

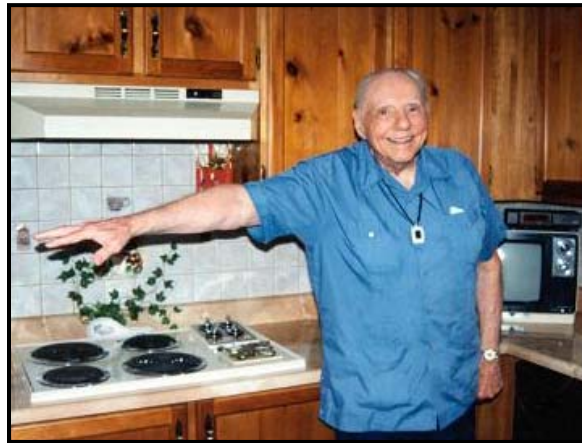
Home Support Exercise Program (HSEP) in Alberta: Chinook Health Region Pilot-Test Evaluation Results

Jennifer Dechaine, BPE

Research Associate, Alberta Centre for Active Living

Tanya Berry, PhD

Research Associate, Alberta Centre for Active Living



The Alberta Centre for Active Living is supported by

©2006 Alberta Centre for Active Living

All rights reserved. No part of this report may be reproduced, transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, or stored in a retrieval system without written permission from the Alberta Centre for Active Living.



Alberta Centre for Active Living
11759 Groat Road
Edmonton AB T5M 3K6
E-mail: active.living@ualberta.ca
Web site: www.centre4activeliving.ca

All photos courtesy of the Canadian Centre for Activity and Aging.

Table of Contents

How We Administered the Pilot-Site Evaluation 4

 HSEP data analysis..... 4

 Response rates 5

Survey Responses 5

Graph 1: Has HSEP improved independence? 5

Graph 2: Has HSEP improved confidence? 6

Graph 3: Has overall health improved because of HSEP? 6

TUG Test Results 7

Graph 4: Change in TUG test times 7

Common Responses: Patterns and Themes 8

 Screening and referral 8

Graph 5: I found it easy to screen and refer my clients to HSEP..... 8

Graph 6: The time it took me to screen and refer my clients to HSEP was appropriate 8

 Health-care aides as coaches 9

Graph 7: The health-care aide is an appropriate HSEP coach..... 9

 Communications and marketing 9

 Client attitude 11

 Program adherence 11

 Flexibility with multi-party involvement 12

 Support for staff..... 12

Remarks on Program Committee Leadership..... 13

Conclusion..... 13

References..... 14

Home Support Exercise Program (HSEP) in Alberta: Chinook Pilot-Test Evaluation Results

The HSEP pilot-test (which ran in three rural communities in the Chinook Health Region) tried to find out how several key stakeholders in the region perceived the HSEP implementation process and how staff and clients viewed the program's effectiveness and impact.

A team of representatives from across the region and from almost all parties affected by the pilot led the program pilot. The Chronic Disease Management and Prevention Network spearheaded the project and the program planning committee.



As with the [Calgary Pilot-Test Results](#) (Alberta Centre for Active Living, 2005), the pilot-site evaluation makes it possible to identify strengths and weaknesses in implementing the program. The evaluation will also help to improve the process and to disseminate the program to other provincial groups.

How We Administered the Pilot-Site Evaluation

We collected self-administered questionnaires with several closed questions (rated on a five-point Likert scale) and open-ended questions from the four groups involved with the HSEP implementation—community-care coordinators, health-care aides, volunteers, and home-care clients.

In addition, clients performed timed-up-and-go (TUG) tests at baseline and two and four months into the program. These test results help measure the impact of the program on clients' physical functioning.

The Alberta Centre for Active Living and the Chinook Health Region invited all trained HSEP staff, volunteers, and all clients referred to HSEP to participate in this evaluation. Due to the program's slower than expected start, we extended the evaluation by six more months to collect data from more clients.

HSEP data analysis

The centre calculated descriptive statistics from the responses to the closed questions and expressed these in percentages. We also analysed data from the open-ended questions to identify patterns and themes that cut across the data. We then compared the responses from the four groups to develop a picture of the issues arising from implementing HSEP.

In September 2004 and June 2005, we conducted HSEP training sessions with Chinook home-care staff, training a total of 45 health-care aides, 29 community-care coordinators, and four volunteers. In June 2005, we also trained six health region staff to be HSEP facilitators and carry on HSEP training in the region. As of February 2006, there were 71 clients participating in the program.

Response rates

We received survey responses from

- 11 community-care coordinators;
- two health-care aides;
- one volunteer;
- 18 clients.

We also received TUG test scores from 68 clients.

The return rate from the health-care aides and volunteers was too low to analyse their response. Based on the number of staff who were trained, the survey response included approximately

- 38% of community-care coordinators;
- 4% of health-care aides;
- 25% of volunteers; and
- 25% of clients.

In addition, 95% of clients completed the baseline TUG test, and 53% of clients did a follow-up test during the data collection phase.

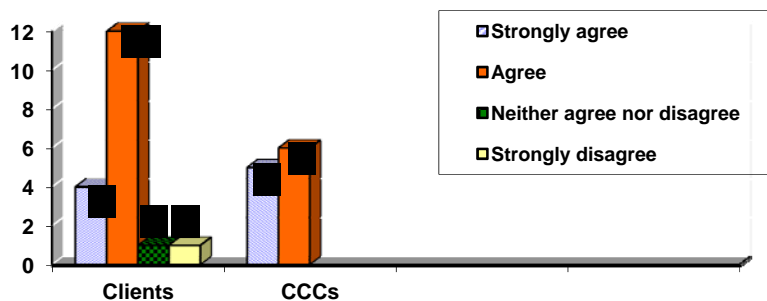
Survey Responses

Responses from all four groups surveyed (clients, health-care aides, volunteers, and community-care coordinators)—stated that they liked the program because

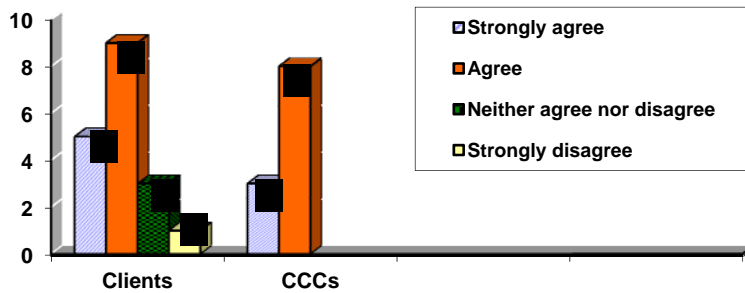
- it was relatively simple to teach and do;
- it improved the mobility, flexibility, independence, awareness of physical activity, and the mental well being of clients.

As shown in graphs 1–3, clients and community-care coordinators (CCCs) responded positively to questions about the program’s benefits and its affect on the clients’ levels of confidence and independence.

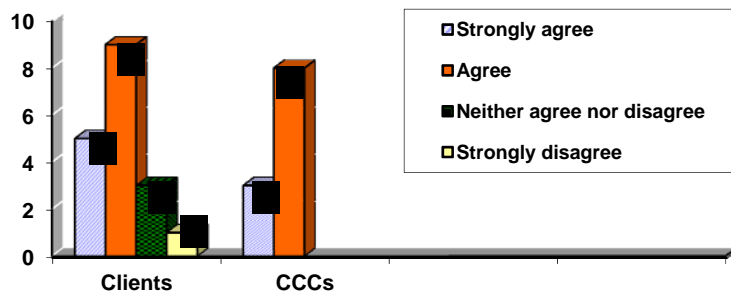
Graph 1: Has HSEP improved independence?



Graph 2: Has HSEP improved confidence?



Graph 3: Has overall health improved because of HSEP?



Comments on HSEP:

“It has helped me in my health and daily living. Thank you and please continue program”—Client.

“It’s simple and not time consuming too. There is some one to report to. I just had surgery on my feet and leg strength exercises have really helped”—Client.

“Able to do it in own time frame, not scheduled”—Client.

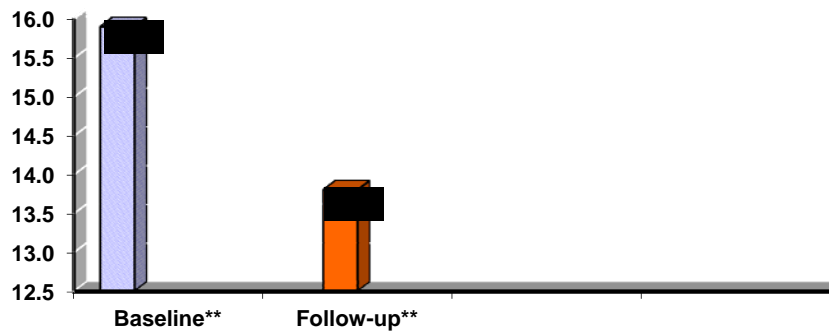
“It does improve mobility and function”—Community-care coordinator.

Clients rated the health benefits, independence, and their improvement since starting the program generally higher than the community-care coordinators did. A larger percentage of the community-care coordinators responded that they did not agree or disagree on questions such as, “Most of my clients are more independent and better able to do daily living activities.”

TUG Test Results

The TUG test results are a very good indicator of the impact of HSEP on the functional mobility of clients. Thirty-eight clients did a second TUG test. Of these, 31 showed improvement and were able to decrease the time it took them to perform the second TUG test (see Graph 4).

Graph 4: Change in TUG test times*



Notes:

- * The graph is adjusted to account for extreme TUG scores and for the time between the two tests, which differed from client to client.
- ** The baseline and follow-up bars show the average TUG time in seconds.

Comments on HSEP:

“Having someone working with clients either directly or in group to do exercises. Client reluctant/forced to do on their own. Numbers of those willing/able/will remember are low. In future I believe these numbers (those willing) will increase significantly!”

“Having support of volunteer or to ensure/assist exercises are done.”

“Increase support by PCA [health-care aide] to assist clients to do exercises initially until clients can feel/see benefit.”

Common Responses: Patterns and Themes

After reviewing all the survey responses to both scaled and open-ended questions, we identified some general implementation issues, including some common views on

- the ease of screening and referral;
- the appropriateness of health-care aides as coaches;
- communications and marketing;
- client attitude;
- program adherence;
- multi-party involvement;
- support for staff.

Screening and referral

All community-care coordinators saw HSEP as an appropriate home-care service for their clients. Coordinators also felt that it was relatively easy to screen and refer the clients to the program (see Graphs 5 and 6).

Graph 5: I found it easy to screen and refer my clients to HSEP



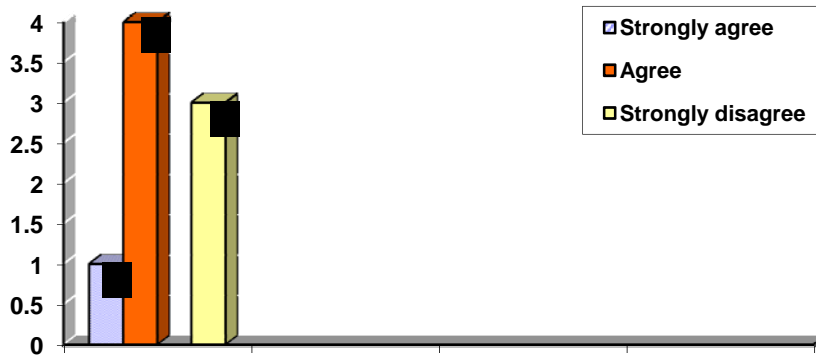
Graph 6: The time it took me to screen and refer my clients to HSEP was appropriate



Health-care aides as coaches

When we asked community-care coordinators about the appropriateness of trained health-care aides as good coaches for the program, the response was mixed (see Graph 7).

Graph 7: The health-care aide is an appropriate HSEP coach



“TV commercials, newspaper ads, magazines, Dr’s offices (e.g., showing seniors participating in these activities plus list benefits)”—Community-care coordinator.

Communications and marketing

Survey respondents and general feedback to the program planning committee suggest the need for greater awareness about the program. The more that health-care staff, family members, and communities are aware of the program, the more potential it has for success. These survey and other comments resulted in a program newsletter for participating communities and all staff. Participants also indicated the need to market the program more widely across the province (we are now undertaking this).

The other aspect of the communications issue is the name of the program. People identified the word “exercise” as a barrier to clients’ interest and participation. In addition, the term “home support” prevented other groups from adopting the program in other settings. As a result of these comments, we began discussing a new name for the Home Support Exercise Program. The Canadian Centre for Activity and Aging (the original developers of the program) have approved a name change for the program in Alberta. After gathering input from all parties across the province, we have changed the program’s name to Active Independence: The Home Support

Exercise Program in Alberta. The name will soon be incorporated into all program materials and communications' pieces.

Client attitude

“The current age group of our seniors do not believe exercise/activity has value. Repeatedly we hear from this generation, “I have worked hard all my life and now I just want to relax/or be taken care of”—Community-care coordinator.

Participation in HSEP is voluntary. Staff approach likely clients, but clients decide whether to participate. As indicated in the quote above, many clients do not see any benefit in doing the program.

Although not everyone responded this way, the comment was general enough among clients that we decided to address this attitude. In some situations, clients who were ready to do it started the program, but staff did not spend time trying to educate and encourage clients who were not yet willing.

Many studies (Benjamin, Edwards, & Bharti, 2005; Bortz, 1982; Canadian Fitness & Lifestyle Research Institute, 2002; García Bengoechea & Spence, 2002; García Bengoechea, Spence, & Fraser, 2005; O’Brien Cousins, 2003) show that people tend to be less active as they get older. This decline occurs for many different reasons—agism, lack of self-efficacy, not knowing what to do, fear, and pain—are just a few reasons older adults give for inactivity. HSEP tries to address these issues in various ways. The next wave of aging adults generally has a different attitude towards exercise and are more educated (Hartman-Stein & Potkanowicz, 2003). The attitude of the current frailer senior population may not be the same as the upcoming older population.



Program adherence

“I enjoyed the exercises, as they are all encompassing and simple. The program is excellent. Sadly, of the 4 clients that were interested, 3 allowed time to teach the exercises. The others did them for 1–2 weeks and then quit. It has been impossible to persuade them to continue. Clients want instant fixes, i.e., equipment, meals and unable to take responsibility”—Health-care aide.

As in the [Calgary Pilot-Test Results](#) (Alberta Centre for Active Living, 2005), Chinook participants identified the issue of adherence to the program. This problem is not unique to the senior population—studies show that all population groups struggle with exercise adherence (see, for example, Dishman, 1994; O’Brien Cousins, 1998; O’Brien Cousins & Gillis, 2005; Stiggelbout, Hopman-Rock, Tak, Lechner, & van Mechelen, 2005).

Community-care coordinators also had good suggestions about how to improve the program. One of the main themes in the comments was that more or alternative support for program clients was needed to improve program adherence. Many home-care staff feel stretched to the limit.

Although home-care staff value the HSEP program, they feel that they need support from other areas and creative coordination to make the program successful.

To improve adherence, staff and program participants suggested

- involving family members;
- using volunteer capacity more;
- allowing staff to spend more time with clients;
- supporting collaborations between home-care staff and recreation therapy staff in delivering community outreach services;
- encouraging lodge staff to work with home-care staff;
- delivering the program in group settings;
- offering more rewards for clients.

Some of these tactics have already been put in place in Chinook. These changes have both increased the number of participants in the program and also the adherence to the program.

Flexibility with multi-party involvement

*“It worked for my client because a volunteer helped with the exercises. Client has dementia and would not have remembered [the exercises]. But with support of the volunteer, the client improved”—
Community-care coordinator.*

Staff and the planning committee recognized early in the pilot that they needed to include other parties involved in the care of clients as well as home-care staff.

In some communities, the program stalled due to a lack of guidance, a low priority level, and staff availability. To help home-care staff with delivery and to try other ways to access the frail, isolated senior, the committee encouraged recreation therapy, family members, and lodge staff to become involved. These and other methods work in various communities. Other health regions may also want to consider these options when they begin delivering the program.

The main message we received from the study is that the program is more successful when the many parties involved in serving seniors work together to implement the program.

Support for staff

In the survey responses and general feedback to the planning committee, we often heard that staff understood the value of the program and liked it. However, staff also said that they didn't have the capacity to implement it fully. In addition, in some cases, staff didn't have the mandate to make the program a priority.

In some communities, the program goes well at first, but then declines due to staff shortages or a large increase in new clients. Although HSEP is a valid prevention and maintenance component of home-care services, support for home-care staff to carry out delivery is lacking.

This is the case with home care in many communities across Alberta. Home-care staff are key in reaching homebound seniors and helping them to maintain their independence and quality of life. However, staff need more funding, resources, and support from the province and the health regions to maintain the quality of this service.

Remarks on Program Committee Leadership

The Chronic Disease Network within the Chinook Health Region pulled together a comprehensive committee to plan and oversee the HSEP pilot test and regional implementation. This committee guided program delivery and communicated with all parties across the region.

Because of the committee's work, there was more support for the pilot and program delivery. The committee also ensured that an interdisciplinary group made decisions and solved any problems. Although this process was challenging at times, it was beneficial in the long run. The group came up with effective solutions to increase uptake of the program during the pilot and to work to make the program fit regional needs.

As a result of Chinook's involvement in the pilot and its proactive committee, Chinook currently leads the province in program implementation, creative partnerships, and positive changes to the program.



Conclusion

The client TUG test results (see Graph 4) prove that the HSEP improves the functional mobility of program participants. This improvement

- enhances clients' ability to perform daily living activities;
- improves quality of life;
- can reduce the load on the care provider;
- reduces the number and consequences of falls.

The time and resources that agencies or health regions spend in sustaining a program such as HSEP seem manageable and the program (as the pilot results indicate) is slowly becoming a priority. The program's sustainability comes from using home care as well as different delivery methods to meet community needs.

The health-care aides' extremely low response rate is a concern. In the future, it would be a good idea to do a focus group with a select group of aides to get more feedback. Their view of the program is not well represented in the pilot-test findings. However, the responses from the two aides and from informal communication to committee and staff members is helpful and has been seriously considered. Overall, we identified that program success depends on the community site, leadership at all levels, stability of staffing, and regional priorities.

The Chinook Health Region has moved forward with the delivery of the program in its region and has taken steps to ensure its sustainability. HSEP facilitators have been trained to make teaching new staff, volunteers, and leaders easier. It will be interesting to see the outcomes of the various delivery models now being used in the region.

References

- Alberta Centre for Active Living. (2005). *Home Support Exercise Program (HSEP) in Alberta: Calgary pilot-test results*. Retrieved March 30, 2006, from <http://www.centre4activeliving.ca/older-adults/hsep/calgary-report.pdf>.
- Benjamin, K., Edwards, N., & Bharti, V. (2005) Attitudinal, perceptual, and normative beliefs influencing the exercise decisions of community dwelling physically frail seniors. *Journal of Aging and Physical Activity*, 13, 276–293.
- Bortz, W. M. (1982). Disuse and aging. *Journal of the American Medical Association*, 248, 1203–1208.
- Canadian Fitness & Lifestyle Research Institute. (2002). *2002 Physical Activity Monitor*. Retrieved March 30, 2006, from www.cflri.ca/cflri/pa/surveys/2002survey/2002survey.html.
- Dishman, R. (1994) *Advances in exercise adherence*. Champaign, IL: Human Kinetics.
- García Bengoechea, E., & Spence, J. C. (2002). *Alberta survey on physical activity: A concise report*. Retrieved March 30, 2006, from http://www.centre4activeliving.ca/publications/physact_survey/2002/report.pdf.
- García Bengoechea, E., Spence, J. C., & Fraser, S. N. (2005). *Alberta survey on physical activity*. Retrieved March 30, 2006, from http://www.centre4activeliving.ca/publications/physact_survey/2005/report.pdf.
- Hartman-Stein, P., & Potkanowicz, E. (2003). Behavioral determinants of healthy aging: Good news for the baby boomer generation. *Online Journal of Issues in Nursing*, 8 (2). Retrieved March 30, 2006, from http://www.nursingworld.org/ojin/topic21/tpc21_5.htm.
- O'Brien Cousins, S. (1998). *Exercise, aging and health: Overcoming barriers to an active old age*. Philadelphia, PA: Brunner/Mazel, Taylor & Francis.
- O'Brien Cousins, S. (2003). A self-referent thinking model: How older adults may talk themselves out of being physically active. *Health Promotion Practice*, 4 (4), 439–448.
- O'Brien Cousins, S., & Gillis, M. (2005). “Just do it”: Voices of active and inactive older adults thinking about physically active lifestyles. *Psychology of Sport & Exercise*, 6 (3), 313–334.
- Stiggelbout, M., Hopman-Rock, M., Tak, E., Lechner, L., & van Mechelen, W. (2005). Dropout from exercise programs for seniors: A prospective cohort study. *Journal of Aging and Physical Activity*, 13 (4), 406–421.