BC Care Providers ASSOCIATION

Health Begins at Home: Strengthening BC's Home Health Care Sector

February 2018

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MESSAGE FROM THE CEO

A system of home health care has been in place in BC for decades, but it is presently playing a more critical part in our health care system than ever before. By supporting seniors to manage their health and maintain their independence, home health care supports seniors to stay in their homes, while providing a cost-effective approach to care. Yet despite the many advantages to a strong home health care system, there remains an overarching opportunity to strengthen the continuum of care by bolstering this component of the seniors' care sector.

The BC Care Providers Association (BCCPA) Board and its Emerging Issues and Policy Committee (EIPC) helped inform the development of *Health Begins at Home: Strengthening BC's Home Health Care Sector,* BCCPA's latest policy paper. It was further influenced by a provincial Listening Tour which sought feedback on the concerns faced by home health care providers across the province and also follows the 2017 release of the major policy paper, entitled *Strengthening Seniors Care: A Made-in-BC Road Map*, which highlighted recommendations relevant to home health care along with more general recommendations for the sector.

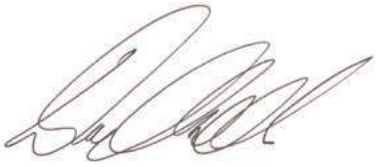
Health Begins at Home highlights four themes which are integral to improving BC's home health care sector including:

- *Investments in Funding* - Ensure resources are sustainable, through adequate funding models;
- *Investments in Seniors* - Increase access to home health care to ensure needs of seniors are met;
- *Fostering Innovation* - Support the adoption of province-wide home health care models; and
- *Investments in Quality* - Provide funding for programs which increase quality of life and quality of service.

As outlined in this latest BCCPA paper, further investments are critical to meeting the needs of BC's aging population and to strengthening BC's home health care system so that the best and most appropriate care can be delivered to seniors.

By focusing on implementing the eight recommendations outlined through this paper, including approximately $110 million per year in targeted funding, the BC Government, Health Authorities, BCCPA, service providers and other partners can create dramatic change in the quality of life and quality of care experienced by seniors accessing home health care services in our province.

Sincerely,



Daniel Fontaine
Chief Executive Officer

SPECIAL RECOGNITION

The BC Care Providers Association (BCCPA) would like to acknowledge its Board of Directors, for agreeing to support this initiative and dedicating the necessary resources to make it happen.

- Karen Baillie - BCCPA Board President, CEO, Menno Place
- Aly Devji - BCCPA Board Vice President, Director of HR/Operators, Delta View Habilitation Centre
- Rizwan Gehlen - BCCPA Treasurer, Vice President of Finance for Park Place Seniors Living
- Elaine Price - Director of Operations, Fraser Valley Care Centre and past BCCPA President
- Bob Boulter - CEO, Beacon Community Services
- Ann Marie Leijen - CEO, Logan Manor
- Sue Emmons - Executive Director, Northcrest Care Centre
- Elissa Gamble - National Director, Home Care Operations, Bayshore HealthCare
- Debra Hauptman – CEO, Langley Lodge
- David Hurford - CEO, Three Links Care Society
- Hilary Manning - General Manager, Chartwell Malaspina Gardens Care Residence
- Joe McQuaid - Executive Director, Alberni-Clayoquot Continuing Care Society
- Celeste Mullin - Vice President, Golden Life Management
- Ron Pike - Executive Director, Elim Village
- Hendrik Van Ryk - COO, H&H Total Care

Many individuals also contributed their time and energy in performing the necessary background research and developing this paper. BCCPA would like to give special thanks to the Emerging Issues and Policy Committee (EIPC):

- Aly Devji - EIPC Co-Chair, Director of HR/Operators, Delta View Habilitation Centre
- Elaine Price - EIPC Co-Chair, Director of Operations, Fraser Valley Care Centre
- Sue Emmons - Executive Director, Northcrest Care Centre
- Karen Baillie - CEO, Menno Place
- Al Jina - Owner and Founder, Park Place Seniors Living
- Elissa Gamble - National Director, Home Care Operations, Bayshore HealthCare
- Becky Marlatt - Regional Director of Operations, Sienna Senior Living
- Gavin McIntosh - Director of Corporate Development and Administration, Insite Seniors Care
- Lenore Pickering - Executive Director, Hawthorne Seniors Care Community

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- Michael Kary, Director of Policy and Research, BCCPA
- Ravin Johl, Policy Analyst, BCCPA
- Rebecca Morris, Manager of Public Affairs, Home Care and Assisted Living, BCCPA
- Lara Croll, Health Human Resource Analyst, BCCPA

Finally, the authors of the report would also like to acknowledge the ongoing support of the staff at the BCCPA.

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

As the British Columbia and Canadian population rapidly ages, home health care has become an increasingly critical part of the health system. Home health care enables seniors to live in their homes while supporting them to manage their health and maintain their independence and well-being. Home health care is also necessitated by rising health care costs and the need to deliver high quality care.

Home health care, which encompasses both home nursing care and home support,[1] has been an integral part of the health system in British Columbia for decades. In recent years, it has evolved over time by responding to changes that have occurred in the acute sector (including hospital bed closures as well as increases in ambulatory care clinics and day surgeries) and long term care (including wait lists for transitions to long term care and limited availability). As noted by the Canadian Health Care Association (CHCA) the four main reasons behind the increased shift to home health care include:

- People generally prefer to receive care where they live;
- Canada is an aging nation with increasing rates of chronic disease;
- A growing cohort of "digital seniors" combined with new and low-cost technology allows us to offer more care in non-congregate settings; and
- Governments are trying to contain their health care budgets and home care can be delivered at a lower cost.[2]

Given these factors, home health care has emerged with increased importance as an integral component of Canada's health care system and is essential to its sustainability.[3] It also has the potential to be a major force in increasing the cost-effectiveness of the overall health care system. [4]

BC's Home Health Care Sector Faces Many Challenges

By 2038, BC's senior population (aged 65 and older) will account for an estimated 24 to 27 per cent of the population, with the proportion of seniors nearly five percent higher than the Canadian average. The Ministry of Health reports that the percentage of BC seniors over 80 years old will grow from 4.4 per cent of the population in 2012 to 7.4 per cent by 2036. At the same time, it is projected that the prevalence of chronic conditions for those 80 or over in BC may increase by 58 per cent within the next 25 years.

In response to an aging population, the total spending on continuing care (including home health and long term care) for seniors is projected to increase from $28.3 billion in 2011 to $177.3 billion in 2046 and spending growth is expected to significantly exceed the pace of revenue growth in most provinces.[5]

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[1] Home care includes professional services such as nursing care, physiotherapy, occupational therapy, speech therapy, respiratory therapy, nutrition, counselling, and social services. Home support includes unregulated services such as bathing, personal care, and meal preparation.
[2] Home Care in Canada: From the Margins to the Mainstream. Canadian Health Care Association. 2009. Accessed at http://www.healthcarecan.ca/wp-content/uploads/2012/11/Home_Care_in_Canada_From_the_Margins_to_the_Mainstream_web.pdf
[3] Home Care Ontario. Accessed at: http://www.homecareontario.ca/public/about/home-care/General/
[4] Synthesis Report: Final Report on the National Evaluation of the Cost-Effectiveness of Home Care, August 2002, pg. xii
[5] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015. The same report estimates that by 2026 over 2.4 million Canadians age 65 and over will require paid and unpaid continuing care support — up 71 per cent from 2011. By 2046, this number will reach nearly 3.3 million.

To ensure the future feasibility of care, shifting delivery to less expensive alternatives – particularly home health care - will be critical.[6]

As outlined in this paper, increasing access to publicly funded home health care services (including home care and support), in ways which are sustainable and innovative, can help seniors maintain their health, live independently and reduce pressure on our hospitals. Yet, despite the benefits of home health care, recent reports including from the BC Office of the Seniors Advocate (OSA) highlight some of the challenges in the systemic delivery of these necessary services. For example, a 2016 OSA report outlines some of the shortcomings with respect to home support in BC, including:

- The number of seniors in BC are growing at twice the rate of Home Support clients (i.e. number of home support clients in BC increased by 2 per cent over 2013/14, while population aged 75 and over increased by 4 per cent);
- The number of home support hours is trending down in three out of five health authorities, while the number of clients has increased in four out of five (discrepancy greatest in NHA); and
- The average home support hours delivered per year per client decreased by approximately 2 per cent from the previous year, while the number of clients increased by 2 per cent, resulting in fewer hours of care, on average, per client.[7]

These and other challenges are outlined in Parts I and II of this paper, while Part III highlights four areas or themes to improve BC's home health care sector including:

- *Investments in Funding* - Ensure current home health care resources are sustainable, through adequate and appropriate funding models;
- *Investments in Seniors* - Increase access to home health care to ensure needs of seniors are met;
- *Fostering Innovation* - Support the adoption of province-wide home health care models which ensure appropriate use of health resources and promote choice; and
- *Investments in Quality* - Provide funding for programs which increase quality of life and quality of service in the home health care sector.

In January 2017, the BCCPA released its paper on sustainability and innovation in the continuing care sector entitled *Strengthening Seniors Care: A Made-in-BC Roadmap* which responded to many of the concerning trends noted above. While addressing continuing care more broadly, many of the 30 recommendations addressed home health care including that the Health Authorities increase minimum home care and support visit times and that a permanent sub-committee be created to deal with the unique and considerable challenges facing the sector. These challenges, as outlined later, include a review of funding, unfunded service expectations, travel costs and improving quality care as well as exploring the adoption of innovative models.

Following the release of *Strengthening Seniors Care*, the BCCPA has also conducted various round tables with representatives from the home health care sector. These consultations, and others including from

[6] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.
[7] Office of the Seniors Advocate. Monitoring Seniors' Services (2016). December 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf

the BCCPA Board and its Emerging Issues and Policy Committee (EIPC) helped inform the development of this paper as well as most of the recommendations.

SUMMARY OF RECOMMENDATIONS

This paper focuses on four key themes and makes eight recommendations designed to meet the challenges faced by home health care operators:

THEME I: Investments in Funding

Ensure current home health care resources are sustainable, through adequate and appropriate funding models.

Recommendation 1:

That the BC government establish a permanent Joint Committee on Home Health Care (JCHHC) consisting of the BC Ministry of Health, Health Authorities, service providers and BCCPA to deal with the unique and considerable challenges facing the publicly funded home health care sector.

Recommendation 2:

That the BC Ministry of Health undertake an independent and immediate review of home health care funding in order to ensure fairness, and sustainability. The aim of the review should be to:

- Develop a process for providing greater transparency with respect to how funding is determined, and ensure funding is provided to fulfill the expectations put forward to providers by government;
- Identify and address funding gaps that exist, including but not limited to administration, scheduling, recruitment, and retention of skilled home health care workers;
- Conduct a review of the relative costs of service delivery in different geographic areas and the potential impacts on funding; and
- To ensure the availability of funds to deliver training, continuing education and appropriate clinical oversight, including occupational work and safety and dementia education care in order to ensure all activities required by the health authorities are fully funded.

$2M PER YEAR

THEME II: Investments in Seniors

Increase access to home health care to ensure the needs of seniors are being met.

Recommendation 3:

That the Health Authorities increase the minimum home care and home support visit times from:

- 15 minutes to an average of 30 minutes (in cluster care settings).
- 30 minutes to 60 minutes (in community care settings).

$50M PER YEAR

Recommendation 4:

That the BC Ministry of Health develop provincial guidelines in coordination with a public awareness campaign whereby the province funds or offers preventative home health care visits to people 75 and older on a proactive basis (i.e. before they are requested), in order to prevent pre-mature frailty and ensure that seniors are provided with the necessary care as soon as possible.

$8M PER YEAR

THEME III: Fostering Innovation

Support the adoption of province-wide home health care models which ensure appropriate use of health resources and promote choice.

Recommendation 5:

That the Ministry of Health and all partners support the adoption of new home health care models province-wide, to allow seniors to remain at home longer as well as reduce alternate level of care (ALC) days and improve overall quality care. These models may include: the hospital at home model; better integrating home health and long term care; better integrating home health and acute care; and supporting greater end of life care at home.

$20M PER YEAR / 4 YEARS

Recommendation 6:

That the BC government explore further the appropriateness or feasibility of the care credit model including its limited phased introduction in the home health and long term care sectors.

$2M PER YEAR

THEME IV: Investments in Quality

Provide funding for programs which increase quality of life and quality of service in the home health care sector.

Recommendation 7:

That a new *Seniors Quality of Life Fund* (SQLF) be established by the BC government with designated funding to support seniors living at home and in congregate settings by:

- Increasing access to recreational therapy, occupational therapy, physiotherapy, nutrition, culturally appropriate care, music and art programs;
- Reducing seniors' isolation through increased Adult Day and similar programs; and
- Enabling care hubs to work more collaboratively with local home health providers.

$25M PER YEAR / 3 YEARS

Recommendation 8:

Develop a made in BC quality assurance model in the home health care sector, with a focus on implementing standards to ensure quality across the sector, specifically to support agencies providing privately paid services, as well as helping seniors and families make informed choices about care.

$3M PER YEAR

CONCLUSION

It is necessary more than ever that we act now to prepare to meet the needs of seniors. As outlined in this paper, further investments are critical in order to meet the needs of BC's aging population to improve BC's home health care system and deliver the most appropriate care possible to seniors.

Through targeted funding of approximately $110 million per year aimed at implementing the above recommendations in full, the BC Government, Health Authorities, BCCPA, service providers and other partners can create dramatic change in the quality of life and quality of care experienced by seniors accessing home health care services.


INVESTMENT IN SENIORS
$58M PER YEAR
• Increase home visits (30 min in cluster settings and 60 min in community care): $50M per year
• Preventative home health visits: $8M per year
INVESTMENTS IN FUNDING
$2M PER YEAR
• Education and training support: $2M per year
$110M
• Increase Choice and Innovation
• Better Health
• Higher Satisfaction
• Increase quality
• Longer visits
FOSTERING INNOVATION
$22M PER YEAR
• Care Credits to offer opportunity to increase choice for seniors: $2M per year
• To support innovation and new home care models: $20M per year
INVESTING IN QUALITY OF LIFE
$28M PER YEAR
• Seniors Quality of Life Fund (SQLF): $25M per year
• Other quality initiatives (Quality Assurance program, etc.): $3M per year

PART I: AN OVERVIEW OF BC'S HOME HEALTH CARE SECTOR

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BACKGROUND

A. Defining home care and home support

In Canada, home health care services are provided to individuals of all ages, with seniors representing the largest group of service users. According to Accreditation Canada, factors such as an aging population, growing levels of chronic conditions and dementia, as well as a need to control health expenditures, will have a major impact on the demand for home health care programs over the next decade and beyond. By properly resourcing home health programs, seniors can be supported to live safely and independently in their own homes. Furthermore, home health care has the ability to play a key role in "aging in place" strategies by: managing chronic disease; reducing hospital admissions, repeat emergency department visits and associated wait times; as well as ensuring quality end-of-life care.[8]

It is estimated that 1.2 million people in Canada use home health care services annually, with most clients being aged 65 and older. According to a recent Conference Board of Canada report, demand for these services will increase at a projected 3.1 per cent annual pace until 2026.[9] According to the Canadian Institute for Health Information (CIHI), a broad definition of home health care includes two main categories: home care and home support.

Home care programs support citizens of all ages by providing an array of services including health promotion, treatment, end of life care and rehabilitation. According to CIHI, home care includes professional services such as nursing care, physiotherapy, occupational therapy, speech therapy, respiratory therapy, nutrition, counselling, and social services.

While not exhaustive, some of the services generally undertaken by nurses or other regulated health professionals include:

- Prevention, screening and service intake;
- Assessment of health status and/or medical condition;
- Performing treatments and procedures;
- Rehabilitation;
- Medication administration / pharmaceutical assistance;
- End of life care; and
- Health promotion and fostering greater self-care.[10]

Home support, like home care services, are intended to support an individual's independence by supporting the person in their own home or in a care setting. Such services help seniors with bathing, personal care and meal preparation. In BC, home support workers, also referred to as Community Health Workers (CHWs), help seniors with daily activities such as getting up and around, changing clothes, using the bathroom, preparing meals and taking medications. In addition to these services, home support may

[8] Accreditation Canada and Canadian Home Care Association. Home Care in Canada: Advancing Quality Improvement and Integrated Care. May 2015. Accessed at: https://www.accreditation.ca/sites/default/files/home-care-in-canada-report.pdf

[9] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015. The same report estimates that by 2026 over 2.4 million Canadians age 65 and over will require paid and unpaid continuing care support — up 71 per cent from 2011. By 2046, this number will reach nearly 3.3 million.

[10] Review of Quality Assurance in Continuing Care Health Services in Alberta. Health Quality Council of Alberta. April 2014. Accessed at: https://d10k7k7mywg42z.cloudfront.net/assets/538f500bd6af685f2a000136/Continuing_Care_FINAL_Report.pdf

include safety maintenance activities and specific nursing and rehabilitation tasks that have been delegated by regulated health professionals.[11]

B. A Summary of Home Health Care Services in BC

The primary focus of this report is on home health care services. Table 1 below provides a high-level summary of publicly funded home health care services in BC. For a better understanding of how home health care fits within the current BC continuing care sector and for an overview of some selected programs (i.e. Better at Home, Choice in Supports for Independent Living and Home is Best) please see Appendix A.

Table 1: BC Home Health Care Services funded through Health Authorities	
Case Management	Case managers provide clinical assessment, care planning and coordinate home and community care services. They determine the nature, intensity and duration of services that would best meet client's needs, in collaboration with the client, family and other members of the care team, and arrange their services. The case manager will stay in touch with the client and make any adjustments necessary in the event their care needs change.
Community Nursing and Community Rehabilitation Services	Professional services, delivered to clients in the community by registered nurses and rehabilitation therapists. Nursing care is available on a non-emergency basis for British Columbians requiring acute, chronic, palliative or rehabilitative support. Rehabilitation therapists can also provide assessment and treatment to ensure a client's home is suitably arranged for their needs and safety.
Home Support Services	Provide accessible in-home services to seniors and other adults with disabilities who cannot live independently, due to health-related problems. Home support services help clients remain in their own homes and provide personal assistance with the activities of daily living, such as bathing, dressing, grooming, and in some cases, light household tasks that help maintain a safe and supportive home.
Choice in Supports for Independent Living (CSIL)	A "self-managed model of care", where clients receive funds directly for the purchase of home support services. They assume full responsibility for the management, coordination and financial accountability of their services, including hiring, training, scheduling and supervising home support workers.
Respite Services	Respite care can provide non-professional caregivers, such as family members or friends, with temporary relief from the emotional and physical demands of caring for a friend or family member. Home support, adult day services, and residential care may be utilized for respite services.
Social Work	Services are available but may be limited in some communities.
Dietetics	Services are limited to home bound clients only.

[11] BC Ombudsperson. The Best of Care: Getting it Right for Seniors in British Columbia (Part 2). February 2012. Accessed at: https://www.bcombudsperson.ca/documents/best-care-getting-it-right-seniors-british-columbia-part-2

Adult Day Services	Adult day services provide supportive group programs and activities that assist with daily activities or give clients a chance to be more involved in their community. Activities vary with each centre and may include: • Personal care services, such as bathing programs and administering medications. • Therapeutic recreation and social activities. • Caregiver respite, education and support. • In some centres, meals and transportation may also be provided or arranged. Clients may attend an adult day program in addition to receiving other services.
End-of-Life Care	Supportive and compassionate care that improves the quality of life of people in the ends stages of a terminal illness or preparing for death. It is provided wherever the client is living, whether in their home, in hospital, hospice, an assisted living residence or a residential care facility. Community end-of-life services include palliative care co-ordination and consultation, professional nursing services, community rehabilitation services, home support and respite for the caregiver. Under the BC Palliative Care Benefits Program, eligible clients living at home receive free medications for pain and symptom relief as well as specified medical supplies and equipment.
Source: Canadian Home Care Association. Portraits of Home Care in Canada. 2013	

C. Home Care Programs in BC

In BC, home care can be provided by a Health Authority, or by a contracted provider (not for profit or for profit). An example of a BC program providing home care is 'Home is Best', which also provides home support and is outlined further in Appendix A of this paper.

As described in a 2015 report by the Office of the Seniors Advocate (OSA), 31,084 seniors, with an average age of 80 years, are receiving home care services. A breakdown of those receiving home care services in BC is outlined in Table 2.

Table 2: Characteristics of BC's Home Care Population

Characteristic	Percent
Female	64%
85 and older	40%
Married	30%
Diagnosis of dementia	34%
Primarily uses a wheelchair	11%
Moderate to severe cognitive difficulties (memory, following direction)	19%
Six or more medical diagnoses	21%
Moderate to severe difficulties in independently performing daily living tasks	15%

Instability in cognitive function, ADLs, mood or behaviour	50%
Taking 9 or more medications	44%
Are in renal failure (on dialysis)	10%
Have a psychiatric or mood disorder	21%
Experience daily pain	47%
Have nursing visits once a week or more	19%

Source: Office of the Seniors Advocate. April 2015. Placement, Drugs and Therapy… We Can Do Better. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2015/09/PlacementReport.pdf

In 2015/16, a total of 87,289 clients received home care services in BC, an increase of 2.3 per cent over 2014/15. Unlike home support, where 88 per cent of clients are aged 65 and older, only 70 per cent of home care clients are aged 65 and older. This number reduces to 50 per cent at age 75 and older. In contrast, 73 per cent of home support clients are aged 75 and older. In 2015/16, a total of 1,111,123 visits were made to clients receiving professional home care services in BC, an increase of 2 per cent over 2014/15.[12]

D. Home Support Programs in BC

In BC, home support (as described above) helps people with chronic illnesses, disabilities or progressive medical conditions, with the tasks of daily living.

Access to publicly subsidized home support services is based on an assessment by Health Authorities. Eligible clients using publicly funded home support services are charged a daily rate based on their after-tax income. As noted in a 2012 report by the BC Ombudsperson:

- Over 70 per cent of people receiving home support services are low-income and pay no fee;
- 3 per cent pay up to $10 per day;
- 6 per cent pay between $10 and $20 per day;
- 20 per cent pay more than $20 per day; and
- Seniors with earned income pay a maximum of $300 per month for home support.[13]

The average cost for health authority delivered home support is approximately $44 an hour (a rate that significantly exceeds the hourly rate paid to contracted service providers providing the same services).[14] In 2015/16, a total of 42,170 clients were registered for publicly subsidized home support services. The number of clients increased in three health authorities and decreased in two. The total number of home support clients in BC increased by 2 per cent over the previous year, while the population aged 80 and over increased by 3 per cent. The total number of home support hours delivered to all clients receiving service in 2015/16 was 11,089,553, a decrease of 0.1 per cent over the previous fiscal year.[15] These figures indicate that the aging population appears to be out pacing service delivery, despite the political impetus to support people to age in place, as discussed later in the paper.

[12] BC Office of the Seniors Advocate. Monitoring Seniors' Services. 2016. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf
[13] BC Ombudsperson. The Best of Care: Getting it Right for Seniors in British Columbia (Part 2). February 2012. Accessed at: https://www.bcombudsperson.ca/documents/best-care-getting-it-right-seniors-british-columbia-part-2
[14] BC Office of the Seniors Advocate. Caregivers in Distress: A Growing Problem. August 2017. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/08/Caregivers-in-Distress-A-Growing-Problem-Final.pdf
[15] BC Office of the Seniors Advocate. Monitoring Seniors' Services. 2016. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf

Subsidized home support services are administered under BC's Continuing Care Act. In BC, more prominent home support programs include Better at Home and Choice Supports in Independent Living (CSIL), which are also profiled further in Appendix A. Seniors who do not qualify for subsidized home support services may also opt to privately purchase various services that are similar in nature to subsidized home support services.

E. Summary

Part I of this paper has defined home health care and its two key components, home care and home support. It has also provided a high-level overview of the home health care sector in BC, while providing a summary of home care and home support programs in the province. The sections of the paper to follow will discuss the challenges facing the home health sector (Part II) and will identify potential solutions to improving home health are for seniors in our province (Part III).

PART II: CHALLENGES FACING THE HOME HEALTH CARE SECTOR

PART II: CHALLENGES FACING HOME HEALTH – COMPLEXITY, ACUITY, FUNDING AND ACCESS

A. Complexity and Acuity in Home Health

Despite being a long standing and critical component of BC's health care system, BC's home health care sector faces a considerable number of challenges, as do other provinces across Canada. In terms of publicly subsidized home health care, many of these challenges can be related to funding models which have not kept pace with changing demographics as well as increasing client complexity and acuity. A 2017 home health care report highlights some of these challenges:

- The complexity and acuity of client's needs are continuing to increase. These increases include cognitive impairment including dementia, increases in chronic conditions and co-morbidities, as well as the number of clients who need assistance with Activities of Daily Living (ADLs), etc.
- Workers may lack necessary training to manage increasing client acuity levels and increasing levels of cognitive impairment.
- Home care is under continuing pressure to facilitate the discharge of patients from the hospital.
- The lack of continuity in the assignment of health care workers and insufficient time allocated to complete assigned tasks remains a challenge.
- Programs are increasingly task driven and scheduling does not allow for travel time.[16]

These and other challenges are resulting in greater unmet home health care needs as highlighted in various reports from Canada and BC.

B. Access to Home Health Care

Issues with respect to accessing home health care in BC also pose barriers to care for BC seniors. Between 2000/01 and 2015/16, the rate of home care client visits in BC declined by 15 per cent, in all but one health authority.[17] BC Ministry of Health data also shows that between 2000/01 and 2015/16, access to home support in BC, measured by number of home support clients per 1,000 seniors aged 75 and older, fell by 30 per cent.[18]

Access issues are highlighted in an August 2017 report by the BC Office of the Seniors Advocate (OSA). The OSA notes that despite the increasing complexity of home support clients the number of home support hours for clients 65 or older increased by 2 per cent, but the average hours per day per client decreased by 5 per cent, signaling less intensive service, the exact opposite of the actual trend. This means that increasingly complex patients are getting less service. Access limitations appeared to extend beyond the home support realm, into other areas of the community care sector – in fact, the number of home support clients accessing adult day programs (ADP) also decreased by 5 per cent and the number of days delivered to these clients declined by 2 per cent.[19]

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[16] The Government of Manitoba Minister of Health, Seniors and Active Living. Future of Home Care Services in Manitoba. January 2017. Accessed at: https://www.gov.mb.ca/health/homecare/future_homecare.pdf

[17] Whereas access decreased in Northern Health (–59 per cent), Vancouver Coastal Health (–25 per cent), Fraser Health (–23 per cent) and Interior Health (–1 per cent), the client visit access rate increased by 9 per cent in Vancouver Island Health.

[18] Home support access declined in all health authorities: Northern Health (–54 per cent), Vancouver Coastal Health (–49 per cent), Interior Health (–25 per cent), Vancouver Island Health (–19 per cent) and Fraser Health (–16 per cent).

[19] Office of the Seniors Advocate. Caregivers in Distress: A Growing Problem. August 2017. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/08/Caregivers-in-Distress-A-Growing-Problem-Final.pdf

BCCPA would argue that by failing to address access issues in a way that is timely, meaningful and cognizant of demographic trends, we are missing an opportunity to ensure the sustainability of other, more costly components of the health care system, such as acute and long term care. By ensuring that seniors have access to the most appropriate care when they need it, it is possible to reduce overall health care expenditures and better ensure the well-being of BC seniors.

One of the main barriers to access as outlined in Appendix C of this paper is the overall shortage of workers. For example, according to a 2017 SafeCare BC survey, 50.2 per cent of home support workers identified staffing shortages as an issue. Many of the survey respondents also predicted that these shortages would continue over the next few years, with only a quarter reporting that they were confident that their organization would have an adequate supply of workers over the next three to five years.

In summary, along with worker shortages, many British Columbians are currently unable to access publicly subsidized home health services as eligibility criteria for publicly subsidized home care and home support also continues to be strict, only allowing access to those with the highest level of need.[20] To meet the BC government's commitment to shift resources from acute care to the community it must include improving the accessibility and availability of home health care services for British Columbians.

C. Client Satisfaction in Home Support

While there are challenges facing the home health care system in BC, general client satisfaction rates are generally good, as seen in a report released in September 2016 by the OSA entitled *Listening to Your Voice: Home Support Survey*. Results from this province wide survey show that clients are satisfied with the quality of the home support services they receive (62 per cent) although many respondents would like services available to them such as housekeeping (28 per cent) and increased assistance with meal preparation (12 per cent).[21]

Additional highlights from this survey include an overwhelming recognition that home support staff are caring and respectful (92 per cent), but that clients have concerns around the number of different workers they receive (20 per cent of clients say they receive care from too many different workers), as well as the lack of skills and training of home support workers. Specific client results from the survey included:

- 78 per cent feel home support services are meeting their needs most or all of the time.[22]
- 80 per cent report workers mostly or always have enough time to provide all prescribed services (in the Vancouver Coastal region, this falls to 68 per cent with 13 per cent reporting their workers rarely or never have enough time).

[20] Association of Registered Nurses of BC. Issue Brief. Home Health Services. November 2016. Accessed at: http://www.arnbc.ca/pdfs/policies-and-advocacy/issues-briefs/community-health/ARNBC-IB-Home-Health-Services.pdf

[21] BC Office of the Seniors Advocate. Listening to your voice: Home support survey results. September 2016. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

[22] 11% of clients feel home support services sometimes meet their needs, while 4% feel the services rarely or never meet their needs Clients with higher degrees of impaired cognition, a high depression rating scale score, wandering and/or the presence of vision problems are more likely to rate home support services as sometimes, rarely, or never meeting their needs.

- 62 per cent rate the quality of their service as above average or excellent. Slightly more than 25 per cent of respondents rate the service as only average, but only 5 per cent rate the service as below average or poor.
- 63 per cent report being satisfied with the number of regular workers providing care, while 56 per cent are satisfied with the number of substitute workers providing care.[23]
- Only 47 per cent report workers have all of the necessary skills to provide good care. Clients in rural communities were most likely to report favourably, with 60 per cent saying their workers had all of the necessary skills.[24]

Overall, the surveys indicate that there are specific and important areas where improvements would be beneficial. These are largely related to funding, visit length and the breadth of services available (i.e., funded hours and other affects of funding level and patterns) rather than service provision which are issues outside of the control of contracted providers. This is concerning as noted later in the paper because quality and satisfaction rates can be used by the Health Authorities to determine funding rates which are provided to contracted home health care operators. This can result in further penalties to funding that are likely to put further pressure on operators, resulting in even poorer satisfaction rates and further cuts.

To summarize, while considerable demographic changes have taken place in home health care over the decades, increased complexity and acuity have remained largely unsupported by associated funding models. As such, there remain significant opportunities to improve and enhance the level of services received by BC seniors. As outlined through the specific recommendations which are identified in the next section of this paper (Part III), this may be done by investing in four key areas: funding, access, innovation and quality.

[23] Almost one-third of clients (28%) think they receive too many substitute workers. There was substantial variation across Health Authorities, with 21% of clients in the Northern Health Authority region feeling they receive too many substitute workers compared to 33% of clients in the Vancouver Island Health Authority region.

[24] BC Office of the Seniors Advocate. Listening to your voice: Home support survey results. September 2016. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

PART III: OPPORTUNITIES FOR STRENGTHENING BC's HOME HEALTH CARE SECTOR

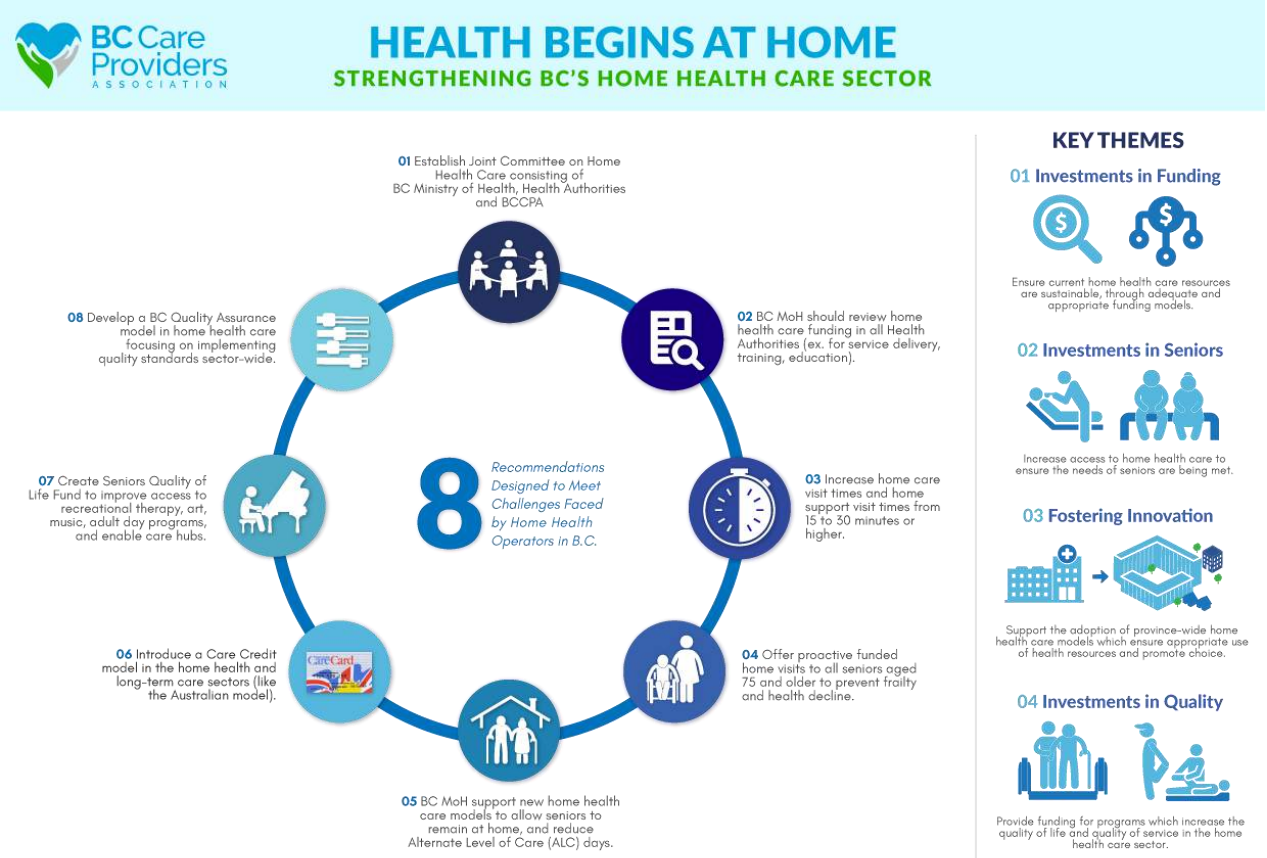
PART III: OPPORTUNITIES FOR STRENGTHENING BC'S HOME HEALTH CARE SECTOR

Overview

This paper has defined home health care and has provided an overview of how the two key components (home support and home care) are delivered in the BC context. It has also outlined the challenges facing the sector – specifically, issues of increased client acuity and complexity, access, and client satisfaction. As outlined in Part II of this paper, even though client satisfaction rates are generally good, there remains opportunities to improve care by increasing the time workers have to provide care and ensuring that the funding is available to guarantee that workers have the necessary skills and training to provide good care.

The BCCPA believes these areas could be improved if the BC government, health authorities, and home health care stakeholders continue to take positive actions in alignment with the following four themes:

- *Investments in Funding* - Ensure current home health care resources are sustainable, through adequate and appropriate funding models;
- *Investments in Seniors* - Increase access to home health care to ensure needs of seniors are met;
- *Fostering Innovation* - Support the adoption of province-wide home health care models which ensure appropriate use of health resources and promote choice; and
- *Investments in Quality* - Provide funding for programs which increase quality of life and quality of service in the home health care sector.



THEME I: INVESTMENTS IN FUNDING

Goal: Ensure current home health care resources are sustainable, through adequate and appropriate funding models.

A. Home Health Care Funding in BC

In 1978, the BC government introduced coverage of home nursing care and long term care services followed by the subsidization of home support services in 1981. Health Authorities are responsible for: delivering programs that are consistent with Home and Community Care (HCC) policies and standards; ensuring operational policies and procedures are in place; planning and monitoring services at regional level; and reporting on their performance.[25]

Currently, the BC Ministry of Health allocates monies annually to five regional health authorities to deliver continuing care (including long term and home health care) to more than 100,000 individuals. While the Ministry provides overall funding and stewardship, the five regional health authorities directly deliver programs and contract with private for-profit and non-profit agencies to provide services.

As outlined in a 2017 BC Auditor General report, in 2015/16, BC's health sector spent $19.2 billion. Of that, the Ministry of Health spent $17.4 billion, or 37 per cent of overall provincial expenses. The majority of this, or two thirds, is allocated to health authorities. BC's expenditures in 2015/16 by health authorities and hospital societies was approximately $13.7 billion. From 2012-13 to 2015-16, the following areas saw spending increases:

- Acute-care (emergency, post-surgical, critical-care) + 11 per cent;
- Long term care (seniors' homes, community group homes) + 5 per cent;
- Community care (in-home nursing care) + 14 per cent; and
- Mental-health and substance-use services + 3 per cent.

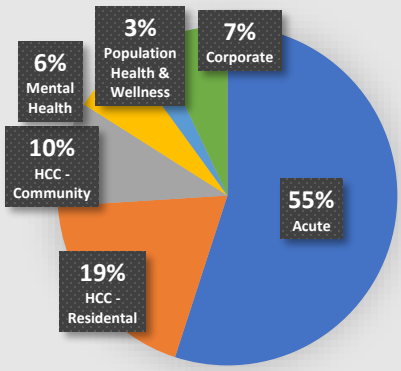
Despite marginal increases to long term and home health care, the bulk of the funding (55 to 59 percent), however, still goes largely goes to acute care. [26] For contracted home support, there has not been any increase for costs of care delivery outside of direct mandated labour cost increases in over 10 years.

Figure 1 provides a breakdown of health authority expenditures based on 2014/15 financial statements. As outlined in the figure and as advocated by the BCCPA, there are significant opportunities to shift financial resources from acute care to the community (see Appendix F). In particular, the BCCPA has previously recommended that Health Authorities redirect a minimum of 1 percent of acute care funding annually over a five-year period to the continuing care sector (including home health care). This concept, which is explored further in Appendix F of this paper, has the potential to address many of the funding challenges facing the home health care sector. As outlined in the appendix this funding shift could equate to eight million additional home support worker hours.

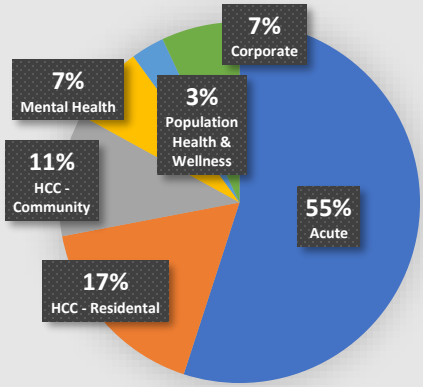
[25] BC Auditor General Report. Home and Community Care Services: Meeting Needs and Preparing for the Future. October 2008. Accessed at: http://www.bcauditor.com/pubs/2008/report7/home-and-community-care-services-meeting-needs-and-prepar. In addition to the health authorities, a number of private operators deliver long term care, assisted living and other services to British Columbia residents who pay directly for the services. These operators are not publicly subsidized and the users of the services pay the full costs.
[26] Ibid.

FIGURE 1: BREAKDOWN OF HEALTH AUTHORITY EXPENDITURES (2014/15)

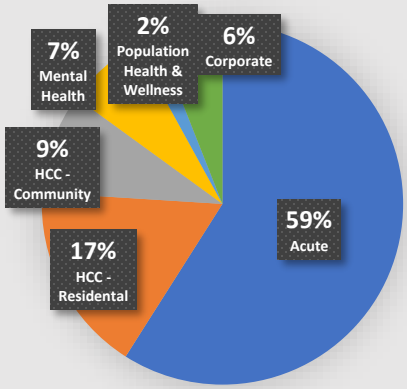
IHA Expenditures



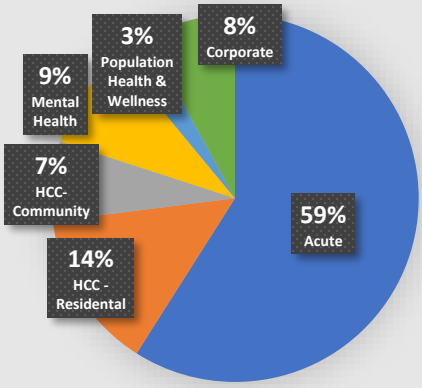
VIHA Expenditures



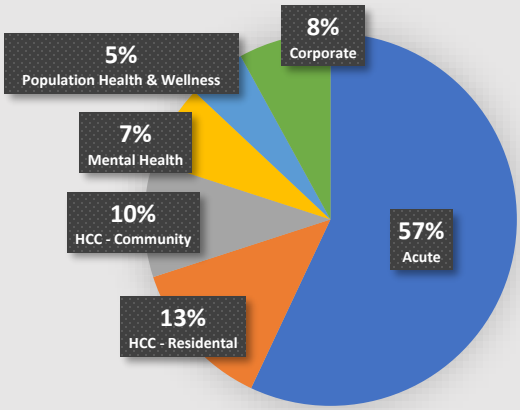
FHA Expenditures



VCH Expenditures



NHA Expenditures

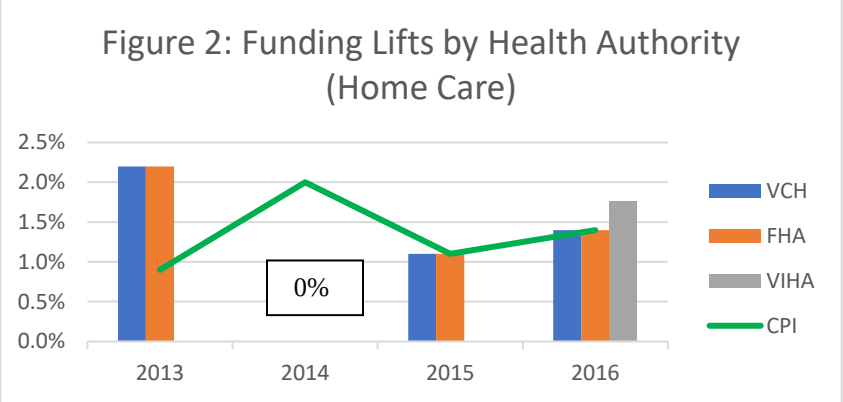


Sources: Financial Statements of Vancouver Coastal Heath Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).

While there have been incremental increases in home health care funding, in total, as outlined above, it is still not enough to meet the growing demands of an aging population. Currently in BC and most of Canada, home and community care (HCC) comprises approximately 4 to 5 per cent of the overall spending of provincial health care expenditure.[27] As outlined in a Conference Board of Canada report, about $7 billion to $8 billion was spent nation wide in 2010 on publicly funded and private home care, or about 4 per cent of all health care spending across the country. That marks an increase from an estimated $4.3 billion in combined spending in 2003-04, according to a report by the CIHI.[28] It is important to note, however, that much of these increases over this time have gone to direct labour costs as opposed to increasing service delivery. In particular, there have been minimal or no funding increases to assist with administration costs which includes clinical management and staff education.

In the BC context, despite current levels of funding, home health care services are not meeting the needs of BC's growing population of seniors. As noted in a 2016 report by the Integrated Care Advocacy Group and the BC Health Coalition, seniors with mild to moderate care needs who could benefit from the preventive care aspects of home support may not be getting the attention they need. This is not only because the eligibility criteria for publicly-funded services has changed becoming more restrictive due to growing demand, but also that the level of service offered has changed. [29]

Further, home health care operators have also faced significant fiscal challenges related to the insufficient funding provided by health authorities. Specifically, the funding increases which flow from health authorities to operators, have not adequately factored in growing acuity levels among clients (i.e. increasing levels of chronic disease, dementia, etc.) as well as travel and other costs. Figure 2 highlights the lack of increases which are at levels near or below inflation. These challenges are discussed further below.



Note: Funding lifts for were for care aide cost increases only while other inflationary periods are not included (i.e. no lift for other costs, such as scheduling, nursing, etc.). Information for Interior Health Authority (IHA) was not available. **In 2014, funding lifts for Vancouver Coastal Health (VCH), Fraser Health Authority (FHA) and Vancouver Island Health Authority (VIHA), in 2014 were 0 per cent.** Consumer Price Index (CPI). Source: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/econ46a-eng.htm

[27] Home care Ontario. Accessed at: http://www.homecareontario.ca/public/about/home-care/General/
[28] Seniors' health in the spotlight: High staff turnover plagues home care. Erin Ellis. Vancouver Sun. September 2014. Accessed at: http://www.vancouversun.com/health/Seniors+health+spotlight+High+staff+turnover+plagues+home+care+sector/10179447/story.html
[29] Integrated Care Advocacy Group and the BC Health Coalition. Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system. May 2015. Accessed at: http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20To%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20%20new%20appendixA.pdf

Sustainability in Funding: Obstacles facing BC home health care operators

Effective delivery of high quality home and community care in BC relies on a strong partnership between clients, government, home health care workers, clinicians, and health care service providers. Clients, workers, and health care service providers are currently expressing dissatisfaction and serious concerns about how funding decisions are negatively impacting care delivery.

Increasing care demands and a lack of proper government funding also threatens the sustainability of BC's vital home health care sector. While long term challenges and actions remain, there are several areas outlined below which should be dealt with in a timelier manner. Among these include the issue of punitive performance funding as discussed later.

As home health care is a critical component of the health system, particularly for the care of frail and elderly seniors, it is vital that funding levels support and enhance these services as well as ensure long term viability of the sector. The BC Government and the health authorities tend to allocate their funding towards costlier acute care services than to less expensive areas of the system, with home health care as a leading example. Like long term care, home health care providers are also facing challenges to remain fiscally sustainable due to an identified shortage of funding to cover inflationary costs and increasing unfunded expectations (see Figure 2).

For home health care providers, these costs can be attributed to a lack of recognition of increasing compensation and benefits, increasing levels of acuity for seniors, as well as unfunded service expectations including training and education for workers. In BC, for example, many home health care providers have not seen funding increases above direct subsector collective agreement cost increases for over ten years. This is also exacerbated by inequities in travel time costs, as the Health Authorities pay all providers the same hourly rate, even though there are significant differences in travel compensation costs due to geographic services areas.

Punitive Performance Funding in Home Support

In BC, home support operators are being penalized unfairly for not meeting specific targets, including for low client satisfaction rates. As a result, the performance-based home support funding model has shifted over time from its original intention as a bonus-based system to create additional incentives, to a more punitive system. Specifically, rather than providing bonuses for operators that are exceeding expectations, full funding at the 'exceeds expectations' rate is considered by most employers to be break-even funding at best. It is this shift, which has occurred partly because funding has not kept pace with cost increases, which has created significant concern and instability among contracted home health care providers across the province. In the 2016 BC's Office of the Seniors Advocate review of Home Support, it suggests this funding scheme may also result in unintended consequences as providers are funded at various levels in different geographies in BC.[30]

Punitive funding is attributable to the Accountability, Responsiveness, and Quality for Clients Model of Home Support (ARQ Model), used since 2006 by Vancouver Coastal Health (VCH) and its service providers for higher density areas in the Vancouver area. Since the new joint contract in 2009, both Fraser Health Authority (FHA) and Vancouver Coastal Health (VCH hold their service providers accountable to the ARQ model and its performance-based funding.

[30] BC Office of the Seniors Advocate. Listening to your voice: Home support survey results. September 2016. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

Under this model, service providers must meet the targets outlined in service agreements and may receive extra funding when they exceed certain performance targets. Key elements of the ARQ model are the use of performance indicators and performance-based funding incentives. One of the performance indicators is the number of clients who receive services from the same home support workers on a "consistent" basis.[31] Ensuring the continuity of care by measuring the percentage of time clients receive care from a worker on their care team is an example of a metric that the BCCPA supports and which is largely within the control of operators.

Punitive Performance Funding in Cluster Care

In addition to these funding challenges, home health care workers struggle to provide high-quality, person-centred care for their clients due to the scheduling of very short client visits – as low as 15 minutes in some congregate settings (often referred to as cluster care). In its latest *Monitoring Seniors Services* report released in December 2017, the OSA found that the while the number of BC home support clients has increased, the hours of service are trending downward overall (i.e. in 2015/16, the average home support hours delivered per year per client decreased by approximately 2 per cent from the previous year, while the number of clients increased by 2 per cent).[32]

The ARQ model integrates cluster care in high-density neighborhoods / buildings with performance-based funding of measurable outcomes.[33] Essentially, cluster care seeks to provide consistent care using a single home support team in neighborhood/building areas where client needs are fluctuating, and by shifting from traditional hour-based funding to block funding.[34]

Cluster care was introduced to drive efficiencies in congregate settings while enabling more responsive client-centered care, and as of 2012, had been implemented in Fraser Health, Island Health and VCH.[35] As outlined in the 2015 paper *Living Up to the Promise*, instead of scheduling community health workers to clients that live far apart, cluster care enables them to have a caseload of clients who live in the same neighbourhood or building. In theory at least, by eliminating time specific referrals when not medically required, community health workers have more flexibility to decide how much time to spend with each client depending on their needs that day.[36]

While there are potential benefits of moving to cluster care, significant concerns have been raised by BCCPA home health care members. In the report *Living Up to the Promise*, workers reported that they still feel rushed and had limited time to respond flexibly to client needs because of the increased number of clients (many with complex needs) they are now expected to visit. In particular, there is an increasing

[31] BC Ombudsperson. The Best of Care: Getting it Right for Seniors in British Columbia (Part 2), p. 119. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf
[32] Office of the Seniors Advocate. *Monitoring Seniors' Services* (2016). December 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf
[33] KPMG (2008). "Central LHIN Health Service Needs Assessment and Gap Analysis. Appendix Q: Jurisdictional review". Slide 16.
[34] Sutherland, J., Repin, N., Crum, R. (2008). "Reviewing the Potential Roles of Financial Incentives for Funding Healthcare in Canada". *Canadian Foundation for Healthcare Improvement.* Accessed at: http://www.cfhi-fcass.ca/Libraries/Reports/Reviewing-Financial-Incentives-SutherlandE.sflb.ashx
[35] BC Ombudsperson. The best of care: getting it right for seniors in British Columbia (Part 2). Public report no. 47 to the Legislative Assembly of British Columbia – Vol 1. February 2012. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf
[36] Integrated Care Advocacy Group and the BC Health Coalition. Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system. May 2015. Accessed at: http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20To%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20%20new%20appendixA.pdf

pressure on the home support services system to provide medically complex care services in the home or assisted living communities – services which historically have been performed in hospital or extended care settings.[37]

One of the major challenges of improving quality of care under a pay-for-performance model is that poor quality can create perverse outcomes of having a funding cut, when what is required is further investments to enhance quality.

Transparency in funding

Currently, much like long term care, there is a general lack of transparency with respect to how funding is allocated. To remedy some of the earlier issues, the BCCPA advocates to improve the overall transparency with respect to how funding rates for home health care are determined. In a previous 2016 White Paper, the BCCPA identified several funding principles with respect to timeliness, fiscal sustainability, equity as well as communication and transparency. With respect to the latter principle on transparency, the BCCPA advocated that contracted service providers be provided with timely and appropriate communication regarding any significant issue related to their funding relationship with the health authority and that the methodology used to calculate annual funding lifts be shared openly with care providers. These principles should also apply to publicly subsidized home health care operators.

As outlined in the January 2017 BCCPA paper *Strengthening Seniors Care* it also recommended the creation of a permanent sub-committee to deal with the unique and considerable challenges facing the home care sector including a review of funding, unfunded service expectations, travel costs and improving quality care. Likewise, this sub-committee could also explore different models in home care to determine their use or adoption in British Columbia.[38]

B. Joint Committee on Home Health Care (JCHHC)

Developing the most collaborative relationship possible between home health care operators, the Ministry of Health and Health Authorities is essential to address many of the issues identified in this paper. In particular, the creation of a joint committee consisting of the BC Ministry of Health, BC Health Authorities, and BCCPA is critical to addressing the unique and considerable challenges facing the home health care sector. As such, the first priority should be the establishment of permanent Joint Committee on Home Health Care (JCHHC) to deal with some of the more immediate challenges facing the home health care sector.

[37] Ibid.

[38] BCCPA. Strengthening Seniors Care: A Made-in-BC Roadmap. January 2017. Accessed at: http://bccare.ca/wp content/uploads/2017/01/BCCPA_Roadmap_Full_Jan2017.pdf

RECOMMENDATION 1:
That the BC government establish a permanent Joint Committee on Home Health Care (JCHHC) consisting of the BC Ministry of Health, Health Authorities, service providers and BCCPA to deal with the unique and considerable challenges facing the publicly funded home health care sector.

Likewise, in conjunction with the establishment of the JCHHC there needs to be an immediate review of home health care funding in all Health Authorities with the goal of consistency, fairness, and sustainability, including developing a process for providing greater transparency with respect to how funding is determined as well as ensure funding is provided to fulfill the expectations put forward to providers by government.

Such a review should also include ensuring that appropriate funding is provided to meet all Subsector Collective Agreement costs negotiated by the Health Employers Association of BC (HEABC),[39] as well as other increased costs related to clinical supervision, administration and scheduling, to ensure the capacity of agencies to recruit and retain skilled health workers and ensure the long term viability of the sector. For example, one such challenge faced by home health care operators is retaining staff as workers often move into a unionized hospital or long term care home position where the wage for similar work is significantly higher.

One of the most pressing issues facing the home health sector is also ensuring sufficient levels of health human resources (HHR) exist. With a rapidly growing population and strengthening economy, the ability to attract qualified home health care workers to British Columbia has increasingly become an unexpected challenge. For home health care employers, it is a province-wide issue with chronic shortages in the North.[40] While the BCCPA acknowledges the importance of addressing home health care workforce shortages, it also believes the best approach is through a broader strategy across the continuing care sector, particularly a rejuvenated BC Cares type program as discussed further in Appendix C of this paper.

Along with identifying and addressing funding gaps that exist, including but not limited to administration, scheduling, recruitment, and retention of skilled home health care workers any such review should also explore the relative costs of service delivery in different geographic areas and the potential impacts on funding. In particular, the costs of service delivery can vary dramatically depending on geographical location (i.e. rural, remote and urban). Other areas of any review should include those outlined below.

[39] While the Health Employers Association of BC (HEABC) is responsible for negotiating collective agreements on behalf of the provincial government, these agreements can also significantly impact the operating costs of home health operators. In terms of operators, both those included in the master collective agreement (i.e. community sub-sector collective agreement, and those not are required to pay competitive wages rates.

[40] BCCPA. Rapidly Ageing Population Triggers Shortages of Care Aides. April 27, 2016. Accessed at: http://www.bccare.ca/shortage-care-aides-outside-metro-vancouver/

C. Home Health Care Costs

Unfunded Service Expectations and Travel Costs

Related to the issue of punitive funding and cluster care is the challenge of unfunded service expectations. In BC, contracted home support providers are paid on a per hour basis for approved services provided. In addition, they are required to deliver education courses to all Community Health Workers (CHWs) but are not reimbursed for these costs. These programs are designed and defined by the Health Authorities as well as made mandatory without any additional compensation for direct labour or associated costs. These costs were also never contemplated nor agreed to at the time contracts were signed.

Training and Education Costs (including dementia, occupational health and safety)

Dementia training

One of the major concerns raised by home health care operators are the costs associated with training and educating staff particularly with seniors facing growing levels of acuity, including higher levels of dementia and chronic disease. In particular, health authorities are mandating this training and education but are not funding home health care providers appropriately to meet these requirements. As outlined in a 2015 report which highlights the lack of adequate training for many home health care workers with higher needs clients, such workers are increasingly being required to perform tasks that are traditionally nursing duties.[41]

According to BC's Dementia Action Plan (2012), the number of people with dementia in the province is between 60,000 and 70,000. The Alzheimer Society of BC also notes that this number is expected to double within the next 25 years.[42] In BC, over 60 percent of people living in long term care have dementia (about 40 per cent of the total population with dementia) while the majority of those (60 per cent) with have been diagnosed at home or in the community.[43] As noted earlier, over one-third of people receiving home health care services in BC have some form of dementia. These numbers are also only likely to increase over time.

Occupational health and safety

According to Safe Care BC,[44] training and education in the home health care sector, with respect to occupational work and safety are critical to improving worker safety and reduce injury rates. In the home health care sector, safety issues include occupational injury, physically or verbally responsive clients or family members, discrimination, racism, and unsafe conditions in the client's home (including cleanliness,

[41] Integrated Care Advocacy Group and the BC Health Coalition. Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system. May 2015. Accessed at: http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20To%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20%20new%20appendixA.pdf

[42] The Provincial Dementia Action Plan for British Columbia. *Priorities and Actions for Health System and Service Redesign.* Ministry of Health November 2012. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf.

[43] BC Ministry of Health, Chronic Disease Information Registries, 2013/14, Alzheimer's Disease and Other Dementia Measures Report.

[44] SafeCare BC is a non-profit organization founded in 2013. SafeCare BC focuses on improving the health and safety of health workers in home support, assisted living, and long term care. Currently, SafeCare BC represents 825 members of non-profit and private operators. SafeCare BC's mandate is to maintain a strong emphasis on injury prevention in long term care and community health support services sector (the continuing care sector) through a variety of initiatives.

smoking, and pets).[45] Poor working conditions such as mental or emotional abuse, can also impact workers' physical health and have been linked to musculoskeletal disorders.[46] According to WorkSafeBC, the home health care sector has an injury rate that is twice the provincial average at 4.4 time-loss claims per 100 workers (provincial average is 2.2 time-loss claims per 100 workers). This amounts to over 36,000 workdays lost per year and costs the sector $7.6 million annually in claims costs (2016 data).[47]

To address these substantially high injury rates, as well as training and education challenges in the home health care sector, the BCCPA recommends a $2 million fund, which the JCHHC or an affiliate body, such as Safe Care BC, could oversee. In summary, the BCCPA advocates that the BC Ministry of Health undertake an independent and immediate review of home health care funding to ensure fairness, and sustainability to address issues outlined above including:

- Developing a process for providing greater transparency with respect to how funding is determined, and ensuring funding is provided to fulfill the expectations put forward to providers by government;
- Identify and address funding gaps that exist (i.e. administration, scheduling, recruitment, and retention of skilled home health care workers);
- Review of the relative costs of service delivery in different geographic areas and the potential impacts on funding; and
- Ensure the availability of funds to deliver training, continuing education, and appropriate clinical oversight, including occupational work and safety and dementia education care.

RECOMMENDATION 2:

That the BC Ministry of Health undertake an independent and immediate review of home health care funding in order to ensure fairness, and sustainability. The aim of the review should be to:

- Develop a process for providing greater transparency with respect to how funding is determined, and ensure funding is provided to fulfill the expectations put forward to providers by government;
- Identify and address funding gaps that exist, including but not limited to administration, scheduling, recruitment, and retention of skilled home health care workers;
- Conduct a review of the relative costs of service delivery in different geographic areas and the potential impacts on funding; and
- To ensure the availability of funds to deliver training, continuing education, and appropriate clinical oversight, including occupational work and safety and dementia education care in order to ensure all activities required by the health authorities are fully funded.

THEME II: INVESTMENTS IN SENIORS

[45] A. Martin-Matthews and J. Sims-Gould, BC home support worker study: Summary report, Department of Sociology, University of British Columbia: Nexus Home Care Research, 2008. Available from www.nexus homecare.arts.ub.ca.
[46] I.U. Zeytinoglu, M. Denton, S. Webband J. Lian. Self reported musculoskeletal disorders among visiting and office home care workers, Women and Health 31 (2000).
[47] WorkSafeBC, 2016. Classification Unity 766066 Community Health Support Services. Accessed May 2, 2017.

Increase access to home health care to ensure the needs of seniors are being met.

A. Short Home Health Visit Times

One of the major issues that has been identified by BCCPA members in home health care is the inadequate time that is available for workers to provide the necessary care to their clients. This is highlighted in a recent OSA survey which shows that only 68 per cent of Vancouver Coastal Health clients report that their workers have enough time to provide all prescribed services. In particular, 13 per cent of clients in this region report their workers rarely or never have enough time, which is more than double the rate for the Fraser Health region. [48]

As outlined earlier, the current funding model of BC's home care and support sector is not sustainable and struggles to deliver consistent high-quality care, despite the best effort of publicly-subsidized home health care providers. Inadequate funding to meet the demand for services, has also resulted in a steady reduction in time spent with each client.

Currently, home support visits are often as short as 15 minutes. As outlined earlier, 15 minute visits generally happen in cluster care situations (i.e. congregate building settings and cluster neighborhoods). Even a six-block radius circle in Point Grey, Vancouver can be deemed a "cluster", which can make it difficult to meet the needs of all clients. In community care (non-cluster), visits are a minimum of 20 minutes and the visit is generally funded at 30 minutes, 10 of which is allocated for travel.[49] Since housekeeping tasks are no longer funded at all, it means community health workers must do personal care as well as complex delegated nursing tasks in very short periods of time.

With such short visit times, BC residents are not being provided with the high-quality care intended by government in the delivery of home health care. As visits get shorter, client satisfaction also drops. As satisfaction declines it can result in funding cuts to providers, even though it is often due to causes beyond the control of operators. As outlined in the OSA 2016 Home Support Survey Report, it shows that in many jurisdictions in BC, clients do not feel that their workers have adequate time to deliver the needed care. [50] Client satisfaction, for example, is one of the Health Authority (HA) performance-based funding metrics and providers may have their hourly rate cut if satisfaction rates do not hit the set targets. Client satisfaction may also be influenced by parameters set by the HA, such as which services they are eligible for.

As discussed earlier, many visits are very short (less than 30 minutes depending on the task) to maximize the number of clients that can be served on each shift. Short visit times also affect continuity of care (consistency of care) which may impact quality of care. Continuity makes it possible for workers to build a relationship with their client and monitor as well as report on any changes in their health status.[51]

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[48] BC Office of the Seniors Advocate. Listening to your voice: Home support survey results. September 2016. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

[49] 10 minutes of every visit has historically always been allocated to travel as a mechanism to have paid travel time funded without addition administration. This has been the Health Authority endorsed practice for decades.

[50] Listening to your voice: Home support survey results released. September 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

[51] Canadian Centre for Policy Alternatives. Cohen et al. (2006). From Support to Isolation: The High Cost of BC's Declining Home Support Services. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/bc_2006/support_to_isolation.pdf

Continuity is even more difficult to achieve with rotating short-term schedules and a high proportion of casual workers.[52]

As outlined in a 2018 report by the Ontario Home Care Association (OHCA), a 15-minute visit also means that professional caregivers can do little more than ensure a patient has taken their medication or has their immediate medical need met but does not provide adequate time to discuss their overall health, or any new issues that could be addressed early and possibly prevent hospital readmission.[53] This shift towards shorter visits has also been detrimental to the quality of work life for community health workers. As such, the OHCA in their 2018 report has also recommended ending the practice of 15 minute visits.

National and International Scan

Like BC, other jurisdictions are also facing the issue of short home health care visits. In Ontario, while there is no publicly available provincial guideline, some regions such as Ottawa, have maximum visits which are closer to an hour on average. In the Ottawa region, however, many workers say their client visits are being reduced from 60 minutes to 45 minutes due to travel and are in some cases as low as 15 minutes.

While no specific provincial guidelines exist on minimum visit times some areas such as the Saskatoon Health Region have developed guidelines with respect to length for each service such as bathing (30 minutes), morning care (30 minutes), home care (15 minutes) and toileting (15 minutes).[54] The table below also outlines the approach the United Kingdom has taken to deal with this issue including the implementation of the following guideline to increase home care visits to at least 30 minutes.

Table 3: United Kingdom – Case Study on Home Care Visit Times
In 2015, the United Kingdom (UK) ordered an end to 15-minute home care visits, after a series of investigations found elderly people being forced to choose between bathing or feeding, under "clock-watching" practices by councils. New draft guidance from the National Institute of Health and Care Excellence (NICE) now says care workers must stay at least half an hour if they are providing personal help, such as dressing or feeding. The new NICE guidance states visits shorter than 30 minutes should only be allowed if they are fulfilling "specific, time limited" functions such as establishing medicine has been taken, or checking a person's welfare.[55] In particular, home care visits shorter than half an hour should only be made if the home care worker is known to the person and the visit is part of a wider package of support and the purpose of the visit can be properly undertaken in that time.[56]

[52] Integrated Care Advocacy Group and the BC Health Coalition. Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system. May 2015. Accessed at: http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20To%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20%20new%20appendixA.pdf

[53] Ontario Home Care Association. More Home Care for Me and You: Preparing Ontario's Home Care System for the Challenges of Tomorrow. January 2018. Accessed at: http://www.homecareontario.ca/docs/default-source/position-papers/home-care-ontario-more-home-care-for-me-and-you-january-24-2018.pdf?sfvrsn=10

[54] Saskatoon Health Region. Home care service guidelines. Revised May 17, 2017.

[55] Ministers pledge an end to 15-minute elderly home care visits. Laura Donnelly. March 5, 2015. Accessed at http://www.telegraph.co.uk/news/health/news/11449948/Ministers-pledge-an-end-to-15-minute-elderly-care-visits.html

[56] Most care home visits should be at least half an hour. NICE. March 12, 2015. Accessed at http://www.nice.org.uk/news/articles/most-home-care-visits-should-be-at-least-half-an-hour

As outlined by NICE, one of the recommendations is that the National Health Service (NHS) commissioners ensure that home care workers be given enough time to do their job without being rushed or compromising the dignity of the person who uses services. This includes having enough time to talk to the person and their carer, and adequate travel time between appointments. [57]

As seen in the UK, and as recommended in the BCCPA paper *Strengthening Seniors Care* (2017), BC Health Authorities should consider increasing the minimum home care and support visit times from 15 to at least 30 minutes. The BCCPA would suggest that, like the UK guidelines, directives be developed to help ensure that this becomes a reality. Funding to ensure this occurs is also critical. In the 2017 BCCPA paper, it was recommended that a portion of the $230 million advocated to increase staffing levels in the continuing care sector go towards increasing home visit times. [58]

The BCCPA believes such investments would go a long way to also increase the overall number of home health hours provided and supporting BC seniors. Along with ensuring care needs are appropriately met it could also significantly improve quality of life and reduce social isolation while also better ensuring the dignity of seniors living at home (see Theme IV on *Investments in Quality*).

Other governments in Canada have also recently outlined their intention to increase such hours including most recently Ontario's October 2017 announcement that it would be strengthening home and community care across the province for patients and their families, by increasing access to services by an estimated 2.6 million additional hours and developing new patient-friendly supports.[59] This includes 1.5 million additional hours of personal support services (i.e. bathing, dressing and exercising).

For this paper, the BCCPA recommends that $50 million in annual funding should be provided to increase the minimum home care and support visit times to ensure the care needs of the client receiving care are appropriately met. In particular, the BCCPA would like to see a move towards at a minimum of 30 minutes across the home health care sector, particularly increasing from 15 minutes to an average of 30 minutes in cluster care settings and from 30 to 60 minutes in community care settings (non-cluster care settings). This investment in seniors would positively impact the quality of the client and worker care experience by ensuring adequate care time per client. In addition, it would fundamentally support the long term sustainability of home support.

RECOMMENDATION 3:

[57] UK Telegraph. Around 16, 000 people still receiving 'flying visits' by carers despite Government's minimum standard. January 10, 2017. Accessed at http://www.telegraph.co.uk/2017/01/10/around-16000-people-still-receiving-flying-visits-carers-despite/. This article notes that more than a fifth of councils in England are still commissioning 15-minute social care visits, despite the Government agreeing half an hour should be the minimum standard.

[58] BCCPA. Strengthening Seniors Care: A Made-in-BC Roadmap. January 2017. Accessed at: http://bccare.ca/wp-content/uploads/2017/01/BCCPA_Roadmap_Full_Jan2017.pdf

[59] Ontario Ministry of Health and Long Term Care. Ontario Boosting Nursing, Personal Support in Major Expansion of Home Care. October 5, 2017. Accessed at: https://news.ontario.ca/mohltc/en/2017/10/ontario-boosting-nursing-personal-support-in-major-expansion-of-home-care.html. The 2.6 million additional hours includes: 1.5 million additional hours of personal support services, which includes help with bathing, dressing and exercising; 390,000 additional hours of nursing care, which includes one-on-one care from a nurse for services such as palliative care, wound care and dressing changes; 110,000 additional hours of therapy, which includes speech and language therapy, occupational therapy and physiotherapy services; and 600,000 additional hours of respite services for caregivers, such as personal support or nursing, so that they can schedule breaks for rest, family commitments or other priorities.

That the Health Authorities increase the minimum home care and home support visit times from:

- 15 minutes to an average of 30 minutes (in cluster care settings).
- 30 minutes to 60 minutes (in community care settings).

B. Annual Preventative Home Health Care Visits

Along with guidelines to ensure longer home health care visits, other jurisdictions have responded by mandating pro-active or preventative visits to seniors. Denmark's Ministry of Social Affairs, for example, passed a law in 1998 obliging municipalities to offer professionally delivered home visits twice a year to all citizens 75 and older. One of the reasons for this is that older and frail people often wait too long to ask for care or are unaware these services exist, by which point their health has severely declined. As noted in the literature, these preventative home health care visits serve multiple purposes including:

- Initiate contact or facilitate encounters with older persons who may not request medical attention as expeditiously as they should to increase their overall health and well-being;
- Help older people with the aim of remaining well and independent for as long as possible;
- Seek to avoid or prevent functional decline;
- Identify safety issues in the home to prevent such things as falls;
- Raise awareness of community services and programs; and
- Facilitate adjustment of home care arrangements a needed.

Denmark has found that these visits quite successful as seen by the reduction in hospital admissions by 19 per cent, while admissions to long term care homes declined by 31 per cent.[60] In 2015, this Danish program was modified slightly as municipalities were required to offer at least one preventative home care visits to seniors once they reach 75 years and at least one visit per year for seniors 80 or older.[61] In the Danish program, nurses with specialized training particularly in preventative health are largely responsible for providing such visits. While the percentage of seniors receiving home support in Denmark has increased, overall health spending on seniors over 80 has decreased. This reduction appears to be the result of funds being diverted from institutional care to a more cost-effective home support program.[62]

BC should also establish similar guidelines that encourage the health authorities to offer free of charge home health care visits at least once a year by a professional to all citizens aged 75 and older on a proactive basis (i.e. before they are requested), in order to prevent pre-mature frailty and ensure that seniors are provided with the necessary care as soon as possible. Likewise, the BCCPA suggests that annual funding of at least $8 million per year should be provided to support such visits including funding for a public awareness campaign as well as for appropriate education and training for those delivering such services. As also outlined in the 2012 Ombudsperson report, approximately 70 per cent of seniors over 80 in British Columbia have never been assessed for home and community care services.

[60] Home Care in Canada: From the Margins to the Mainstream. Canadian Health Care Association. 2009. Accessed at http://www.healthcarecan.ca/wp-content/uploads/2012/11/Home_Care_in_Canada_From_the_Margins_to_the_Mainstream_web.pdf
[61] Eva Pedersen. The Ideal Home Care Model: Experience from Denmark. Presentation to the Alberta Continuing Care Association. IQ 2107 Conference: A World of Caring. September 27, 2017.
[62] BC Ombudsperson. The Best of Care: Getting it Right for Seniors in British Columbia (Part 2). February 2012. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf

While many of these seniors may be in good health, others may have care needs that could qualify for assistance and support. [63]

RECOMMENDATION 4:
That the BC Ministry of Health develop provincial guidelines in coordination with a public awareness campaign whereby the province funds or offers preventative home health care visits to people 75 and older on a proactive basis (i.e. before they are requested), in order to prevent pre-mature frailty and ensure that seniors are provided with the necessary care as soon as possible.

THEME III: FOSTERING INNOVATION

Support the adoption of province-wide home health care models which ensure appropriate use of health resources and promote choice.

Considering the continued increase in service demand and an aging population, home health care is a crucial component for the effective functioning of the BC health system.[64] One of the biggest factors, however, contributing to dissatisfaction with home health care is its design. While publicly funded home care was first tried as a pilot nearly 50 years ago, its design has not evolved to reflect the increasingly complex and chronic patients who need care in the home. [65]

Improving satisfaction as well as meeting the increased need and demand for home health care will not only require increased investments but also looking at new care models that can support seniors to live and remain at home longer until going into other care settings such as assisted living, long term or end of life care.[66] This is particularly critical as one of the priorities outlined by the BC Ministry of Health is to enable more seniors to live at home. These models should also focus at least in part on reducing pressures in the health system particularly acute care and alternate level of care (ALC) days, as well as better integrating home health care with other areas of the health system and improving access to end of life and palliative care.[67]

A. Innovative Home Health Care Models

As described below, the models or approaches outlined in this paper focus on the four following areas:

- Reducing acute care pressures including ALC days;
- Better integrating home health and acute care, including hospital at home;
- Better integrating home health and long term care; and

[63] BC Ombudsperson. The Best of Care: Getting it Right for Seniors in British Columbia (Part 2). February 2012. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf
[64] Accreditation Canada and Canadian Home Care Association. Home Care in Canada: Advancing Quality Improvement and Integrated Care. May 2015. Accessed at: https://www.accreditation.ca/sites/default/files/home-care-in-canada-report.pdf
[65] Healthy Debate. Are home care complaints being heard? March 16, 2017. Karen Palmer et al. Accessed at: http://healthydebate.ca/2017/03/topic/ccac-home-care-complaints
[66] As noted by the BC Seniors Advocate, the majority of seniors in BC are living independently (93%), including approximately 80% who own their own home. In total, less than 2% of seniors in BC live in provincially subsidized Assisted Living setting, while 4% live in long term care.
[67] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

- Improving access to end of life / palliative care at home.

1. Reducing Alternate Level of Care (ALC) Days

A critical reason to increased home health care is to reduce the pressures faced in the costlier acute and emergency care system, including reducing the number of people who no longer require acute care, but who continue to occupy a hospital bed because they are unable to access home and community care services (commonly referred to as ALC beds). In BC, the cost of treating a senior in hospital ranges from $825 to $1,968 per day, whereas the cost of long term care is approximately $200 per day.[68] Depending on services needed, the costs can be less for home care at less than $50 per day.[69] As outlined in a 2018 report by the OHCA, the average cost of one week of care for seniors in hospitals is 20 times more expensive than the same services provided through home care.[70]

Research has shown that home care and home support services can prevent admission to hospitals and long term care homes as well as improve clinical outcomes. A 2008 study by Professor Markle-Reid and colleagues from McMaster University demonstrated the pivotal role of unregulated home support services in preventing, delaying, or substituting for admission to care homes, at a lower cost. Markle-Reid's work also shows that for a sizeable proportion of people age 75 and older, minimal levels of home support services are associated with improvements in health and related quality of life.[71]

As outlined in an August 2011 OHCA report entitled *Home Care is the Future*, research indicates that a substantial portion of ALC patients waiting for long term care placement in acute and complex care hospitals may be more appropriately cared for in community with intensive and targeted home care services or with supportive living options. A transitional care has an important role in returning ALC patients back to their community setting.[72]

Home support is particularly important for ALC patients who are discharged home, as many of them are still vulnerable and require varying levels of assistance. If appropriate supports for patients and caregivers are not available when patients are discharged home, then patients may be at higher risk for readmission to hospital or for requiring more extensive care in long term homes at an earlier stage. Clients are often discharged directly from the acute care setting to the home setting to minimize hospital length of stay.

In 2016/17, the proportion of total ALC days in BC was 16 per cent for patients aged 65 to 84, and 26 per cent for those aged 85 or older. This rate was higher for the 85 or older population in all health authorities with the longest in the Northern Health Authority (NHA) where half of all hospital days were ALC days.[73] About one-half of ALC patients in BC are awaiting discharge into long term care, while others

[68] Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf

[69] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

[70] Ontario Home Care Association. More Home Care for Me and You: Preparing Ontario's Home Care System for the Challenges of Tomorrow. January 2018. Accessed at: http://www.homecareontario.ca/docs/default-source/position-papers/home-care-ontario-more-home-care-for-me-and-you-january-24-2018.pdf?sfvrsn=10

[71] Ontario Homecare Association. OHCA Submission to Drummond. October 2011. Accessed at: http://www.homecareontario.ca/docs/default-source/ohca-submissions/drummond-submission-2011.pdf?sfvrsn=6

[72] Ontario Home Care Association. Home Care is the Future: Supporting Seniors to remain at home. August 2011. Accessed at: http://homecareontario.ca/docs/default-source/position-papers/home-care-is-the-future---supporting-seniors-to-remain-at-home.pdf

[73] BC Office of the Seniors Advocate. December 2017. Monitoring Seniors' Services 2017 http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf

are waiting for home care, assisted living, rehabilitation or are residing in acute care due to an inefficient transfer processes.[74]

As outlined in the 2015 BCCPA Quality Innovation Collaboration paper, a 50 per cent reduction in ALC days could generate significant cost savings to the health system. For example, assuming 50 per cent of ALC days could be reduced by caring for patients in long term care homes (average daily cost of $200) instead of in a hospital (average daily cost of $1,200) it could generate over $200 million in annual cost savings.[75] The savings would be even greater if able to care for patients at home. [76]

As such, the BCCPA believes that new approaches and funding models should be explored further to reduce ALC rates. The BCCPA has advocated that the Health Authorities and Ministry of Health better utilize the existing capacity and expertise amongst non-government care operators. The BCCPA has also recommended the creation of a new publicly accessible online registry to report on ALC and vacant long term care beds, as well as the use of current vacant beds within long term care homes, assisted living units, and home support to reduce acute care pressures.

Given the significance of the ALC issue, in the BCCPA paper *Strengthening Seniors Care* (2017), it was recommended that the BC Ministry of Health set as a target by the year 2021 to have no more than 5 per cent of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate long term care or home care setting. To support this goal and reduce ALC rates new funding models will need to be explored that attempt to better integrate home health care and acute care together such as the BC's 'Home is Best' and the Integrated Comprehensive Care Program in Ontario as discussed below. Such models, for example, are also better designed to achieve person-centred care outcomes including keeping patients out of hospital and reducing readmissions to hospital.

1.1 Home Is Best (reducing repeat hospital admissions and ALC Days)

Under BC's 'Home is Best' program, in-home care is provided to individuals with the goal to keep people out of acute and long term care as well as to help seniors live safely at home and avoid future hospital emergency admissions. It embraces three fundamental components: 1) Home care integration with primary care; 2) Enhanced home and community programming; and 3) Strengthened acute care linkages. The main tenet is that the health care team can keep people safe at home and/or return them home from hospital as soon as they are ready. By partnering with family doctors and other health care professionals, more in-depth care can be provided, and attention placed on the client's full range of health care needs.[77]

The philosophy states that home, not hospital or long term care, is the best place to recover from an illness or injury, manage long term conditions and live out final days. Although 'Home is Best' was pioneered by Fraser Health it is now being adopted by other BC Health Authorities.

At a system level, 'Home is Best' is a bundle of system enablers, such as proactive discharge planning, expanded community support services, increased access to home care services, and telephone outreach,

[74] Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. Canadian Health Services Research Foundation. September 2011. Accessed at: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/0666-HC-Report-SUTHERLAND_final.pdf

[75] Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC. BC Care Providers Association. September 2015. Accessed at: http://www.bccare.ca/wp-content/uploads/BCCPA-White-Paper-QuIC-FINAL-2015.pdf

[76] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

[77] Canadian Home Care Association. Integrated Models of Care. Developing an Integrated Primary and Home & Community Care System. Accessed at: http://www.cdnhomecare.ca/media.php?mid=4717. November 2016.

that will help seniors stay healthy in their homes for longer, return home after a hospital stay as soon as possible, and prevent or delay admission to hospital or long term care until necessary. [78]

In March 2013, the BC government as part of an annual funding announcement of $50 million over the next three years for targeted primary and community care programs noted that the 'Home is Best' Program would be rolled out in all five Health Authorities. This program has had some positive impact with fewer admissions to acute and long term care. In Vancouver Coastal, the program resulted in a 30 per cent decrease in acute care use and a 25 per cent reduction in emergency department visits.[79]

While there have been benefits to the 'Home is Best' model, ultimately it needs to be funded at higher rates to be sustainable. That unfortunately is not the case.

2. Integrating home health and acute care

Integrating home health care and acute care should be a goal in the development of any new models. The proposed two models to accomplish this that are outlined below include Ontario's *Integrated Comprehensive Care Program* (i.e. Bundled Care) and *Hospital at Home* which has been largely only trialed in the United States.

2.1 Integrated Comprehensive Care Program (ICC)

The Integrated Comprehensive Care Program (ICC) was undertaken first at St. Joseph's Health System in Ontario. The pilot project ran for a year and integrated case management between hospital and community based care.[80] The idea behind ICC was that after patients undergo surgery and leave to their homes, they would receive access to the same care team on a 24/7 basis, if needed. In order to deliver care services, ICC uses inexpensive technology such as a computer or telephone, so patients can access their care team via skype or phone and maintain an electronic health record.[81] Dedicated care coordinators keep track of complex care patients, from the moment they are admitted to the hospital, to when they are discharged. Using technology to connect with patients ensures that there will be reduced duplication, shorter hospital stays and fewer re-admissions.[82]

Important features of the program include having one contact number, so the patient can direct their needs to one individual on the team, a shared electronic health record, as well as flexibility in communications by using the latest technology to connect and community partner support.[83] Under this model, hospital staff and community workers work as a single team. Nurses, personal support workers, and other professionals making home visits share information regarding client progress on a weekly basis. They treat clients with similar conditions and get training and support from the hospital, so they gain expertise and know, for instance, when a picture of a wound might need to be sent to a care coordinator

[78] Canadian Home Care Association. Integrated Models of Care. Developing an Integrated Primary and Home & Community Care System. Accessed at: http://www.cdnhomecare.ca/media.php?mid=4717. November 2016.
[79] BC Ministry of Health. B.C. continues to expand primary and community care. March 1, 2013. Accessed at: http://www.newsroom.gov.bc.ca/2013/03/bc-continues-to-expand-primary-and-community-care.html
[80] Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home___Community_Care_Released.aspx
[81] Integrated Comprehensive Care Project. Accessed at: http://www.sjhs.ca/integrated-comprehensive-care-project.aspx
[82] St. Mary's General Hospital (2013) Successful model for complex care patients expands to St. Mary's. Accessed at: http://www.smgh.ca/successful-model-for-complex-care-patients-expands-to-st-marys/
[83] Ministry of health and long term care (2013) "Integrated Comprehensive Care Project". Accessed at: http://news.ontario.ca/mohltc/en/2013/09/integrated-comprehensive-care-project.html

for a doctor to review. Each patient also leaves the hospital with a 1-800 number that puts them in touch with a member of the care team who has access to their records.

So far, the project has reduced length of hospital stays by 24 per cent and has seen a 15 per cent drop in hospital re-admissions after surgery.[84] Under this model, a single payment to a team of health care providers is provided to cover care for patients both in the hospital and at home.[85] This initiative, which started over four years ago in Hamilton began as a pilot project that has now been renewed and targets three groups – those undergoing lung-cancer surgery, hip and knee replacements, and those with chronic obstructive pulmonary disease (COPD) or congestive heart failure. The model is being expanded to nine hospitals at 22 sites in the Hamilton area for patients with COPD and congestive heart failure – about 2,400 patients annually. It also is being used in Kitchener-Waterloo by another hospital.[86]

Based in part on the ICC (Bundled Care) project, a 2015 report on home and community care from Ontario recommended that province link funding for home and community care services to the achievement of clearly defined outcomes and results.[87] As noted by the OCHA, by providing bundled funding to achieve outcomes, such as successfully treating a wound or avoiding hospital readmission, rather than paying per visit, the government would ultimately improve patient care and provide space for the innovation that is required to address the needs of an aging population. [88]

2.1 Hospital at Home Model

If faced with a choice to obtain safe, high-quality, hospital-level care in the comfort of one's home during an acute illness versus in the hospital, most older adults would likely opt to receive their care at home.[89] In studies comparing the outcomes of older adults receiving hospital-level care at home for common illnesses versus routine in-hospital care, it has been demonstrated that Hospital at Home patients are less likely to experience clinical complications such as delirium and functional decline, are more likely to be alive at six months, and along with their families are more likely to be satisfied and less stressed with the care they receive, which can cost overall nearly one third less. [90]

In North America, the Hospital at Home model was developed by researchers at the Johns Hopkins University Schools of Medicine and Public Health as an innovative model that sought to provide older adults the opportunity to receive hospital-level care at home as a complete replacement for acute hospital care. After arriving at an emergency department, the model offers eligible older patients, who require hospital admission for certain medical conditions like community-acquired pneumonia, congestive heart failure and chronic obstructive pulmonary disease, dehydration, urinary tract infection,

[84] Ministry of health and long term care (2013) "Ontario Helping More Patients to Benefit from New Model of Care".
[85] Ontario Ministry of Health and Long term care. Ontario Funds Bundled Care Teams to Improve Patient Experience. September 2, 2015. Accessed at: https://news.ontario.ca/mohltc/en/2015/09/ontario-funds-bundled-care-teams-to-improve-patient-experience.html
[86] Program linking hospital staff to home-care workers pays off. Elizabeth Church. Globe and Mail. February 14, 2016. Elizabeth Church. Accessed at: http://www.theglobeandmail.com/news/national/program-linking-hospital-staff-to-home-care-workers-pays-off/article28757453/
[87] Donner, G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., Thomson, D. (2015). Bringing Care Home: Report of the Expert Group on Home and Community Care. Retrieved from: http:// health.gov.on.ca/en/public/programs/lhin/docs/ hcc_report.pdf
[88] Ontario Home Care Association. More Home Care for Me and You: Preparing Ontario's Home Care System for the Challenges of Tomorrow. January 2018. Accessed at: http://www.homecareontario.ca/docs/default-source/position-papers/home-care-ontario-more-home-care-for-me-and-you-january-24-2018.pdf?sfvrsn=10
[89] Leff, B et al. 2005. Hospital at Home: Feasibility and Outcomes of a Program to Provide Hospital-level Care at Home for Acutely Ill Older Patients. *Annals of Internal Medicine.* 143:798-808.
[90] Leff, B et al. 2005. Hospital at Home: Feasibility and Outcomes of a Program to Provide Hospital-level Care at Home for Acutely Ill Older Patients. *Annals of Internal Medicine.* 143:798-808.

deep venous thrombosis and pulmonary embolism, the opportunity to receive their treatment and ongoing care at home.[91]

Not only were better care outcomes realized at lower overall costs, but patients and family members judged the quality of the care provided through the Hospital at Home model to be better than the care provided in an acute hospital.[92] The Hospital at Home Model has four principal components:

1. *Assessment:* clinician determines that the patient has an acute illness that could be treated at home;
2. *Transportation:* patient is transported home with a nurse or physician and any necessary equipment;
3. *Home Care:* the designated nurse remains with the patient and provides the necessary care with the support of an on-call physician and, in conjunction, with the patient's primary care provider; and
4. *Discharge*: the care team, including the patient, family or caregiver, and physician, develop a discharge and follow-up care plan.

In Australia, the State of Victoria has experienced similar results from their Hospital at Home model which has now become an established model of acute care that is highly valued by patients and caregivers, as well as is used to treat a range of conditions. With nearly all state hospitals offering this care, 32,462 patients received care through this model in 2008-09.[93]

In Canada, there have been a few small-scale trials of models substituting acute care services in hospital with acute care being provided in the home. Where they have been trialed, these models appear to vary in the type of clients they serve, the model designs, and resources utilized. Many of these early trials were also not entirely substitution models, so they resulted in the duplication of home care services and were not developed in a sustainable way that could be integrated into the overall health care system.[94]

Like the Hospital at Home model concept, in April 2017, the Winnipeg Regional Health Authority (WRHA) announced that it was planning to launch a new intensive home care service within six months aimed at keeping seniors out of hospitals and care homes. Clients will be able to access up to three months of intensive medical care to stay in their own home after being released from hospital. With a budget of about $8 million for the first year, the program will include physicians and rapid response nurses, but be primarily staffed by health care aides. As noted in one article, jurisdictions in Ontario and Alberta that have brought in a similar model have also found about 70 percent of clients discharged do not need to enter a long term care home.[95]

3. Integration of home care and long term care

Along with models that integrate home health care and acute care it is also important to explore approaches to better integrate areas within the continuing care sector (i.e. home health and long term care). This paper explores two such models namely the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) model in Alberta and the Continuing Care Hub as advocated by the BCCPA. Such

[91] Leff, B et al. 2012. *Hospital Care Is Not Always Best for Older Adults*. Accessed on September 21, 2012 at: http://www.hospitalathome.org/about-us/overview.php.
[92] Leff, B et al. 2012. *Hospital Care Is Not Always Best for Older Adults*. Accessed on September 21, 2012 at: http://www.hospitalathome.org/about-us/overview.php.
[93] Hospital in the Home Society of Australasia. 2011. *Economic Analysis of Hospital in the Home (HITH)*. Kingston, Victoria.
[94] Martin, CM et al. 2004. Acute Hospital Services in the Home: New Role for Modern Primary Health Care? *Canadian Family Physician*. 50: 965-968.
[95] CBC News. WRHA planning to launch new short-term intensive home care. Marianne Klowak. April 18, 2017. Accessed at: http://www.cbc.ca/news/canada/manitoba/gina-trinidad-wrha-enhanced-home-care-service-1.4073048

models like CHOICE, for example, have emerged in Canada and the United States that attempt to better integrate long term and home care by providing recreational activities at an adult day centre, as well as home support and community care services to the elderly.

3.1 Comprehensive Home Options of Integrated Care for the Elderly (CHOICE)

Developed in 1996, the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) program in Edmonton, Alberta has become a recognized delivery model for home care to elderly adults. In partnership with Capital Care and The Good Samaritan Society, the CHOICE program provides adults over the age of 60 options for care at home and at the same time operates itself like a day clinic. The program also offers a variety of services to seniors throughout the week and is run by a multi-disciplinary team of physicians, nurses, pharmacists, dieticians, occupational and physiotherapists and social workers.[96] Under CHOICE, seniors are delivered all basic health services – this includes personal care (bathing, dressing, etc.), dental care, respite care, meals and snacks, medication and home care services.[97]

The program offers care to seniors who have complex long term care issues and live at home. Clients must be willing to change their health care provider and should be able to use transportation provided by the program.[98] Two examples of the CHOICE Program are the independent living complex of the Good Samaritan Place and onsite at the continuing care centre / auxiliary hospital of Dr. Gerald Zetter Care Centre in Edmonton.[99] According to Alberta Health Services, six months after joining the program, all CHOICE clients saw a reduction in emergency visits by 30 per cent.[100]

The CHOICE program in Edmonton was modeled after the Program of All-inclusive Care for the Elderly (PACE). Developed in the early 1970s, the PACE model first emerged in Northern California, where it was co-founded by dentist Dr. William L. Gee, and Social Worker Marie-Louise Ansak.[101] The idea developed to address the needs of elders that had immigrated from Italy, China, and the Philippines whom required continuing care services, to create a "community hub" where seniors medical, emotional and physical needs could all be met in one place. Gee and Ansak formed a non-profit corporation called On Lok Senior Health Services, to provide community care to elders.[102] On Lok Lifeway care providers work in interdisciplinary teams to offer similar services at a specific location or centre.

Similar to the CHOICE program, the PACE model's key features include flexibility (i.e. coordinating care based on individual needs), all-inclusive care preventive, primary, acute and continuing care, interdisciplinary teams, and capitation funding.[103] The PACE program offers community care to seniors aged 55 and up, where CHOICE offers the program to anyone 60 or older. One disadvantage of both the PACE and CHOICE programs are that they do include frailer portions of society, as one of the program requirements is that seniors must be certified by government to require home care.

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[96] DeSantis, B. (2014) "CHOICE Edmonton Day Program: An outlet for social seniors". Senior Care Canada. Accessed at: http://seniorcarecanada.com/articles/choice_edmonton_day_program#sthash.nxuSwoyF.C8bmbATx.dpuf
[97] Hollander Analytical Services Ltd. (2006). Home care program review: Final report. Accessed at: http://www.health.gov.sk.ca/HomeCareReview2006_FinalReport.pdf
[98] Choice© Program. The Good Samaritan Society, accessed at: https://www.gss.org/find-housing-support-services/community-care/choice/
[99] For more information on the Good Samaritan Place & Dr. Gerald Zetter Care Centre, see: https://www.gss.org/find-housing-support-services/community-care/choice/
[100] Alberta Health Services. Accessed at: http://www.albertahealthservices.ca/1362.asp
[101] McGregor Pace. "History of Pace". Accessed at: HTTP://WWW.MCGREGORPACE.ORG/ABOUT/HISTORY/
[102] Wong, J. (2013) "For Chinese Speaking Seniors, Better Service in San Francisco and Toronto". *The Tyee*. Accessed at: http://thetyee.ca/News/2013/04/04/Chinese-Speaking-Seniors/print.html
[103] What is PACE? On Lok PACEpartners, accessed at: http://pacepartners.net/what-is-pace/

3.2 BCCPA Continuing Care Hub model

As initially outlined in the 2015 BCCPA Paper, *Quality-Innovation-Collaboration*, the BCCPA has been advocating for the creation of a new Continuing Care Hub model which could provide seniors currently living in long term care as well as those in the community a broader array of care or quality of life services. The Continuing Care Hub is a network of individual care homes sharing services, specializing in care over a large geographical area but are formally networked in some manner.

In this model, the long term care home or the new Continuing Care Hub, could be a centre for the delivery of a wide range of seniors' services some of which could be co-located within a Campus of Care or managed by a network of care homes. Although not exhaustive, the services that could be delivered include: primary care, chronic disease management, rehabilitation, sub-acute, dialysis, oral care, foot care, adult day/night programs, and satellite specialized geriatric services collaboratively delivered with hospital and community partners.

Overall, one of the key features of a Continuing Care Hub model is the provision of procedures or services that may be commonly performed in alternative care settings such as a hospital or in primary care setting including dialysis, rehabilitation, frailty screening, seniors health promotion, and other potentially non-complicated surgical or treatments. Services would be based on the existing expertise of providers as well as the community needs.

While the provision of expanded services within long term care such as IV, dialysis, rehabilitation and palliative care could be co-located in one physical location such as a Campus of Care it is also possible that such services could be provided by a group of care homes who have decided to work collaboratively to provide such care amongst themselves as part of a cluster or virtual network arrangement. For example, two or more care homes could join within a formal affiliated network to provide services with each providing different types of specialty or other services for seniors. Such a network or affiliated group could also potentially operate within a specific geographical location to provide care for seniors. Some could also operate across Health Authorities provided appropriate arrangements are in place. It is also feasible that Health Authority operated care homes could be part of such a network along with non-government operated care homes.

Likewise, the Continuing Care Hubs could potentially offer care or other quality of life programs (see Theme IV on *Investments in Quality*) to seniors in the community including those receiving home health care. As such the Continuing Care Hub could potentially contract directly with health authorities to provide such services on-site or could potentially contract with health authorities or private home health care operators to provide such services directly in the senior's home or in the community. This includes, for example, Adult Day Programs (ADPs), which as outlined later in this paper are vital to the overall health and well-being of seniors (Theme IV – Investments in Quality). Further details of the Continuing Care Hub model are outlined in Appendix D of this paper.

4. End of Life / Palliative Care at home

In December 2016, the BCCPA released a major report on end of life care with recommendations to assist the BC government in its commitment to double the number of hospice spaces province-wide by 2020. This paper included specific recommendations to better utilize the existing excess capacity in the

continuing care sector to increase capacity with respect to end of life care.[104] While the focus of this paper was on using existing long term care capacity, there is also a potential for greater end of life care to be provided at home.

In British Columbia alone, 53 per cent of the over 30,000 people who die annually do so in hospital.[105] This is despite the fact research indicates that most Canadians would prefer to die at home.[106] Not only it is the preferred option it is also the most cost effective. In fact, a report by the Auditor General of Ontario, estimates that the costs of caring for terminally ill patients in an acute-care hospital is more than double the cost of providing care in a hospice bed and over 10 times more than providing at home. The cost of providing palliative care in the last month of a patient's life averages about:

- $1,100 per day in an acute-care hospital bed;
- $630 to $770 per day in a bed in a palliative-care unit (at the two hospitals visited that tracked this information in a comparable way);
- $460 per day in a hospice bed; and
- Under $100 per day where at-home care is provided.[107]

As also outlined in a report from Health Quality Ontario, people who receive palliative home care are more satisfied with their care, and less likely to go to the emergency department, be admitted to hospital, or die in hospital.[108]

Building on the BCCPA End-of-Life paper (2015) and as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap (2016)*, the BCCPA recommended that the Ministry and Health Authorities invest up to $20 million in annual funding to use existing capacity in long term care particularly using a portion of under-used long term care beds and transitioning them to end of life beds. The BCCPA would also support some of this potential funding to allow for more end of life care to be provided at home.

B. New technologies and home health care models

Earlier this paper recommended a joint committee consisting of the BC Ministry of Health, Health Authorities, and BCCPA be established to deal with the unique and considerable challenges facing the home health care sector including a review of funding levels, unfunded service expectations and travel costs. This Joint Committee on Home Health Care (JCHHC) could also be tasked with looking at new innovative home health models as well as new funding approaches as discussed later in the paper.

The development of new home health care models should also be supported using new and innovative technologies which can improve seniors care and allow seniors to remain in their home. Not only does this include devices such as ceiling lifts it also entails new and existing communication technologies. The use of communication technologies is one area, for example where BC has generally taken the lead

[104] BCCPA. Doubling Hospice & End-Of-Life Bed Capacity in British Columbia By 2020. December 2016. Accessed at: http://bccare.ca/wp-content/uploads/2016/12/BCCPA-EOL-Paper-December-2016.pdf
[105] Statistics Canada. *Table 102-0503 - Deaths, by age and sex, Canada, provinces and territories, annual (2012),* CANSIM (database). (accessed: January 5, 2016)
[106] Donna M. Wilson, Joachim Cohen, Luc Deliens, Jessica A. Hewitt, and Dirk Houttekier. Journal of Palliative Medicine. May 2013, 16(5): 502-508. doi:10.1089/jpm.2012.0262.
[107] Office of the Auditor General of Ontario. Annual Report 2014. Chapter 3.08 Palliative Care. http://www.auditor.on.ca/en/content/annualreports/arreports/en14/308en14.pdf
[108] Healthy Debate. Palliative care access still lacking. Vanessa Milne, Joshua Tepper & Maureen Taylor. May 4, 2017. Accessed at: http://healthydebate.ca/2017/05/topic/palliative-care

particularly with regards to home health monitoring. In June of 2016, for example, the BC Ministry of Health announced that funding will be reaching up to $52 million for a home health monitoring partnership with TELUS to advance access for British Columbians with complex care needs using technology to help manage their health conditions.[109]

Along with redirecting acute care expenditures, to support the development of home health care models, new federal and provincial funding should be provided. As a start, the federal government plans to provide targeted funding of $6 billion over 10 years to provinces and territories to improve access to home care services.[110] BC's portion of the new Health Accord monies includes $1.4 billion over the next ten years, with $785.7 million directed to address the needs of our rapidly aging population.[111]

As such, the BCCPA suggests that potentially as part of the new federal funds, the BC government provide $20 million in annual funding over four years to support the adoption of new home health care models province-wide to allow seniors to remain at home longer as well as reduce ALC days and improve overall quality care by focusing models that: advance the hospital at home model (i.e. WHRA Intensive Home Care Program); better integrate home health and long term care (i.e. CHOICE and Continuing Care Hubs); better integrate home health and acute care (i.e. Bundled Care); and support greater end of life care at home. Where feasible these models should be supported by new technologies that can improve seniors care and allow seniors to remain in their home.

RECOMMENDATION 5:
That the Ministry of Health and all partners support the adoption of new home health care models province-wide, to allow seniors to remain at home longer as well as reduce alternate level of care (ALC) days and improve overall quality care. These models may include: the hospital at home model; better integrating home health and long term care; better integrating home health and acute care; and supporting greater end of life care at home.

C. Care Credits: New Funding Approaches for Home Health Care

Along with development of care models this next section of the paper examines the potential for new innovative funding approaches to home health care particularly personal directed care or the use of care credits – a concept explored in detail in the 2017 BCCPA paper entitled *Strengthening Seniors Care*.

Care Credits

Based on available information, the BCCPA believes the use of care credits (or commonly referred to as vouchers) should be explored further for adoption. As outlined below, mitigating drawbacks such as cream skimming and increasing prices for services will also need to be looked at further if such a model of funding is adopted on a wide scale.

[109] BC Ministry of Health. Home health monitoring: Improving health care through technology. June 6, 2016. Accessed at: https://news.gov.bc.ca/releases/2016HLTH0043-000933
[110] Government of Canada. Minister Philpott highlights significant investments to improve access to home care. April 11, 2017. Accessed at: https://www.canada.ca/en/health-canada/news/2017/04/minister_philpotthighlightssignificantinvestmentstoimproveaccess.html
[111] BCCPA. Media Release: New Federal Health Accord Will Benefit BC's Seniors. February 17, 2017. Accessed at: http://bccare.ca/2017/02/media-release-new-federal-health-accord-will-benefit-bcs-seniors/

In Canada – in contrast to countries such as France, Germany, Sweden, Finland, and Denmark – the provision of subsidized continuing care services is provided in-kind or directly by government as opposed to using vouchers or personal directed care funding approaches. Client co-payments for both home care and long term care services are also fixed, and the provincial government pays the residual costs of services supplied to subsidized clients.[112]

As outlined in a 2012 C.D. Howe report, new funding models, such as vouchers (or care credits), are intended to be more reactive to clients' needs by enhancing ability of people to stay in their homes for as long as possible. In particular, financial and service flows for funding continuing care in France and Nordic countries are intended to give clients a greater say over their path of care. [113] Instead of acting as the agent that pays for continuing care on behalf of recipients, government provides needs and risk-adjusted transfers to clients with which they can purchase services from a variety of potential providers. While governments in these countries still play a critical role in regulating providers and ensuring they meet a minimum quality of care, they no longer contract with providers, who now engage clients directly. [114]

The trend in many advanced countries toward the use of care credits rather than providing services was motivated in part by the belief that more choice for clients and competition among providers would lead to efficiency gains in the system and promote greater independence. The available evidence so far is not clear as to whether these efficiency gains have materialized, although providing greater choice generally has seemed to increase the reported satisfaction of clients. As noted in one study although many clients who were receiving cash or voucher transfers were not aware of the choices available to them and very few reported switching from one provider to another, they nevertheless appear to have valued being involved in decisions about their care, especially when also required to pay significant private costs. [115]

Although there are potential benefits of vouchers (or care credits), they do have possible drawbacks. One concern is that providers will seek out clients with low-care needs relative to costs (i.e. cream-skimming problem). Another concern is the increased difficulty of governments to exercise a high level of control over their annual health budgets. Furthermore, under a voucher or care credit system, providers could increase the prices of their services knowing that the government subsidizes the cost for the individuals with the lowest ability to pay. A final potential challenge of such a system is that the size of the care credit or public subsidy, needs to change over time to reflect a client's needs. [116]

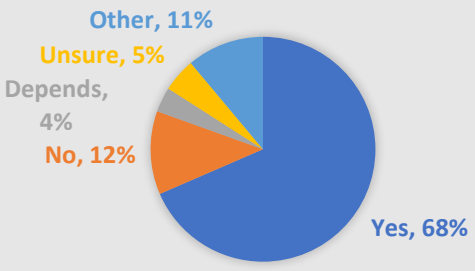
As noted by authors Blomqvist and Busby, establishing a new comprehensive self-directed model such as the use of a voucher would require the following: an assessment system; means testing; a funding mechanism that is based on need but controls government costs; an oversight system to ensure quality and enforce restrictions on use; and establishing who will oversee, coordinate and be accountable. [117] Some of the pros and cons of this funding approach are summarized in the table below.

[112] Long term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_367_0.pdf
[113] Ibid.
[114] Ibid.
[115] Ibid.
[116] Long term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012. Long term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_367_0.pdf
[117] CD Howe Institute. Commentary No. 443. January 2016. Ake Blomqvist and Colin Busby. Shifting Towards Autonomy: A Continuing Care Model for Canada. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_443.pdf

Table 4: Pros and Cons of Care Credits / Vouchers	
Pros	Cons
• Are intended to be more reactive to clients' needs by enhancing the ability of people to stay in their homes rather than in long term care homes for as long as possible. • Increases client satisfaction and empowerment as well as gives clients a greater choice and say over their path of care. • More choice for clients and competition among providers could lead to efficiency gains in the system and promote independence. • Has been implemented with relative success in other jurisdictions (i.e. Nordic countries, France, Germany, Australia, etc.).	• Not clear as to whether efficiency gained • Administrative costs to implement a voucher system, including adjusting the size of the voucher, or public subsidy, to change over time with a client's needs. • Providers may seek out clients with low-care needs relative to costs (i.e. cream-skimming). • Providers could increase the prices of their services knowing that the government subsidizes the cost for the individuals with the lowest ability to pay. • Could decrease governments ability to exercise a high level of control over their annual health budgets.

As part of an earlier BCCPA survey, respondents were asked if they would support the use of vouchers or care credits for seniors to purchase directly continuing care support services. As outlined in the following Figure 3 below, the proposal received good support, with 68 per cent of respondents felt favorably towards care credits, and an additional 4 per cent indicating depends. Similar support was seen at the 2016 BCCPA Inaugural Continuing Care Collaborative event with over 70 per cent support.

Figure 3: Do you think seniors should be able to choose their own long term care or Home Support Provider through the allocation of "Care Credits" – i.e. a government subsidized voucher for seniors care services?



N = 731

Based on the above results and as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap* (2017) the BCCPA recommended the BC government allocate up to $2 million per year to launch a new Care Credits program which provides seniors, or their family carers, the option to select the service provider of their choice. In particular, it was recommended that a Care Credit or Personal Directed Care model should be introduced initially in the home care sector as well as to study further its use in long term care including a possible pilot project.

As also outlined in *Strengthening Seniors Care*, this study should also analyze best practices from Community Living BC (CLBC) which offers their clients direct opportunities to select the care provider of their choice. CLBC's Individualized Funding program assists people with disabilities to participate in activities and live in their community by allowing individuals (and their families) to access services from a provider of their choice.[118] CLBC provides two different options to manage funds. In the first option, the client and an identified agent (e.g. a chosen friend, family member or other representative who can act responsibility) manage the funds directly, pay the employees, and report to CLBC on how they spend the money. The second option is to work with a Host Agency that has been approved by CLBC to administer the money; this option gives the client the benefits of Individualized Funding, but with fewer paperwork and record-keeping responsibilities.[119]

While countries like Australia (see Appendix E for further details) have implemented care credit programs with some success, other Canadian jurisdictions are also exploring the further use of person-directed care approaches. In October of 2017 the Ontario government, for example, announced that along with increasing access and hours to home care it would be implementing new, innovative self-directed care models to provide eligible clients and caregivers with more control over their care including the establishment of a new personal support services organization in early 2018. [120]

RECOMMENDATION 6:
That the BC government explore further the appropriateness or feasibility of the care credit model including its limited phased introduction in the home health and long term care sectors.

[118] The program operates through a five-step process. Once eligibility for the program is confirmed, individualized funding is allocated based on the client's assessed need and the estimated costs of the supports required. CLBC then works with the client to identify, review, and then finally select a qualified service provider based on the person's preferences. Finally, CLBC works with the client and providers to arrange services and to create a contract that ensures quality standards and reasonable costs.

[119] Community Living BC, Individualized Funding, CLBC Fact Sheet. Accessed at: http://www.communitylivingbc.ca/wp-content/uploads/Individualized-Funding-Fact-Sheet.pdf

[120] Ontario Ministry of Health and Long term Care. Ontario Boosting Nursing, Personal Support in Major Expansion of Home Care. October 5, 2017. Accessed at: https://news.ontario.ca/mohltc/en/2017/10/ontario-boosting-nursing-personal-support-in-major-expansion-of-home-care.html. The 2.6 million additional hours includes: 1.5 million additional hours of personal support services, which includes help with bathing, dressing and exercising; 390,000 additional hours of nursing care, which includes one-on-one care from a nurse for services such as palliative care, wound care and dressing changes; 110,000 additional hours of therapy, which includes speech and language therapy, occupational therapy and physiotherapy services; and 600,000 additional hours of respite services for caregivers, such as personal support or nursing, so that they can schedule breaks for rest, family commitments or other priorities.

THEME IV: INVESTMENTS IN QUALITY

Provide funding for programs which increase quality of life and quality of service in the home health care sector.

While improving staffing levels and increasing home visit times, as discussed earlier, will enhance seniors care over the long term, further initiatives will need to be undertaken to improve the overall quality of life for seniors in long term care and living at home. Today's seniors face critical challenges such as having multiple chronic conditions, increasing levels of dementia and mental health concerns, high rates of falls, as well as escalating levels of social isolation and depression. These are detrimental to quality of life and strategies to address these areas will be critical going forward.

As over twenty-five per cent of BC's population will be 65 years or older by 2036, it is clear the current health system is not prepared to meet the challenges of an aging population, including managing the rising number of mental health and chronic diseases. As discussed in previous BCCPA papers, the health system is still largely acute care oriented and not optimally designed to provide care for those with ongoing care needs, such as chronically ill or frail elderly.[121]

The BC Office of the Seniors Advocate (OSA), for example, has addressed some of these issues in a report highlighting the need for greater supports in the community particularly Adult Day Programs (ADPs). A 2015 OSA report, notes that ADPs provide important benefits to both clients and their informal caregivers, yet they face a number of challenges and limitations. In particular, the OSA indicates that the capacity of ADPs in BC has not kept pace with the aging demographics. The report indicates that in real terms, the number of ADP clients decreased 20 per cent, and the number of days utilized had decreased 18 per cent between 2011 and 2014.[122] Since 2015/16, there has also been an 8 per cent decrease in the number of funded ADP days offered and a 4 per cent decrease in clients. [123]

Like the OSA, the BCCPA believes ADPs are vital to the overall health and well-being of seniors. As such they should be one of key areas of a Seniors Quality of Life Fund as outlined in detail below.

A. SENIORS QUALITY OF LIFE FUND (SQLF)

Quality of life refers to activities that take place beyond basic shelter, food, and medical needs. These activities enrich lives and have been proven to improve the mental and physical health, as well as the productive longevity, of participants.[124] To help meet these goals and address the aforementioned gaps in quality of life programming, the BCCPA has previously recommended new funding for the creation of a *Seniors Quality of Life Fund* (SQLF) to support quality of life for seniors, focusing on person-centered care that improves their physical, spiritual, mental, and psychosocial well-being.

The SQLF would also address some of the challenges seniors face in receiving culturally appropriate care and appropriate supports including Recreational Therapy (RT), Occupational Therapy (OT) and Physical

[121] National Health Leadership Conference. The Great Canadian Healthcare Debate. Issue Briefs: Top 5 motions. Second Edition. June 2016. Accessed at: http://www.nhlc-cnls.ca/assets/2016%20Ottawa/E- Issues%20Brief%20Booklet.pdf
[122] BC Office of the Seniors Advocate. Caregivers in distress: More respite needed. September 2015. Accessed at: http://www.seniorsadvocatebc.ca/wp- content/uploads/sites/4/2015/09/CaregiversReport.pdf
[123] BC Office of the Seniors Advocate. December 2017. *Monitoring Seniors' Services 2017* http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf
[124] Measured Outcome. Wellness & Quality-of-life Programs for Low-income Seniors. Rebecca Thomas. 2017. Accessed at: http://measuredoutcome.org/wp-content/uploads/2017/03/MO_Seniors-Wellness-Programs_Updated-Version_WEB.pdf

Therapy (PT). Additional areas that should also be addressed as part of any intervention to improve the quality of life include increasing the number of, and access to ADPs, and other initiatives to deal with issues of seniors' isolation.

According to a 2012 study of the National Academy of Sciences, social isolation and loneliness are associated with a higher risk of mortality in older adults.[125] One study, for example, notes isolation is as strong a factor in early death as smoking 15 cigarettes a day,[126] while another notes it can be twice as unhealthy as obesity, increasing chances of early death by 14 per cent.[127]

While a review of all the relevant research to improve seniors quality of life goes beyond the scope of this paper, the BCCPA has outlined some of this in its 2017 paper *Strengthening Seniors Care: A Made-in-BC Roadmap*. This 2017 report recommended that the BC government establish a new annual $22 million SQLF for three years to support quality of life for seniors in long term care and in the community. Since the release of that paper, the BCCPA has developed and submitted a more formal proposal to the BC government for a $25 million SQLF, which includes the $22 million proposed fund outlined in *Strengthening Seniors Care* and a $3 million component geared towards specialized province-wide programs. These programs, which would be managed by BCCPA directly, will improve the health and well-being of seniors in BC, such as the *Concerts in Care* and a new pilot program, *Collaborating Artists in Residence (CAiR)*.

As outlined in the latest $25 million proposal, along with providing services to community, the SQLF would provide up to $100 per month per senior living in a non-government operated long term care setting. Up to $22 million per year would be provided to care homes based on the fact there are approximately 18,300 non-government operated care beds that receive public funding.[128]

Care providers would apply for funding based on the number of publicly subsidized beds in their homes and would be eligible to receive funding provided they follow the parameters outlined in the BCCPA SQLF proposal. While the $22 million fund would largely be allocated to long term care operators, care providers applying for funding must demonstrate how the seniors living at home would also benefit. This includes provisions to help increase transportation for seniors to and from the care home to attend programs or receive care including ADPs. Overall, potential benefits of the SQLF include:

- Increasing access to RT, OT, and PT for seniors living at home;
- Increasing access to a broad array of music programs such as Concerts in Care and Sing for Your Life, in the community;
- Reducing seniors' isolation through increased Adult Day and similar programs;
- Reduce the impact on seniors transitioning across the continuum of care;
- Creating a catchment and care hub model that enables care providers to work more collaboratively with each other; and
- Providing care and access to programs that are culturally appropriate.

[125] Social isolation, loneliness, and all-cause mortality in older men and women. Proceedings of the National Academy of Sciences of the United States of America. Andrew Steptoe et al. February 15, 2013. Accessed at: http://www.pnas.org/content/110/15/5797.full
[126] Holt-Lundstedt, J., Smith, T.B., and Layton, B.L. (2010). Social relationships and mortality risk: A meta- analytic review. PLoS Medicine, p. 12. Retrieved from http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316
[127] Loneliness twice as unhealthy as obesity for older people, study finds. The Guardian. Ian Sample. February 16, 2014. Accessed at: http://www.theguardian.com/science/2014/feb/16/loneliness-twice-as-unhealthy-as-obesity-older-people.
[128] According to the March 2016 Facilities report, in BC there were approximately 27,422 residential care beds in BC including 18,338 non-government and 9,084 government operated. To determine SQLF it equates to number of non-government operated care beds (18,338) x $100 x 12 months.

RECOMMENDATION 7:
That a new *Seniors Quality of Life Fund* (SQLF) be established by the BC government with designated funding to support seniors living at home and in congregate settings by: • Increasing access to recreational therapy, occupational therapy, physiotherapy, nutrition, culturally appropriate care, music and art programs; • Reducing seniors' isolation through increased Adult Day and similar programs; and • Enabling care hubs to work more collaboratively with local home health providers.

To support the funding of the new SQLF, along with redirecting acute care expenditures (see Appendix F), new federal funding could be allocated to home care. In particular, the federal government plans to provide targeted funding of $6 billion over 10 years to provinces and territories to improve access to home care services.[129] BC's portion of the new Health Accord monies includes $1.4 billion over the next ten years, with $785.7 million directed to address the needs of our rapidly aging population.[130]

As such the BCCPA suggests that potentially as part of any redirected funding or new federal funds, the BC government provide $25 million annually to establish a SQLF to improve the quality of life and well-being of seniors in the provinces.

B. QUALITY ASSURANCE OF HOME HEALTH CARE IN BC

In BC, Health Authorities hold publicly-contracted providers to a very high set of standards and guidelines. While there is significant oversight and requirements which publicly subsidized home health operators are required to meet as part of contractual arrangements with the Health Authorities, there is very little or no oversight for private, non-subsidized operators. This is outlined in the table below.

Publicly-Subsidized, privately delivered home health care	Privately provided home health care
Accreditation or certification by an approved third party, this includes regular third-party audits performed by an approved quality management system.	Option to seek third-party certification or accreditation but prohibitively expensive and time consuming for small and mid-sized operators.
Compliance with all regulatory standards required under contract. Audited by the Health Authorities.	No regular audits required, as not held to government- imposed regulations.
Required under contract to ensure an appropriate complaint process is in place.	Although some providers will have their own complaint process in place, they are not required to do so.

[129] Government of Canada. Minister Philpott highlights significant investments to improve access to home care. April 11, 2017. Accessed at: https://www.canada.ca/en/health-canada/news/2017/04/minister_philpotthighlightssignificantinvestmentstoimproveaccess.html
[130] BCCPA. Media Release: New Federal Health Accord Will Benefit BC's Seniors. February 17, 2017. Accessed at: http://bccare.ca/2017/02/media-release-new-federal-health-accord-will-benefit-bcs-seniors/

Required under contract to have an incident reporting procedure.	While many larger private providers may have a protocol for incident reporting, none is required.
Operators can only send Community Health Workers who are registered with the BC Care Aide and Community Health Worker Registry to any publicly subsidized client.	Can hire and send any worker, not required to hire from the BC Care Aide and Community Health Worker Registry.
Criminal record check and vulnerable sector check required.	No criminal record check required.
Required under contract to adhere to all Policies and guidelines within the BC Home and Community Care Policy Manual.	Not governed by the policies and guidelines of the BC Home and Community Care Policy Manual.

For seniors and family members who are purchasing services privately, this means that there are limited measures required to ensure quality care, and little recourse should they experience poor care. While the BCCPA does not support excessive regulation, additional guidelines or standards would likely improve the quality of care in the home health care sector. To assist in this process and as outlined in its recently approved Strategic Plan (2017 – 2020), the BCCPA will be exploring the feasibility of developing a voluntary "Quality Assurance Designation" program for home health care operators in 2018. In January 2018 the BCCPA announced the formation of a Working Group that will assist further in exploring the potential development of such a program.[131]

Overall, a Quality Assurance program could have significant benefits, including the creation of standards or guidelines to strengthen the quality of home health care services provided, while minimizing the risk for seniors, and consequences related to excessive regulation. Adequate funding is necessary to assist in the development of this quality assurance model, specifically as it relates to removing barriers for smaller providers to participate in such a program. As such, the BCCPA suggests that $3 million in annual funding be provided to help develop and oversee a BC Quality Assurance model for BC's home health care sector. In particular, such as model should focus on implementing standards to ensure quality across the sector as well as helping seniors and families make informed choices about care.

RECOMMENDATION 8:
Develop a made in BC quality assurance model in the home health care sector, with a focus on implementing standards to ensure quality across the sector, specifically to support agencies providing privately paid services, as well as helping seniors and families make informed choices about care.

[131] BCCPA. BCCPA launches quality assurance in home health project. January 4, 2018. Accessed at: http://bccare.ca/2018/01/bccpa-launches-quality-assurance-home-health-project/

CONCLUSION

As populations in British Columbia and Canada rapidly age, home health care has become an increasingly critical part of the health system. Home health care enables seniors to live in their homes while supporting them to manage their health and maintain their independence and well-being. Home health care is also necessitated by rising health care costs and the need to deliver high quality care.

Home health care has evolved over time by responding to changes that have occurred in the hospital sector (including bed closures as well as increase in ambulatory care clinics and day surgery) and long term care (including wait lists for transitions to long term care and limited availability). As noted by the Canadian Health Care Association (CHCA) the four main reasons behind the increased shift to home health care include:

- People generally prefer to receive care where they live;
- Canada is an aging nation with increasing rates of chronic disease;
- A growing cohort of "digital seniors" combined with new and low-cost technology allows us to offer more care in non-congregate settings; and
- Governments are trying to contain their health care budgets and home care can be delivered at a lower cost.[132]

Given these factors, home health care has emerged with increased importance as an integral component of Canada's health care system and is essential to its sustainability.[133] It also has the potential to be a major force in increasing the cost-effectiveness of the overall health care system. [134]

By 2038, BC's senior population (aged 65 and older) will account for an estimated 24 to 27 per cent of the population, with the proportion of seniors nearly five percent higher than the Canadian average. The Ministry of Health reports that the percentage of BC seniors over 80 years old will grow from 4.4 per cent of the population in 2012 to 7.4 per cent by 2036. At the same time, it is projected that the prevalence of chronic conditions for those 80 or over in BC may increase by 58 per cent within the next 25 years.

In response to an aging population, the total spending on continuing care (including home health and long term care) for seniors is projected to increase from $28.3 billion in 2011 to $177.3 billion in 2046 and spending growth is expected to significantly exceed the pace of revenue growth in most provinces.[135] To ensure the future feasibility of care, shifting delivery to less expensive alternatives – particularly home health care – will be critical.[136]

As outlined earlier in this paper, increasing access to publicly funded home health care services (including home care and support), in ways which are sustainable and innovative, can help seniors maintain their health, live independently and reduce pressure on hospitals. Yet, despite the benefits

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[132] Home Care in Canada: From the Margins to the Mainstream. Canadian Health Care Association. 2009. Accessed at http://www.healthcarecan.ca/wp-content/uploads/2012/11/Home_Care_in_Canada_From_the_Margins_to_the_Mainstream_web.pdf
[133] Home Care Ontario. Accessed at: http://www.homecareontario.ca/public/about/home-care/General/
[134] Synthesis Report: Final Report on the National Evaluation of the Cost-Effectiveness of Home Care, August 2002,pg. xii
[135] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015. The same report estimates that by 2026 over 2.4 million Canadians age 65 and over will require paid and unpaid continuing care support — up 71 per cent from 2011. By 2046, this number will reach nearly 3.3 million.
[136] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

of home health care, recent reports including from the BC Office of the Seniors Advocate (OSA) highlight some of the challenges in the systemic delivery of these necessary services. For example, a 2016 OSA report outlines some of the shortcomings with respect to home support in BC, including:

- The number of seniors in BC are growing at twice the rate of Home Support clients (i.e. number of home support clients in BC increased by 2 per cent over 2013/14, while population aged 75 and over increased by 4 per cent);
- The number of home support hours is trending down in three out of five health authorities, while the number of clients has increased in four out of five (discrepancy greatest in NHA); and
- The average home support hours delivered per year per client decreased by approximately 2 per cent from the previous year, while the number of clients increased by 2 per cent, resulting in fewer hours of care, on average, per client.[137]

These and other challenges are outlined in Parts I and II of this paper, while Part II highlights four areas or themes to improve BC's home health sector including:

- *Investments in Funding* – Ensure current home health care resources are sustainable, through adequate and appropriate funding models;
- *Investments in Seniors* – Increase access to home health care to ensure needs of seniors are met;
- *Fostering Innovation* – Support the adoption of province-wide home health care models which ensure appropriate use of health resources and promote choice; and
- *Investments in Quality* – Provide funding for programs which increase quality of life and quality of service in the home health care sector.

In January 2017, the BCCPA released its paper on sustainability and innovation in the continuing care sector entitled *Strengthening Seniors Care: A Made-in-BC Roadmap* which responded to many of the concerning trends noted earlier. While addressing continuing care more broadly, many of the 30 recommendations addressed home health care including that the Health Authorities increase minimum home care and support visit times and that a permanent sub-committee be created to deal with the unique and considerable challenges facing the sector. As outlined earlier, some of these challenges include a review of funding, unfunded service expectations, travel costs and improving quality care as well as exploring the adoption of innovative models.

As outlined in this latest BCCPA paper, it is necessary more than ever that we act now to prepare to meet the needs of seniors. As such, further investments are critical to meet the needs of BC's aging population to improve BC's home health care system and deliver the most appropriate care possible to seniors.

Through targeted funding of approximately $110 million per year aimed at implementing the eight recommendations in full, the BC Government, Health Authorities, BCCPA, service providers and other partners can create dramatic change in the quality of life and quality of care experienced by seniors accessing home health care services.

[137] Office of the Seniors Advocate. Monitoring Seniors' Services (2016). December 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf

SUMMARY OF RECOMMENDATIONS

This paper focuses on four key themes and makes eight recommendations designed to meet the challenges faced by home health care operators:

THEME I: Investments in Funding

Ensure current home health care resources are sustainable, through adequate and appropriate funding models.

Recommendation 1:

That the BC government establish a permanent Joint Committee on Home Health Care (JCHHC) consisting of the BC Ministry of Health, Health Authorities, service providers and BCCPA to deal with the unique and considerable challenges facing the publicly funded home health care sector.

Recommendation 2:

That the BC Ministry of Health undertake an independent and immediate review of home health care funding in order to ensure fairness, and sustainability. The aim of the review should be to:

- Develop a process for providing greater transparency with respect to how funding is determined, and ensure funding is provided to fulfill the expectations put forward to providers by government;
- Identify and address funding gaps that exist, including but not limited to administration, scheduling, recruitment, and retention of skilled home health care workers;
- Conduct a review of the relative costs of service delivery in different geographic areas and the potential impacts on funding; and
- To ensure the availability of funds to deliver training, continuing education, and appropriate clinical oversight, including occupational work and safety and dementia education care in order to ensure all activities required by the health authorities are fully funded.

$2M PER YEAR

THEME II: Investments in Seniors

Increase access to home health care to ensure the needs of seniors are being met.

Recommendation 3:

That the Health Authorities increase the minimum home care and home support visit times from:

- 15 minutes to an average of 30 minutes (in cluster care settings).
- 30 minutes to 60 minutes (in community care settings).

$50M PER YEAR

Recommendation 4:

That the BC Ministry of Health develop provincial guidelines in coordination with a public awareness campaign whereby the province funds or offers preventative home health care visits to people 75 and older on a proactive basis (i.e. before they are requested), in order to prevent pre-mature frailty and ensure that seniors are provided with the necessary care as soon as possible.

$8M PER YEAR

THEME III: Fostering Innovation

Support the adoption of province-wide home health care models which ensure appropriate use of health resources and promote choice.

Recommendation 5:

That the Ministry of Health and all partners support the adoption of new home health care models province-wide, to allow seniors to remain at home longer as well as reduce alternate level of care (ALC) days and improve overall quality care. These models may include: the hospital at home model; better integrating home health and long term care; better integrating home health and acute care; and supporting greater end of life care at home.

$20M PER YEAR / 4 YEARS

Recommendation 6:

That the BC government explore further the appropriateness or feasibility of the care credit model including its limited phased introduction in the home health and long term care sectors.

$2M PER YEAR

THEME IV: Investments in Quality

Provide funding for programs which increase quality of life and quality of service in the home health care sector.

Recommendation 7:

That a new *Seniors Quality of Life Fund* (SQLF) be established by the BC government with designated funding to support seniors living at home and in congregate settings by:

- Increasing access to recreational therapy, occupational therapy, physiotherapy, nutrition, culturally appropriate care, music and art programs;
- Reducing seniors' isolation through increased Adult Day and similar programs; and
- Enabling care hubs to work more collaboratively with local home health providers.

$25M PER YEAR / 3 YEARS

Recommendation 8:

Develop a made in BC quality assurance model in the home health care sector, with a focus on implementing standards to ensure quality across the sector, specifically to support agencies providing privately paid services, as well as helping seniors and families make informed choices about care.

$3M PER YEAR

APPENDIX A: OVERVIEW OF BC'S HOME HEALTH CARE SECTOR

Table 5: Types of Home and Community Care Support	
Type of Support	Services / Supports Provided
Home Support	Home support services are direct care services provided by community health workers to clients who require personal assistance with activities of daily living, such as mobility, nutrition, lifts and transfers, bathing and dressing, grooming, and toileting, as well as some safety maintenance activities where appropriate (e.g. clean-up, laundry of soiled bedding or clothing, and meal preparation). In addition, community health workers may perform some specific nursing and rehabilitation tasks that have been delegated by health care professionals.
Choice in Supports for Independent Living	Clients receive funds, either directly or through a client support group, to purchase and manage their own home support services.
Home Care	Professional health services delivered in the home such as nursing care, physiotherapy, and occupational therapy.
Adult Day centres	Supportive group programs for seniors and adults with disabilities living at home. May include bathing programs, personal care, social activities, meals, and transportation.
Caregiver relief / respite	Temporary relief to informal caregivers in either the client's home, or the client may be admitted temporarily to a care home.
Assisted Living	Publicly subsidized apartments with support services for frail seniors and people with disabilities. Housing, meals, laundry, housekeeping, and some personal care services are provided. Nursing care is not provided but is a 24-hour emergency response system in place.
Long term care home	24-hour professional nursing care and supervision in a care home.
Family Care Homes	Single-family residences that provide supportive accommodation for up to two residents.

Table 6: Home Health Statistics in British Columbia	
Home Support services in BC	Home Care in BC
• 88 per cent of clients are aged 65 and older, and 73 per cent of clients are aged 75 and older. • In 2015/16, a total of 42,170 clients were registered for publicly subsidized home support services. The number of clients increased in three health authorities and decreased in two. • The total number of home support clients increased by 2 per cent over previous year, while population aged 80 and over increased by 3 per cent. • Total number of home support hours delivered to all clients receiving service in 2015/16 was 11,089,553 - 0.1 per cent decrease over previous fiscal year.	• Only 70 per cent of home care clients are aged 65 and older, and this number reduces to 50 per cent at age 75 and older. • In 2015/16, a total of 87,289 clients received professional home care services in BC, an increase of 2.3 per cent over 2014/15. The number of clients increased in all but one health authority. • In 2015/16, a total of 1,111,123 visits were made to clients

• The number of hours delivered increased in three health authorities and decreased in two. In 2015/16, the average hours delivered per client per year was 263, or 5 hours per week. This represents a provincial decrease of 2 per cent from 2014/15. Average hours did, however, increase in one health authority.[138]	receiving professional home care services, an increase of 2 per cent over 2014/15.
Source: 2016 Office of the Seniors Advocate Monitoring Report. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf	

Examples of Home Care and Support Programs in BC

Home is Best (home care program)

Providing care to individuals in their home rather than acute and long term care is designed to better support clients, their families and caregivers. Under BC's Home is Best program, in-home care supports are tailored to an individual's need. Home support care can include bathing and washing, dressing, grooming, taking medication and other personal care needs. The goal is to keep people out of acute and long term care as well as to help seniors live safely at home and avoid future hospital emergency admissions. This program has had a positive impact with fewer admissions to acute and long term care as noted in the quarterly reports by health authorities.

In March 2013, the BC government as part of an annual funding announcement of $50 million over the next three years for targeted primary and community care programs noted that the Home is Best Program would be rolled out in all five health authorities. The program, which was piloted in Vancouver Coastal Health's North Shore and in Fraser Health, has shown some positive results. In Vancouver Coastal, the program resulted in a 30 per cent decrease in acute care use and a 25 per cent reduction in emergency department visits.[139]

Better at Home (home support program)

Better at Home, is a program funded by the BC government and managed by the United Way of the Lower Mainland (UWLM) to support BC seniors to remain in their own homes longer by giving them access to non-medical services such as transportation to appointments, light housekeeping and yard work, minor home repairs and friendly visiting. Better at Home is being implemented in over 65 communities around the province. Services are provided by local non-profit organizations selected through a community engagement process, which includes local seniors. The services are delivered by a mix of volunteers and paid workers. The BC government has provided over $20 million to the UWLM to develop implement and manage the program. The UWLM, in turn, funds local non-profit organizations to deliver services. The goals of program are to help seniors live independently and remain connected to the community. It supports all the age friendly community domains but particularly the following domains: transportation; respect and social inclusion; and community support and health services.

[138] The 2017 OSA Monitoring Services report notes the average home support hours delivered per client per year decreased by 3% from 2016, while the number of clients increased by 3.5%. See: http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf
[139] BC Ministry of Health. B.C. continues to expand primary and community care. March 1, 2013. Accessed at: http://www.newsroom.gov.bc.ca/2013/03/bc-continues-to-expand-primary-and-community-care.html

Choice in Supports for Independent Living (home support program)

Introduced in 1994 BC's Choice in Supports for Independent Living (CSIL) is a self-managed care model that provides an alternative for home support patients who want more flexibility in arranging home support services. Patients approved for CSIL receive funds to purchase their own services, and manage the recruiting, training, scheduling and supervision of community health workers. Individuals who are unable to direct own care can obtain CSIL funding through a patient support group, which manages services on the person's behalf. There are provisions for funding of family members as caregivers within the CSIL program. Health authorities determine the amount of funds based on assessment of need.

Under this program, client care needs are assessed as well as care hours are determined with funding provided to the client at a rate of $30.39 per hour (current rate). It is generally accepted that CSIL allows clients more flexibility in choosing who will provide their care and when the care will be provided. There are audit and review processes in place to ensure the money is being spent appropriately and the care is delivered. A 2017 report by the Office of the Seniors Advocate notes that caregivers of clients under the CSIL program have a 50 per cent lower risk of caregiver distress even though they are caring for someone who, on average, has a higher level of complex care needs than non-CSIL home support clients. The same report notes that the program appears to be more cost effective as the average cost for health authority delivered home support is $44 an hour compared to about $30 per hour for CSIL.[140]

[140] BC Office of the Seniors Advocate. Caregivers in Distress: A Growing Problem. August 2017. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/08/Caregivers-in-Distress-A-Growing-Problem-Final.pdf

APPENDIX B: OVERVIEW OF ALTERNATE LEVEL OF CARE (ALC) DAYS

Approximately 14 per cent of Canadian hospital beds are filled with patients (85 per cent of which are over 65) who are ready to be discharged but for whom there is no appropriate place to go (i.e. Alternative Level of Care or ALC beds). Over a single year, these patients' use of acute hospital beds exceeds 2.4 million days, which equates to over 7,500 acute care beds each day.[141] A national estimate of these ALC days to provincial governments is approximately $3 billion per year.[142]

The problem of ALC beds not only creates fiscal challenges, but quality of care and access issues as well. The Wait Time Alliance (WTA), for example, has noted that the ALC issue represents the single biggest challenge to improving wait times across the health care system.[143] Such wait times and access issues have been well documented. In 2012, for example, it was reported that 461,000 Canadians were not getting the home care they thought they required, while wait times for access to long term care in Canada also ranged anywhere from 27 to 230 days.[144]

There are many reasons for the high rates of ALC days, including lack of appropriate community supports to prevent hospitalizations.[145] The ALC issue is also closely tied to dementia, a common diagnosis among ALC patients. A dementia diagnosis often results in at least once instance of hospitalization and escalates ALC rates when co-morbidities or other chronic diseases are present (i.e. 90 per cent of community-dwelling persons with dementia have two or more chronic diseases). A study in New Brunswick found that one third of the hospital beds in two hospitals were occupied by ALC patients, of whom 63 per cent had been diagnosed with dementia. It also found their mean length of stay was 380 days, with 86 per cent of these patients waiting for a bed in a long term care home while their health declined.[146]

As outlined by the WTA, adequate attention to seniors' care including having the necessary health human resources, being aware of their environmental surroundings thereby preventing unnecessary emergency department visits and hospitalizations, as well as collaborative care models are key to reducing the numbers of ALC patients. [147] One critical area for improving the ALC situation is the better reporting of such data. The UK's National Health Service, for example, reports monthly ALC rates as delayed transfers of care including outlining the causes of delay by region and facility.[148]

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[141] Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. Canadian Health Services Research Foundation. September 2011. Accessed at: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/0666-HC-Report-SUTHERLAND_final.pdf

[142] CD Howe Institute. Commentary No. 443. Shifting Towards Autonomy: A Continuing Care Model for Canada. Ake Blomqvist and Colin Busby. As noted in one report from the Canadian Life Health Insurance Association (CLHIA), 7,550 acute care beds are taken up by individuals who should be in home and community care or in rehabilitation. This represents about 7% of all hospital beds in Canada. The report also notes that if systemic reform were able to transition all those in a hospital setting to a more appropriate continuing care setting, the savings to the system would be about $77 billion over the time period examined (35 years). Source: Improving the accessibility, quality and sustainability of long term care in Canada. CLHIA Report on Long Term Care Policy. June 2012)

[143] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf

[144] Canadian Medical Association. Doctors to leaders: Canadians want a Seniors Care Plan in election. August 2, 2015. Accessed at: http://www.newswire.ca/news-releases/doctors-to-leaders-canadians-want-a-seniors-care-plan-in-election-520419582.html

[145] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf

[146] McCloskey R, Jarrett P, Stewart C, Nicholson P. Alternate level of care patients in hospitals: What does dementia have to do with this? Can Geriatr J 2014;17(3):88–94.

[147] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf

[148] NHS England. Delayed transfers of care statistics for England 2014/15. 2014/15 annual report. London: NHS England; 2015 May 29. Available: www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/2014-15-Delayed-Transfers-of-Care-Annual-Report.pdf

APPENDIX C: HEALTH HUMAN RESOURCES IN HOME HEALTH CARE

One of the critical challenges facing BC's home health sector is the shortage of home health care workers. Home care may be provided by nurses (licensed practical nurses and registered nurses which are both regulated by their licensing body), or home support workers (known as health care aides or assistants in some parts of Canada), who are unregulated and usually have 6 to 9 months (7 months on average) of education through a public or private vocational school. HSWs provide paid, non-professional services such as personal care and housework to individuals with demonstrated needs in their homes and are the largest occupational group in home care.

As outlined in one article, the four key human resource issues affecting home health care workers in Canada include: compensation, education and training, quality assurance and working conditions.[149] According to a recent Conference Board of Canada report, demand for home health care services will increase at a projected 3.1 per cent annual pace until 2026, while overall home care employment is only projected to grow at 1 per cent. [150]

Dealing with HHR shortages

To better deal with issues around the recruitment and retention of health care workers, there must be a coordinated role between the continuing care sector, Ministry of Health, and Health Authorities working collaboratively with colleges and universities. Not only do colleges and universities play an important role in educating and training appropriate numbers of health providers but they also have a responsibility in ensuring that such training is relevant and practical to their appropriate field. This includes opportunities to gain more practical hands on experience or training in seniors care. All stakeholders have a role in ultimately improving public perceptions of such careers.[151]

In the home health care sector, worker shortages are exacerbated by the increasing acuity of clients in home care and advances in in-home technology are also affecting worker skill requirements. This is making it increasingly important that home health care workers have the necessary skill sets and training. As discussed earlier, much of this training is not adequately funded appropriately by BC Health Authorities.

In BC, much like the rest of Canada, care aides are not regulated by any professional or governmental regulatory body. This raises several issues for quality assurance, including confusion among agencies, workers, and other health team members as to the HSW's role; and differing job titles and scopes of practice across jurisdictions and between privately and publicly hired workers. [152] Many provinces,

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[149] Work 40(1):21-8. January 2011. Key issues in human resource planning for home support workers in Canada. Key issues in human resource planning for home support workers in Canada. Janice Keefe et al. Accessed at: http://www.msvu.ca/site/media/msvu/Key%20issues%20in%20human%20resource%20planning%20for%20home%20support%20workers%20in%20Canada.pdf

[150] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015.

[151] BCCPA. Op-ed: Addressing Health Human Resource Challenges in BC's Continuing Care Sector. April 26, 2016. Accessed at: http://www.bccare.ca/op-ed-addressing-health-human-resource-challenges-bcs- continuing-care-sector/

[152] Work 40(1):21-8. January 2011. Key issues in human resource planning for home support workers in Canada. Key issues in human resource planning for home support workers in Canada. Janice Keefe et al. Accessed at: http://www.msvu.ca/site/media/msvu/Key%20issues%20in%20human%20resource%20planning%20for%20home%20support%20workers%20in%20Canada.pdf

including BC, also face acute care recruitment and retention challenges in rural and remote areas. Limited amenities, as well as social isolation and long distances between clients, are also disincentives to attracting HSWs to these regions. [153]

Integration of health professionals into home health

In addition to a shortage of home health workers, another HHR challenge is the need to better integrate health professionals, including physicians and nurses, into the home health care sector. For example, while the number of family physicians (FPs) has increased by about 10 per cent over the past ten years, very few do home health visits. This is even though approximately 100,000 older Canadians are housebound and unable to access a physician and these numbers are expected to quadruple over the next twenty years. To help solve this issue, Ontario has established a House Calls program. Data has found that among seniors who enrolled into the program after hospitalization, the rate of readmission dropped by 53 per cent. For those patients who were readmitted, the overall length of hospital stays was cut by nearly 70 per cent.[154]

Dealing with HHR issues also requires looking at the role that new professionals, such as Nurse Practitioners (NPs) and Physician Assistants (PA), could potentially have in home health care. Recent studies have highlighted the benefits of PAs, including that they can: increase access to medical care for seniors[155], have an important role in preventing illness for many geriatric patients,[156]and can reduce 30-day readmission rates by 25 per cent through home care visits.[157] Along with only a very small number of PAs there are limited number of NPs (in January 2014, there were only 287 NPs registered in British Columbia) and very few note home care as a practice setting.[158]

Case managers, who assess client need, coordinate care, and develop care plans with the client and family, are also often too stretched to provide much orientation to home care and home support. Overall, the number of home care case managers has remained relatively stagnant since 2010, while the number of clients receiving home care has increased dramatically.[159] The case manager plays a pivotal gatekeeper role in home and community care. In particular, clients cannot access services until they have been assessed by a case manager and a care plan is developed. As outlined in one report, the case manager plays an important role in accessing and co-ordinating services but currently there is a bottleneck in the system due to the shortage of them.[160]

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[153] Work 40(1):21-8. January 2011. Key issues in human resource planning for home support workers in Canada. Key issues in human resource planning for home support workers in Canada. Janice Keefe et al. Accessed at: http://www.msvu.ca/site/media/msvu/Key%20issues%20in%20human%20resource%20planning%20for%20home%20support%20workers%20in%20Canada.pdf

[154] CBC News. House Calls program helps seniors live independently at home. October 5, 2015. Accessed at: http://www.cbc.ca/news/health/housecalls-seniors-funding-1.3256805

[155] CAPA. New Study Shows Canadians Want Physician Assistants to Play a Greater Role in Their Health Care. October 24, 2014. Accessed at: http://www.newswire.ca/en/story/1433470/new-study-shows-canadians-want-physician-assistants-to-play-a-greater-role-in-their-health-care

[156] Hooker, Cawley and Asprey. (2010). Physician Assistant Specialization: Nonprimary care. PA Specialty Care. Ch. 7. p.p. 235. Accessed at: http://capa-acam.ca/wp-content/uploads/2013/09/PA-FACT-SHEET-2013_FINALcopy.pdf

[157] Nabagiez JP, Shariff MA, Khan MA, Molloy WJ, McGinn JT Jr. J Thorac Cardiovasc Surg. 2013 Jan;145(1):22531, 233; discussion 232-3. doi: 10.1016/j.jtcvs.2012.09.047. (2013). Physician assistant home visit program to reduce hospital readmissions. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/23244257

[158] Survey of Nurse Practitioner Practice Patterns in British Columbia. University of Victoria and Michael Smith Foundation for Health Research. January 2014. Accessed at: http://www.uvic.ca/research/projects/nursepractitioners/assets/docs/NP%20Practice%20Patterns%20Report.pdf

[159] Healthy Debate. Are home care complaints being heard? Karen Palmer et al. March 16, 2017. Accessed at: http://healthydebate.ca/2017/03/topic/ccac-home-care-complaints

[160] Integrated Care Advocacy Group and the BC Health Coalition. Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system. May 2015. Accessed at: http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20To%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20%20new%20appendixA.pdf

In addition to reports from care providers, a recent survey from SafeCare BC indicates that the home health sector is experiencing chronic health human resources shortages. According to SafeCare BC, 50.2 per cent of home support workers identified staffing shortages as an issue. Many respondents from the survey predicted that these shortages would continue over the next few years, with only a quarter of survey participants reporting that they were confident that their organization would have an adequate supply of workers over the next three to five years. The positions most often identified as having chronic shortages were home support workers (56 per cent), care aides (37 per cent), LPNs (9 per cent), and RNs (7 per cent).

BC Cares

The 2017 BCCPA report *Strengthening Seniors Care: A Made-in-BC Roadmap*, recommended that the provincial government invest $25 million for a Continuing Care Health Human Resource (CCHHR) Fund over 5 years to address chronic labour shortages currently facing the continuing care sector. These funds include investments for training home health care workers to deliver care for clients living with dementia. While the BCCPA still endorses this recommendation, some of this funding should be specifically directed to the home health care sector. A portion of this new HHR funding, for example, could contribute towards new campaigns or initiatives to improve the recruitment and retention. An example of an earlier such campaign was the BC Cares initiative.

In 2007, the BCCPA initiated BC Cares, a successful industry-led partnership with the BC Ministries of Health and Advanced Education, as well as 20 public and accredited private BC universities and colleges. BC Cares encouraged and provided easier access to the required courses necessary to become a qualified care aide. It focused on increasing the enrollment rate of immigrants, youth, and those living in dominantly Aboriginal or rural communities.[161]

The BC Cares campaign was able to boost enrollment by 75 to 100 per cent for long term care aides, registered care aides (RCAs), and HSWs. By the fall of 2008, almost all participating post-secondary institutions reported their courses were near or at capacity. The campaign featured radio and print advertising, brochure distribution, a comprehensive website, and social media marketing tactics.[162]

The BCCPA is looking to build on the success of the original BC Cares by proposing a renewal of the program or as part a new Canada Cares initiative.[163] The initiative would help with identifying training and education opportunities.

Along with improving training opportunities, a renewed BC or new Canada Cares initiative could assist with meeting any potential guideline for a minimum 30-minute home visit, as discussed earlier in the paper. The BCCPA has submitted a formal proposal to the BC and federal governments about a rejuvenated BC Cares Program with $10 million in funding over three years. The BCCPA believes such a program would help address the existing shortages of workers in the continuing care sector (including home health care and long term care) through targeted recruitment and retention initiatives.

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[161] BCCPA. Rapidly Ageing Population Triggers Shortages of Care Aides. April 27, 2016. Accessed at: http://www.bccare.ca/shortage-care-aides-outside-metro-vancouver/

[162] Ibid.

[163] The BCCPA has developed a proposal for a grant of $10 million in funding from the Federal and BC Provincial governments over three years to support the Canada Cares, BC Implementation: a HHR strategy for the continuing care sector in BC. After three years, this industry-led provincial strategy will progress toward the implementation of a federal initiative in collaboration with the Canadian Association of Long Term Care (CALTC).

Worker injury rates

HHR challenges with respect to home health care workers are also exacerbated by high sector injury rates. In the home health sector, safety issues include occupational injury, physically or verbally responsive clients or family members, discrimination, racism, and unsafe conditions in the client's home (including cleanliness, smoking, and pets).[164] Poor working conditions can impact workers' physical health and have been linked to musculoskeletal disorders.[165] According to WorkSafeBC and SafeCare BC, the home health sector has an injury rate that is twice the provincial average at 4.4 time-loss claims per 100 workers (provincial average is 2.2 time-loss claims per 100 workers). According to 2016 data this amounts to over 36,000 workdays lost per year and costs sector $7.6 million annually in claims costs.[166]

Did you Know? Injury rates in the Home Health Sector

- The most common accident time in the community support sector is Overexertion (42.5 per cent), followed by Falls (22.3 per cent). Motor vehicle incidents and Acts of Violence account for 5.7 per cent and 5.1 per cent of incidents respectively.
- The most commonly injured body parts are the back (30.4 per cent), shoulders (11.5 per cent), and hands/wrists (8.5 per cent).
- The most common cause of injury is people (27.6 per cent), following by working surfaces (20.1 per cent), and vehicles (18.5 per cent)
- Nurse Aides and Orderlies (57.8 per cent) and home support workers (14.5 per cent) account for the majority of injured workers in the sector.

Source: WorkSafeBC, 2016. Classification Unity 766066 Community Health Support Services. Accessed May 2, 2017.

As part of their release of *Action Plan to Strengthen Home and Community Care for Seniors*, and an additional $500 million for seniors care over four years, the Ministry of Health announced, prior to the provincial election that it would be providing $10 million to help industry fund equipment like wheelchairs and patient lifts to assist seniors with limited mobility in long term care.[167]

This is the first time the Ministry of Health is funding the industry through BCCPA directly to manage infrastructure including where funding is allocated. This new funding should also help assist in reducing the high number of workplace injuries in the long care sector. While the BCCPA applauds this initiative, a similar fund should also be considered to support the home health care sector. Such a fund, for example, could support items like wheelchairs, mobile ceiling lifts, or other innovative technologies including home monitoring devices (i.e. sensors, telehealth, etc.).

[164] A. Martin-Matthews and J. Sims-Gould, BC home support worker study: Summary report, Department of Sociology, University of British Columbia: Nexus Home Care Research, 2008. Available from www.nexus homecare.arts.ub.ca.
[165] I.U. Zeytinoglu, M. Denton, S.Webband J. Lian. Self reported musculoskeletal disorders among visiting and office home care workers, Women and Health 31 (2000).
[166] WorkSafeBC, 2016. Classification Unity 766066 Community Health Support Services. Accessed May 2, 2017.
[167] BC Ministry of Health. An Action Plan to Strengthen Home and Community Care for Seniors. March 2017. Accessed at http://www.health.gov.bc.ca/library/publications/year/2017/home-and-community-care-action-plan.pdf

APPENDIX D: CARE HUB MODEL – INTEGRATING LTC AND HOME HEALTH CARE

Current 24/7 Residential Care Model

- Accommodation
- Development and maintenance of resident's Care Plan
- Clinical Support Services
- Ongoing, Planned Physical, Social and Recreational Activities
- Meals, Meal Replacements and Nutrition Supplements
- Laundry Service
- General Hygiene Supplies
- Routine Medical Supplies
- Medication supervision
- 24-hour surveillance
- Professional nursing care and/or supervision
- Incontinence Management
- Any other specialized services

New Continuing Care Hub or Continuing Care Campus (C3)

- All services currently provided in 24/7 residential care model
- Could be physically co-located (i.e. Continuing Care Campus or Campus of Care) or provided as part of virtual affiliated network of care homes
- No one size fits all – services provided will differ based on expertise and needs of the community

<u>New Services Offered</u>

- Expanded adult day programs
- Use of physical infrastructure to provide community services for seniors
- Respite care for frail elderly
- Physical co-location of urgent care or sub –acute
- Expanded sub-acute care and paramedic services (i.e. wound care, dialysis and IV care)
- Greater preventative and health promotion services (i.e. CDM and frailty screening)
- Expansion and integration of end-of-life care
- Expanded pharmacy services and medication management
- Expanded mental health services for seniors including dementia care
- Provision of some diagnostic and laboratory services (X-rays, blood tests etc.)
- Provision of supplemental care services (i.e. dental, oral, optical and foot care, etc.)
- Expanded rehabilitation and recovery care (i.e. OT/PT and post-operative care)
- Use of technologies to link with care homes particularly to rural areas
- New funding models (outcome-based funding)
- New roles for care providers (creation of new care aide roles and multidisciplinary LTC team)
- Integration of health professionals (Nurse Practitioners, Physician Assistants / Paramedics and family in seniors care)

Table 7: Four Key Features of new Continuing Care Hubs
Integration of health professionals and family in seniors care • Physically and virtually integrating nurse practitioners, family physicians and physician assistants into the continuing care hub or campus. • Use of other health and emergency professionals including but not limited to paramedics and firefighters with enhanced training. • Increasing the proportion of LTC nurses with advanced or specialized training, particularly in areas such as behavior as well as pain and symptom management. • Self-regulated professions work to full scope of practice, which includes delegation of acts to other health professionals and unregulated staff. • Directly integrate the family into the care team and overall care of the resident as a strategy to potentially reduce unnecessary hospitalizations.
New roles for care providers • Creation of new Health Care Aide roles that enable nursing staff to focus on clinical care and leadership rather than routine tasks that can be safely delegated. • Creation of a multidisciplinary LTC team core competencies task force to examine the composition, skill-set and level of interdisciplinary integration required to support the delivery of safe, high-quality care and other models of care delivery. • A comprehensive review and update to college and university curricula to better prepare front-line workers for the emerging long term care environment. • Develop an on-going foreign worker recruitment or relocation incentive program to ensure access to adequate clinical staff willing to work in rural and remote areas.
New funding models (outcome-based funding) • Performance or outcome-based funding that considers optimal staffing mix for different groups of residents, along with care outcomes. • Empower Continuing Care Collaborative to develop a model which better links funding to outcomes. • In collaboration with private-sector service providers, develop mutually agreed upon quality indicators in continuing care including incentives to encourage integration of care and team-based models (i.e. paramedics, rehabilitation, pharmacy, etc.). • Development of alternate LTC physician and nurse practitioner reimbursement models which provide incentives for mentoring LTC staff and students and achieving key care outcome targets such as reducing hospital transfers.
Expanded role and co-location of services • Use of physical infrastructure to provide community services for seniors in order to reduce seniors' isolation (i.e. seniors care lodges) including expanded provision of Adult Day or related programs. • Physical co-location of urgent care centres or sub-acute care centres as well as ambulatory care / paramedics to reduce acute care and emergency hospitalizations.

- Expanded sub-acute care and paramedic services including but not limited to less complicated surgical treatments, greater wound care, dialysis and intravenous (IV) care.
- Greater preventative and health promotion services for seniors such as frailty screening, chronic disease management programs, etc.
- Improved respite services particularly to care for frail elderly.
- Improved adult-day programs which allow seniors to live at home longer which accessing the care and social networks they need.
- Expansion and integration of end-of-life care including palliative and hospice care.
- Expanded pharmacy services including medication management, etc.
- Expanded mental health services for seniors including but not limited to treating dementia, depression and integrating psychologists as part of the care team.
- Provision of some diagnostic and laboratory services such as minor x-rays, blood tests, etc.
- Provision of supplemental care services including dental / oral health care, optical, foot care, etc.
- Expanded rehabilitation and recovery care including occupational therapy, physical therapy and post-operative care.
- Use of technologies to link with care homes in smaller rural and/or remote communities.

Source: BCCPA. Strengthening Seniors Care: A Made-in-BC Roadmap. January 2017. Accessed at: http://bccare.ca/wp content/uploads/2017/01/BCCPA_Roadmap_Full_Jan2017.pdf

APPENDIX E: AUSTRALIA – CASE STUDY ON HOME CARE AND CARE CREDITS

Australia's home and community care services are jointly funded by state and commonwealth governments. Home and community care services' original aim was to meet the needs of aging clients transitioning from living in the community to long term care and offer domestic services to prolong the period before requiring long term care.[168] Restorative Home Care Services (see below) are offered free of charge for six weeks for all assessed eligible clients. Clients are either referred at the community level for the Home Independence Program or following a hospital admission for the Personal Enablement program based on the Aged Care Gateway model.

Where enablement does not suffice, traditional home and community care services are supplemented. Australia is one country that is proceeding with the introduction of vouchers or care credits, particularly in the home care sector. For example, as of February 2017, citizens in that country will be able to receive funding directly to choose the home care package of their choice.[169]

Table 8: Australia – Home Care Packages Program

The Australian Government recognises many older people want to remain living independently in their own homes for as long as possible. To support this, it subsidises packages to provide home-based care that can improve older Australians' quality of life and help them to remain in their homes and connected to their communities. Under a home care package, a range of personal care, support services, clinical services, and other services is tailored to meet the assessed needs of the consumer.

Since July 2015, all home care packages were required to be delivered on a consumer directed care (CDC) basis. CDC provides greater transparency to consumers about what funding is available under their package and how those funds are spent through an individualised budget. CDC also aims to give a consumer more choice and flexibility about the types of care and services they access and how the care is delivered to best meet their needs.

Eligibility and the level of Home Care Package an older person can receive is determined through an assessment by an Aged Care Assessment Team (ACAT). The Home Care Packages Program provides four levels of packages, each with a different associated subsidy amount: Home Care Level 1 – to support people with basic care needs; Home Care Level 2 – to support people with low level care needs; Home Care Level 3 – to support people with intermediate care needs; and Home Care Level 4 – to support people with high care needs.

Source: Australian Government – Department of Health. The Aged Care Workforce, 2016. March 2017. Accessed at: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/03_2017/nacwcs_final_report_290317.pdf

[168] Michael Smith Foundation for Health Research and BC Ministry of Health. Best Practices in Home Care for Seniors Synthesis Report from the 2014 International Forum. 2014. Accessed at: http://www.msfhr.org/sites/default/files/Seniors_Home_Care_Best_Practices.pdf

[169] Australian Government: Department of Health. Consumer Directed Care Fact Sheet. October 14, 2016. Accessed at: https://agedcare.health.gov.au/programs/home-care/consumer-directed-care.

Restorative Approach in Home Care

Along with the consumer directed model, Australia has taken a more restorative approach to home care. This approach is one in which individuals are assisted to maximize their ability to engage independently in everyday living and social activities, rather than simply having essential tasks done for them so that they can remain living in their homes.[170] Instead of simply having the worker do specific tasks for the individual the senior is supported by an interdisciplinary team, as part of the restorative approach, to be as independent as possible. The goal is to support older adults to develop or redevelop the skills and confidence to do things for themselves and build connections with new networks of social support.[171]

In Australia, a restorative approach has proven more effective than regular home support at improving self-rated health, confidence and well-being, and at reducing mortality and the need for long term care. The seniors in these restorative care programs required less ongoing support and used fewer emergency and/or in-hospital services, and as a result, overall healthcare costs were lower. In addition, the home support workers, who were provided with additional training in care co-ordination, played a key role in making this program successful.[172]

As noted in a 2015 report, in BC's home health system there is very little focus on restorative care for people who are at risk of functional decline but who, if supported to develop their skills and confidence to do things for themselves could be more independent, would have better health outcomes and reduced service costs. [173]

[170] Journal of Current Clinical Care March/April 2011. Restorative Home Care Services. Gill Lewin. Accessed at: http://orbis.cssam.com/files/content/2011/April/0102Restorative.pdf

[171] Integrated Care Advocacy Group and the BC Health Coalition. Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system. May 2015. Accessed at: http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20To%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20%20new%20appendixA.pdf

[172] Ibid.

[173] Ibid.

APPENDIX F: SHIFTING RESOURCES FROM ACUTE TO HOME AND COMMUNITY CARE

One percent solution

As outlined in the *Quality-Innovation-Collaboration* paper (2015) the BCCPA has previously recommended that Health Authorities redirect acute care expenditures such as a minimum of 1 per cent annually over a five-year period to the continuing care sector.[174] In particular, as part of its 2017 provincial Budget Submission, the BCCPA recommended that, beginning in the 2017/18 fiscal year, the Performance Agreements between the Ministry of Health and the Health authorities include a specific target to reinvest expenditures from acute care to continuing care – specifically, a minimum target of 1 per cent per year over a five-year period.

Based on 2014/15 budget figures, expenditures by Health Authorities for acute care is over $6.4 billion or between 55 to 59 per cent of total budgets (see Figure 4).

FIGURE 4: HEALTH AUTHORITY SPENDING (2014/15)

	Dollars spent on Acute Care	HCC - Residential	HCC - Community	Corporate	Mental Health	Pop Health and Wellness	TOTAL
Vancouver Coastal Health	$1,856,996,000 (59%)	$443,387,000 (14%)	$234,385,000 (7%)	$239,816,000 (8%)	$284,293,000 (9%)	$98,396,000 (3%)	**$3,157,273,000 (100%)**
Vancouver Island Health	$1,150,853,000 (55%)	$357,994,000 (17%)	$229,994,000 (11%)	$157,498,000 (7%)	$156,549,000 (7%)	$57,732,000 (3%)	**$2,110,570,000 (100%)**
Interior Health	$1,079,080,000 (55%)	$367,783,000 (19%)	$196,492,000 (10%)	$132,738,000 (7%)	$113,061,000 (6%)	$55,762,000 (3%)	**$1,944,916,000 (100%)**
Fraser Health	$1,893,608,000 (59%)	$544,780,000 (17%)	$289,088,000 (9%)	$200,612,000 (6%)	$228,747,000 (7%)	$79,077,000 (2%)	**$3,235,912,000 (100%)**
Northern Health	$435,760,000 (57%)	$99,153,000 (13%)	$75,878,000 (10%)	$63,711,000 (8%)	$49,677,000 (7%)	$37,330,000 (5%)	**$761,509,000 (100%)**
TOTAL	**$6,416,297,000 (57%)**	**$1,813,097,000 (16%)**	**$1,025,787,000 (9%)**	**$794,375,000 (7%)**	**$832,327,000 (7%)**	**$23,532,287 (3%)**	$11,210,180,000 (100%)

Sources: Financial Statements of Vancouver Coastal Heath Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).

Using 2014/15 Health Authority budget figures, a one per cent re-allocation from acute to community care for the five regional health authorities would amount to approximately $64 million in the first year (see Figure 5). Excluding any annual funding increases to health authorities that would have occurred anyways this would equate to a five-year reinvestment from acute to home and community care of approximately $320.8 million by year five. Along with potentially funding many of the recommendations outlined in this paper it equates to the annual operation of 4,395 new care beds; or 12,832,000 care aide hours; or 8,020,000 HSW hours.

[174] BCCPA. Op-ed: Quality, Innovation, Collaboration – Strengthening Seniors Care Delivery in BC. October 2015. Accessed at: http://www.bccare.ca/op-ed-quality-innovation-collaboration-strengthening-seniors-care-delivery-in-bc/

FIGURE 5:
HEALTH AUTHORITY 1% REINVESTMENT FROM ACUTE TO CONTINUING CARE

	Dollars spend on Acute Care (2014/15)	1st Year	2nd Year	3rd Year	4th Year	5th Year
Vancouver Coastal Health	$1,856,996,000	$18,569,960	$37,139,920	$55,709,880	$74,279,840	$92,849,800
Vancouver Island Health	$1,150,853,000	$11,508,530	$23,017,060	$34,525,590	$46,034,120	$57,542,650
Interior Health	$1,079,080,000	$10,790,800	$21,581,600	$32,372,400	$43,163,200	$53,954,000
Fraser Health	$1,893,608,000	$18,936,080	$37,872,160	$56,808,240	$75,744,320	$94,680,400
Northern Health	$435,760,000	$4,357,600	$8,715,200	$13,072,800	$17,430,400	$21,788,000
Total	$6,416,297,000	$64,162,970	$128,325,94	$192,488,910	$256,651,880	$320,814,850

Sources: Financial Statements of Vancouver Coastal Heath Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).

Overall, reinvesting in continuing care makes sense, as costs are substantially lower – the cost of treating a BC senior in hospital ranges from $825 to $1,968 per day (average is about $1,200), whereas the cost of long term care is approximately $200 per day or less than $50 for home care.[175] Not only will it reduce costs in emergency and acute care, it will improve the overall quality of seniors' care in BC by allowing seniors to live at home longer or the most appropriate care setting.

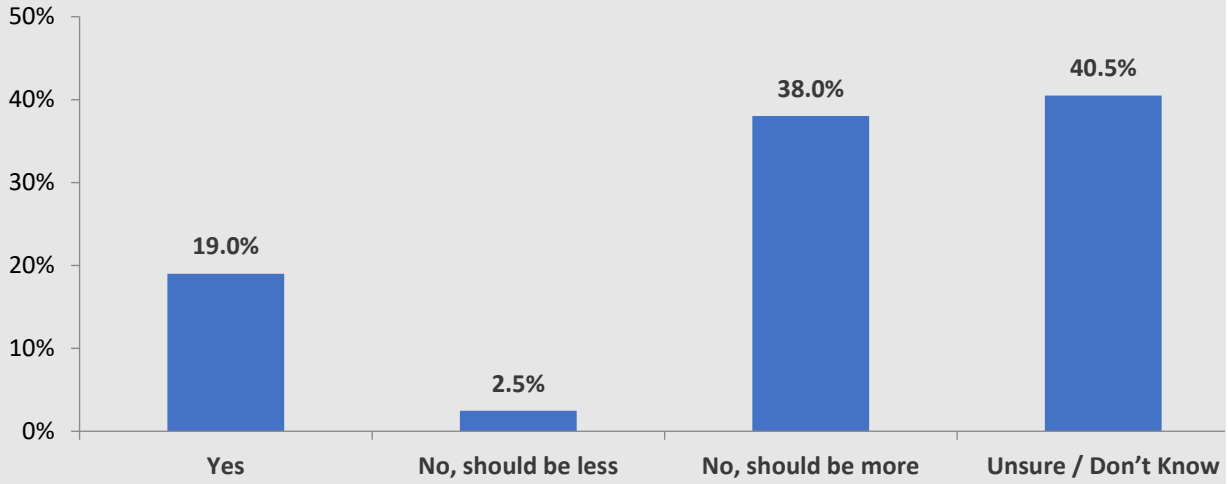
The BCCPA believes that re-directing funding from acute care to continuing care could also be achieved partially through a reduction of alternate level of care (ALC) beds (see Appendix B). Along with reviewing how funds are allocated, it may also require exploring new revenue sources.

Dealing with these fiscal challenges should be a priority for governments, including finding ways to redirect existing funding from more-costly acute care as well as looking at new ways to finance seniors and continuing care in the future. Some of these options such as long term care insurance is outlined earlier along with the BCCPA White Papers and were also areas of discussion at the inaugural BC Continuing Care Collaborative on September 20, 2016 at the SFU Wosk Centre for Dialogue.

When participants were asked at the BCCPA Continuing Care Collaborative whether the proposed 1 per cent shift in health authority acute care expenditures to home and community care is the right amount to meet the growing demands of an aging population, there was broad consensus as close to 60 per cent said was enough or should be more. Another 40 per cent were unsure.

[175] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

Figure 6: Support for 1 per cent shift in health authority acute care expenditures to home and community care



APPENDIX G: LIST OF ACRONYMS

Acronym	
ACAT	Aged Care Assessment Team
ADL	Activities of Daily Living
ADP	Adult Day Programs
ALC	Alternate Level of Care
AGM	Annual General Meeting
ARQ	Accountability, Responsibility, Quality
BCCPA	BC Care Providers Association
BCSLA	BC Seniors Living Association
CADTH	Canadian Agency for Technology and Health
CCPA	Canadian Centre for Policy Alternatives
CDC	Consumer Directed Care
CHCA	Canadian Health Care Association
CHOICE	Comprehensive Home Options Integrated Care for the Elderly
CHW	Community Health Workers
CIHI	Canadian Institute for Health Information
CLBC	Community Living BC
COPD	Chronic Obstructive Pulmonary Disease
CSIL	Choice in Support of Independent Living
EIPC	Emerging Issues and Policy Committee
FHA	Fraser Health Authority
HCC	Home and Community Care
HEABC	Health Employers Association of British Columbia
HHR	Health Human Resources
HSW	Home Support Workers
ICC	Integrated Comprehensive Care
IHA	Island Health Authority
IV	Intravenous
JCHHC	Joint Committee on Home Health Care
LHIN	Local Health Integration Network
NHA	Northern Health Authority
NHS	National Health Service
NICE	National Institute of Center for Health and Care Excellence
OSA	Office of Seniors Advocate
OT	Occupational Therapy
PA	Physician Assistant
PACE	Program of All-Inclusive Care for the Elderly
PT	Physiotherapy
QIC	Quality-Innovation-Collaboration

RAI-HC	Resident Assessment Instrument – Home Care
RT	Recreational Therapy
NP	Nurse Practitioner
OHCA	Ontario Home Care Association
UWLM	United Way Lower Mainland
VCH	Vancouver Coastal Health
WRHA	Winnipeg Regional Health Authority
WTA	Wait Time Alliance

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