualized home-care budgets (SK
- working towards pooled budgets across levels of governments, systems, organizations, and teams (MB ON, QC).

Specific examples of innovations include:

- individualized funding in Saskatchewan and additional funds for medical devices.

Innovations in how decisions are made about home care

Innovations at the federal level in the provinces and territories included one innovation noted in the framework. These include:

- improving coordination between provincial and territorial home-care services and Veteran-specific home-care services (i.e., those funded by Veterans Affairs Canada) (MB, ON, NS).

Specific examples of innovations include:

- providing funding to specialized services, like the Kinsmen Veterans' Village in Winnipeg that supports the integration and living of Veterans
- additionally, during the 2022–23 fiscal year, the Soldier's Aid Commission approved 21 applications and provided $37,281 in financial assistance.

Next steps based on the identified evidence

- Efforts can be made to better understand the effects of trauma-informed and culturally appropriate approaches for Veterans as well as to better understand eligibility thresholds for Veterans who may need home care and to provide more funding options that can help them to meet their individual needs.
- Further, additional efforts can be made to improve communication with Veterans and citizens about how decisions related to providing home-care services for Veterans are made and how they coordinate their services with provinces and territories.

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