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# The Relationship Between Agency Characteristics and Quality of Home Care

Dawn M. Dalby, PhD  
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**ABSTRACT.** *Background.* This project assessed the relationship between home care quality indicators (HCQIs) and agency characteristics.

*Methods.* Twelve agencies completed a mailed survey on a variety of characteristics, including size of their caseload and for-profit (FP) status of contracted service providers. The HCQIs were derived from standardized assessments completed voluntarily for home care clients in Ontario and in Manitoba, Canada.

*Results.* The average caseload was 121.3 clients per case manager, and over 40% of nursing, personal support and therapy providers were con-

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sidered FP. For individual HCQIs, few correlations were statistically significant. An overall summary measure of quality was correlated with the size of the population served ( $r = -0.80$ ;  $p < 0.05$ ) and the number of clients per case manager ( $r = -0.56$ ;  $p < 0.1$ ).

*Conclusion.* These data represent unique information on home care quality and organizational characteristics in Canada. The question remains as to how best to use HCQI data to inform practice in an era of limited resources and increasing caseloads. doi:10.1300/J027v27n01\_04 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2008 by The Haworth Press. All rights reserved.]

**KEYWORDS.** Quality indicators, quality assessment, organizational characteristics, Resident Assessment Instrument-Home Care, interRAI

## INTRODUCTION

In Canada, as well as other countries around the world, there is an increasing interest in measuring quality of health care services and also in refining methods to continuously monitor and improve service provision. In North America, research into the quality of long-term care (LTC) has a much longer history than in the home care sector. For example, in LTC in the United States, a standardized, comprehensive assessment instrument, the Resident Assessment Instrument (RAI) 2.0, was mandated for use in 1987 as part of the Omnibus Budget Reconciliation Act (Hawes et al., 1997). Quality indicators first became available for the RAI 2.0 in 1995 (Zimmerman et al., 1995) and have since undergone major review and revision (Berg et al., 2002).

There is little evidence within the home care sector in Canada regarding the quality of care, and virtually no evidence linking organizational factors to this construct. However, some research has been carried out in the LTC and acute care sectors exploring the relationship between quality of care and staffing levels (Porell & Caro, 1998; Zinn, Aaronson, & Rosko, 1993; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002), the size of the organization (Zinn et al., 1993; Porell & Caro, 1998; Teare, Hirdes, Ziraldo, Proctor, & Nenadovic, 2000), for-profit (FP) versus not-for-profit status (NFP) (Hillmer, Wodchis, Gill, Anderson, & Rochon, 2005) and accreditation results (Miller et al., 2005).

The development of a set of home care quality indicators (HCQIs) based on the Resident Assessment Instrument for Home Care (RAI-HC) and associated risk adjustment methods (Hirdes et al., 2004; Dalby, Hirdes, & Fries, 2005) represents an important first step in quality assessment in home care. The RAI-HC was developed by interRAI (Morris et al., 1999) and is a comprehensive, standardized instrument for evaluating the needs and strengths of elderly home care clients. Several studies have documented the reliability and validity of the RAI-HC items, and the embedded summary scales (Landi et al., 2000; Morris et al., 1997; Hartmaier et al., 1995; Morris, Fries, & Morris, 1999). It is currently used in eight Canadian provinces/territories and 15 U.S. states, and is mandatory for all long-stay home care clients in Ontario (e.g., clients anticipated to need service for at least 60 days).

This project represents a unique opportunity to utilize standardized assessment data to generate a set of HCQIs and to explore the relationship between characteristics of home care agencies and quality of care.

## **METHODS**

In Ontario, trained case managers from 14 Community Care Access Centres (CCACs) voluntarily used the RAI-HC as part of usual practice for all adult (18 years and older) home care clients. CCACs are considered the single-point of entry for home care services and LTC placement. In addition, care coordinators from the Winnipeg Regional Health Authority (WRHA) implemented a pilot of the RAI-HC for their adult home care clients. The WRHA represents one of 12 regional health authorities within the province of Manitoba.

A mailed survey, developed for the project, assessed agency characteristics thought to be potentially relevant to the quality of care, including: the number of individuals on their current caseload, the proportion of FP service providers with whom they have service contracts, accreditation status through the Canadian Council on Health Services Accreditation, and whether they serve a mainly urban or rural population. These values were applied at the level of the individual client such that all clients from a particular home care agency were assigned that value for a specific factor. The protocol for data collection was reviewed and received full ethics clearance through the Office of Research Ethics at the University of Waterloo.

There are 22 HCQIs that can be calculated based on the RAI-HC (Hirdes et al., 2004). Of these, 16 represent prevalence indicators

(e.g., prevalence of weight loss, dehydration, disruptive or intense daily pain), and the remaining six represent failure to improve or the incidence of a new condition (e.g., bladder incontinence, skin ulcers). All HCQI rates were expressed as proportions. The actual HCQI rates, comparing Ontario and the WRHA have been published previously (Dalby et al., 2005).

Agency characteristics were examined for their relationship with each of the HCQI rates. For agency characteristics representing continuous outcomes, the median was used to split the sample into those with more (i.e., at least as high as the median) or less (i.e., lower than the median) of the characteristic of interest and an independent samples t-Test was used for statistical comparisons. In addition, a Pearson correlation coefficient was calculated for each characteristic compared with each of the HCQIs. A small number of characteristics represented dichotomous outcomes (e.g., accredited or not), and the rates were compared for each HCQI using an independent samples t-Test.

Agencies were ranked, in terms of their rate, across each of the 22 HCQIs. The ranks were then added across the set of indicators, such that a higher summary score represented better performance on the HCQIs. A Pearson correlation coefficient was then calculated comparing the sum of the ranks with each of the agency characteristics. The unit of analysis was the home care agency. Since the sample size was limited, an alpha level of 0.1 was used to represent findings that were potentially important and 0.05 for results that were considered statistically significant. All analyses were carried out using SAS software (version 9.1; Cary, NC).

## **RESULTS**

The sample size for the project represents a total of 12 home care agencies, since one site did not respond to the survey and another had an insufficient sample size for calculating the HCQIs. In only four agencies were the data sufficient to permit the calculation of the incidence in HCQIs.

The HCQI rates were based on a total of 11,767 clients. Descriptions of client characteristics in the two regions have been reported elsewhere (Dalby et al., 2005). Briefly, clients in the two regions were very similar in terms of average age, sex, and the primary language spoken. In the WRHA, clients were slightly more likely to have never married (11.5%) compared with clients in Ontario (8.7%) and they were significantly more

likely to report being of Aboriginal origin (3.2 vs. 1.6%, respectively). Clients in Ontario were more likely to have some level of cognitive impairment, to require assistance with activities of daily living (ADLs) and were more likely to experience severe daily pain (see Table 1).

Among the 12 sites, the average monthly caseload was 7,394.6 clients, with an average of 121.3 clients per case manager. There was a roughly equal split between FP and NFP nursing and personal support contracted

TABLE 1. Characteristics of Home Care Clients in the WRHA and Ontario\*

|  | WRHA%<br>(n = 6,704) | ON%<br>(n = 5,063) | p Value  |
|--|----------------------|--------------------|----------|
| Age M (95% CI**)                             | 76 (74.9, 77.0)      | 75.6 (75.2, 76.0)  | 0.49     |
| 18-64  | 13.4                 | 16.5               | < 0.0001 |
| 65-74  | 16.5                 | 19.2               |          |
| 75-84  | 39.9                 | 40.7               |          |
| 85 and older                                 | 30.0                 | 23.6               |          |
| Sex  |                      |                    |          |
| Female                                       | 69.2                 | 70.5               | 0.14     |
| Marital status                               |                      |                    |          |
| Never married                                | 11.5                 | 8.7                | < 0.0001 |
| Married/widowed                              | 79.4                 | 82.7               |          |
| Separated/divorced                           | 8.2                  | 7.9                |          |
| Other  | 0.8                  | 0.7                |          |
| Primary language                             |                      |                    |          |
| English                                      | 85.6                 | 85.1               | 0.63     |
| French                                       | 3.5                  | 3.8                |          |
| Other  | 10.9                 | 11.1               |          |
| Aboriginal status                            |                      |                    |          |
| Origin/Inuit, Metis or North American Indian | 3.2                  | 1.6                | < 0.0001 |
| Cognitive performance scale                  |                      |                    |          |
| M (95% CI)                                   | 0.8 (0.8, 0.8)       | 0.8 (0.8, 0.9)     | 0.07     |
| 0-intact                                     | 63.0                 | 60.4               | < 0.0001 |
| 1-borderline intact                          | 15.0                 | 18.4               |          |
| 2-mild impairment                            | 8.4                  | 7.3                |          |
| 3-moderate impairment                        | 10.9                 | 10.1               |          |
| 4-moderate/severe impairment                 | 0.8                  | 1.0                |          |
| 5-severe impairment                          | 1.5                  | 2.5                |          |
| 6-very severe impairment                     | 0.5                  | 0.4                |          |

TABLE 1 (continued)

|  | WRHA%<br>(n = 6,704) | ON%<br>(n = 5,063) | p Value  |
|--|----------------------|--------------------|----------|
| ADL Self-Performance Hierarchy             |                      |                    |          |
| M (95% CI)                                 | 0.5 (0.5, 0.6)       | 0.7 (0.6, 0.7)     | < 0.0001 |
| 0-independent                              | 78.0                 | 72.9               | < 0.0001 |
| 1-supervision required                     | 5.2                  | 7.9                |          |
| 2-limited impairment                       | 8.9                  | 8.5                |          |
| 3-extensive assistance required (level I)  | 4.7                  | 5.4                |          |
| 4-extensive assistance required (level II) | 1.6                  | 2.6                |          |
| 5-dependent                                | 1.1                  | 2.0                |          |
| 6-total dependence                         | 0.5                  | 0.7                |          |
| Pain Scale                                 |                      |                    |          |
| M (95% CI)                                 | 1.2 (1.2, 1.2)       | 1.3 (1.3, 1.4)     | < 0.0001 |
| 0-no pain                                  | 39.8                 | 34.9               | < 0.0001 |
| 1-less than daily pain                     | 14.4                 | 14.1               |          |
| 2-daily pain but not severe                | 31.6                 | 33.8               |          |
| 3-severe daily pain                        | 14.2                 | 17.2               |          |
| Top 3 medical diagnoses***                 |                      |                    |          |
| Arthritis                                  | 49.4                 | 44.8               | < 0.0001 |
| Hypertension                               | 42.2                 | 37.4               | < 0.0001 |
| Diabetes                                   | 19.1                 | 20.1               | 0.24     |

Source: Dalby et al., 2005.

\*Client characteristics and scale values based on first submitted MDS-HC assessment for each client (where multiple assessments were submitted).

\*\*CI = confidence interval.

\*\*\*Disease was present and was or was not being treated or monitored by a home care professional.

providers. However, the vast majority (81.8%) of providers of supplies and equipment were FP. Most case managers had a nursing background, with a small percentage trained in social work, physiotherapy or occupational therapy. Most sites (75%) were accredited or were in the process of pursuing accreditation. These home care agencies served a mostly urban or mixed urban/rural population (see Table 2).

When comparing mean HCQI rates between agencies, only eight HCQIs had noteworthy differences (i.e., at least 10% difference or  $p < 0.1$ ). Table 3 shows, for example, that those agencies accredited/pursuing accreditation had higher rates of the HCQI for clients not receiving

TABLE 2. Characteristics of Home Care Agencies (n = 12)

|                                   | n (95% CI)<br>Mean (95% CI)      |
|-----------------------------------|----------------------------------|
| Characteristics                   |                                  |
| Active monthly caseload/agency    | 7,394.6 (4,812.9, 9,976.3)       |
| Clients managed by a case manager | 121.3 (110.4, 132.1)             |
| Number of staff                   | 188.3 (95.8, 280.8)              |
| Population of catchment area      | 636,113.2 (275,309.1, 99,6917.2) |
| Contracted service providers      |                                  |
| Nursing (FP)                      | 44.9% (24.5, 65.3)               |
| Nursing (not FP)                  | 55.0% (34.7, 75.4)               |
| Personal support (FP)             | 58.4% (42.5, 74.2)               |
| Personal support (NFP)            | 41.6% (25.7, 57.4)               |
| Therapies (FP)                    | 71.6% (45.4, 97.9)               |
| Therapies (NFP)                   | 28.4% (2.1, 54.6)                |
| Supplies and equipment (FP)       | 81.8% (54.6, 100.0)              |
| Supplies and equipment (NFP)      | 18.2% (0.0, 45.4)                |
| Formal training of case managers  |                                  |
| Nursing (degree level)            | 67.7% (53.2, 82.2)               |
| Nursing (RN level)                | 20.7% (6.4, 34.9)                |
| Physiotherapy                     | 0.4% (0.0, 1.0)                  |
| Occupational therapy              | 1.8% (0.5, 3.1)                  |
| Social work                       | 8.5% (0.0, 17.4)                 |
| Other                             | 0.8% (0.0, 1.7)                  |
| Accreditation status              |                                  |
| Accredited                        | 41.7%                            |
| Pursuing accreditation            | 33.3%                            |
| Not accredited/not pursuing       | 25.0%                            |
| Type of population served         |                                  |
| Mainly urban                      | 50.0%                            |
| Mainly rural                      | 16.7%                            |
| Mixed urban/rural                 | 33.3%                            |

an influenza immunization, social isolation ( $p < 0.05$ ) and no assistive device among clients with difficulty in locomotion. Agencies that had more FP contracted therapy providers had higher rates of triggering on the HCQI for no assistive devices among clients with difficulty in locomotion and for failure to improve/incidence of bladder incontinence.



|                                       |      |      |      |       |
|---------------------------------------|------|------|------|-------|
| Failure to improve/incidence of HCQIs |      |      |      |       |
| Bladder incontinence                  | 11.6 |      | 11.6 |       |
| Skin ulcers                           |      |      |      |       |
| Decline on ADL long form              |      |      |      | -11.2 |
| Impaired locomotion in the home       |      | 10.4 | 10.4 | 10.4  |
| Cognitive decline                     |      |      |      |       |

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\*p < 0.1; \*\*p < 0.05.

†Differences were reported only when p < 0.1 or when the difference was at least 10%. The difference reported represents the difference between agencies at or above the median versus those below the median. In the case of accreditation status, it represents those who were accredited/pursuing accreditation versus those who were not. In the case of urban/rural location, it represents the difference between those serving an urban or mixed population versus those serving a mainly rural population.

Note: HCQIs = Home care quality indicators; CM = case manager; FP = for-profit; ADL = Activities of daily living.

The size of the population in the catchment area was important for two HCQIs: (1) not receiving a medication review by a physician and (2) inadequate pain control among those with pain.

In all cases but one, the direction of the difference was positive, indicating a tendency toward higher HCQI rates (i.e., worse performance) among agencies that were accredited/pursuing accreditation, who had more FP providers and who served a larger population. The exception was for the number of clients per case manager, in which the difference was negative indicating slightly better performance among agencies with fewer clients per case manager.

Statistically significant correlations, at the 0.05 level, were observed for four HCQIs. For example, the prevalence of ADL/rehabilitation potential and no therapies was significantly ( $p < 0.05$ ) and negatively correlated with both the percent of FP nursing providers ( $r = -0.67$ ) and the percent of FP supply and equipment providers ( $r = -0.87$ ). The prevalence of injuries and the number of FP nursing providers was also negatively correlated ( $r = -0.70$ ). The size of the population served was positively correlated with the rate of neglect/abuse ( $r = 0.86$ ) (see Table 4).

Many other correlations were as high as 0.70 and yet were not statistically significant at the 0.05 level. Since the statistical significance of the relationship is heavily influenced by the sample size, one could instead consider an arbitrary cut-point for evaluating the strength of the association. For example, values between 0.40 and 0.59 can be considered as representing moderate associations, values between 0.60 and 0.79, strong associations and values of 0.80 or greater, to represent very strong correlations (*British Medical Journal*, 2003).

Using these reference points, the size of the population served had the largest number of at least moderate associations (i.e., correlations of 0.40 or greater) across the 22 HCQIs with 11 correlations at 0.4 or higher. All of the correlations were positive. The percent of FP supply and equipment providers had the next highest number at ten (six of which were positive correlations and four were negative), followed by the percent of FP nursing providers at seven (four of which were negative correlations and three were positive).

When examining the summary value representing the rank across the set of HCQIs, the highest correlation was observed for the size of the population served ( $r = -0.80$ ;  $p < 0.05$ ), indicating better performance among those agencies that served smaller populations. The next highest correlation was for the number of clients per case manager, which

TABLE 4. Correlations Between HCQIs and Characteristics of Home Care Agencies

|   | Monthly Caseload | FP Nursing Providers | FP Personal Support Providers | FP Therapy Providers | FP Supply and Equip. Providers | Clients Per CM | FTE Staff | Size of Population Served |
|---|------------------|----------------------|-------------------------------|----------------------|--------------------------------|----------------|-----------|---------------------------|
| Prevalence HCQIs                              |                  |                      |                               |                      |                                |                |           |                           |
| Inadequate meals                              | 0.10             | 0.22                 | 0.29                          | -0.06                | 0.48                           | 0.11           | -0.15     | 0.49                      |
| Weight loss                                   | 0.26             | 0.01                 | 0.49                          | -0.16                | -0.09                          | 0.51*          | -0.02     | 0.35                      |
| Dehydration                                   | 0.09             | 0.09                 | 0.25                          | -0.31                | 0.39                           | 0.11           | -0.27     | 0.53*                     |
| No physician medication review                | -0.03            | 0.21                 | 0.17                          | -0.19                | 0.29                           | 0.43           | -0.27     | 0.39                      |
| No assistive device/ locomotion difficulty    | 0.46             | 0.08                 | 0.17                          | 0.60**               | 0.01                           | 0.29           | 0.40      | 0.07                      |
| ADL rehabilitation potential/no therapies     | 0.25             | -0.67**              | -0.45                         | -0.47                | -0.87**                        | -0.10          | 0.41      | 0.05                      |
| Falls   | -0.23            | 0.46                 | 0.29                          | 0.24                 | 0.39                           | -0.10          | -0.16     | -0.07                     |
| Social isolation                              | 0.20             | -0.37                | 0.16                          | -0.44                | -0.11                          | 0.35           | -0.09     | 0.45                      |
| Delirium                                      | 0.00             | -0.05                | 0.09                          | -0.02                | 0.25                           | 0.16           | -0.10     | 0.29                      |
| Negative mood                                 | -0.13            | -0.04                | 0.19                          | -0.02                | -0.01                          | 0.27           | -0.15     | 0.04                      |
| Disruptive or intense daily pain              | -0.22            | 0.34                 | 0.59                          | 0.50                 | 0.53*                          | 0.13           | -0.28     | -0.27                     |
| Inadequate pain control among those with pain | 0.41             | 0.49                 | 0.36                          | 0.10                 | 0.31                           | 0.17           | 0.19      | 0.49                      |
| Neglect/abuse                                 | 0.42             | 0.005                | -0.09                         | -0.17                | 0.14                           | 0.49           | 0.17      | 0.86**                    |
| Injuries                                      | -0.04            | -0.70**              | -0.26                         | -0.45                | -0.52*                         | 0.24           | 0.03      | 0.06                      |
| Not receiving influenza vaccination           | 0.25             | 0.02                 | 0.06                          | 0.03                 | 0.41                           | 0.23           | 0.05      | 0.54*                     |
| Hospitalization                               | -0.26            | 0.16                 | 0.23                          | -0.24                | 0.42                           | -0.13          | -0.33     | 0.10                      |

TABLE 4 (continued)

|                                       | Monthly Caseload | FP Nursing Providers | FP Personal Support Providers | FP Therapy Providers | FP Supply and Equip. Providers | Clients Per CM | FTE Staff | Size of Population Served |
|---------------------------------------|------------------|----------------------|-------------------------------|----------------------|--------------------------------|----------------|-----------|---------------------------|
| Failure to Improve/Incidence of HCQIs |                  |                      |                               |                      |                                |                |           |                           |
| Bladder incontinence                  | 0.65             | -0.18                | -0.30                         | -                    | -0.37                          | 0.28           | 0.54      | 0.65                      |
| Skin ulcers                           | 0.03             | 0.33                 | 0.20                          | -                    | 0.13                           | 0.74           | 0.00      | -0.03                     |
| Decline on ADL long form              | 0.90*            | -0.80                | -0.87                         | -                    | -0.90                          | -0.19          | 0.88      | 0.68                      |
| Impaired locomotion in home           | 0.06             | 0.50                 | 0.60                          | -                    | 0.66                           | 0.08           | -0.18     | 0.62                      |
| Cognitive decline                     | 0.81             | -0.66                | -0.75                         | -                    | -0.79                          | -0.08          | 0.81      | 0.53                      |
| Difficulty communicating              | 0.22             | 0.25                 | 0.37                          | -                    | 0.44                           | -0.13          | 0.00      | 0.71                      |

\*p < 0.1; \*\*p < 0.05.

Note: HCQIs = Home care quality indicators; CM = case manager; FP = for-profit; ADL = Activities of daily living.

was also negatively, but not significantly, correlated with the sum of the ranks ( $r = -0.56$ ;  $p < 0.1$ ).

## **DISCUSSION**

The size of the population served was an important predictor of quality. This variable had at least moderate correlations with 11 HCQIs and had a very strong correlation with the overall summary measure of quality. In all cases, agencies that served a larger population had less favorable results in terms of quality. A previous review in the LTC sector showed mixed findings (Davis, 1991). In more recent studies of complex continuing care and LTC, some suggest that better quality of care is found among larger organizations (Nenadovic, Gilbert, Hallman, Teare, & Hirdes, 1999; Teare et al., 2000) and others suggest the opposite to be true (Zinn et al., 1993).

For individual HCQIs, the relationship between FP service providers and quality was mixed and none of these variables were significantly related to the summary measure of quality. Although Hillmer et al. (2005) concluded that FP nursing home status was often associated with reduced quality of care across many important indicators, these data do not provide definitive evidence that FP status is associated, either negatively or positively, with quality of home care.

The number of clients per case manager was negatively correlated with the overall measure of quality of care, such that home care agencies with fewer clients per case manager had better performance. In long-term care in both Canada and the U.S., staffing levels have been shown to be an important predictor of quality of care, but the direction of this relationship is mixed (Porell & Caro, 1998; Zinn et al., 1993). In acute care, increased levels of registered nursing staff was related to lower rates of adverse outcomes such as urinary tract infections and gastrointestinal bleeding (Needleman et al., 2002).

The finding that smaller caseload size per case manager is related to quality of care is important and matches anecdotal information expressed by home care agencies. The concern here lies in the ability of a given case manager to provide high quality of care as the number of clients for whom they are responsible increases. The range in the number of clients per case manager was between 90 (one agency) and 130 (three agencies). When we examine the ranking of these agencies among those with the highest rates (i.e., worst performers), the agency with the smallest caseload was ranked only once within the worst performers,

compared with four to six times among those with the larger client caseload. The difference in the number of clients was only 40 individuals, on average, and yet this translated into poorer rankings for agencies whose case managers have a larger roster.

If one assumes that a Community Care Access Centre (CCAC) in Ontario with the highest number of clients per case manager wanted to reduce this value to 90 clients (i.e., the lowest value), they would need an additional 0.44 full-time equivalent staff, an expense of roughly \$24,000 to \$26,000. This cost seems like a reasonable expenditure if in fact, as these results suggest, a reduction of this magnitude in the average caseload could translate into better performance on the HCQIs.

It is acknowledged that quality indicators are not definitive measures of quality. They are intended to be flags of potential issues that require further investigation by the provider. In the current study, we have used the HCQIs as a means to assess the quality of care and have gone one step further to make the assumption that organizations with higher rates are showing poorer performance on these indicators. However, without assessing the process of care for a given home care provider, it is difficult to know whether an agency is in fact providing sub-standard care to its clients. If the HCQIs were used in everyday practice, as opposed to being used strictly for research purposes, it would be vital for an organization to further explore indicators with high (or low) rates to determine which care processes made important contributions to the issue.

This project was also limited in its ability to assess the relationship between quality and agency characteristics due to the small number of sites involved in the initial RAI-HC pilot study. It appears that for several agency characteristics, there is an important relationship with quality; however, future research with a larger number of home care providers is needed to fully explore these relationships. Now that Ontario has mandated the RAI-HC for all long-stay clients, and given the fact that other provinces (e.g., British Columbia, Saskatchewan, Alberta) are implementing the tool in several regions, future research addressing this question with a much larger sample of organizations will be possible.

The current results, however limited in scope, are unique in that they begin to bring some understanding into how quality varies by characteristics of the home care agency. These results are important as very little is known about home care quality in Canada. From a policy perspective, this issue has become increasingly important as home care agencies attempt to provide high quality of care within limited budgets, with an increasingly complex population of clients and with ever increasing caseloads.

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