Ronayne, Bruce HLTH:EX

From: Cook, Heather G HLTH:EX
Sent: August 27, 2018 11:11 AM
To: 'vmsmithvictoria@gmail.com'
Cc: Mackenzie, Isobel HLTH:EX
Subject: RE: Monday update
Attachments: Home Support Review Draft Report 2018-01-18.docx

Hello Vivian,

Please find attached the most recent DRAFT of the Home Support Report as per Isobel's request.

Thank you

Heather Cook, RN, MScN
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From: Mackenzie, Isobel HLTH:EX
Sent: Monday, August 27, 2018 9:23 AM
To: 'vmsmithvictoria@gmail.com'
Cc: Cook, Heather G HLTH:EX
Subject: RE: Monday update

Hi Vivian:

We will email it to you today. Heather – latest version of Home Support Report.

This report is based on quantitative not qualitative data. The data you see in the report will likely all be updated slightly using the latest CIHI data and what we can get out of the Ministry. This is not in response to any action plan. This report is part of the OSA's on- going mandate to monitor services, address systemic issues, provide recommendations and engagement with seniors and their families.

While we want the report to be readable for the public, it is aimed at those in the public that have some knowledge and understanding and we want it to be fact and evidenced based.

The rough outline to follow:

1. Home Support- what is it: this will be a description of the service, we can use some of the language from the current provincial home and community care manual as reference, also reference the two goals of the program, assisting people to live independently (on-going) and supporting earlier discharge from hospital (episodic)
2. Who gets it- this will be a description of the clients based on the latest InterRAI assessments. We need to decide what to include and not include, but I err on the side of including more. I think it will also be helpful to show a time comparison and I a m thinking 2017/18 compared to the first year we have good data for (Heather to advise)

3. How much are people getting – we will be using Ministry data for this, and I think we can update the numbers in the report. We need to stratify long term and short term and CSIL. We will likely want to break this down by Health Authority.
4. How much are people paying – we will use the data on co-payment.
5. What do those who use the program have to say about it – a small section on the survey, remembering that we did an entire report on the results of the home support survey.
6. How Effectively is HS achieving its goals;
    a. Discuss the decrease in intensity- link to LTC data and RC survey, this is impacting the ability to maintain people at home. Link to data on admissions to long term care without HS or with < 4hrs/day
7. Is Cost limiting the uptake – talk about the co-payment, give the examples etc.
8. Is Program Design limiting the uptake – talk about client direct funding;
9. Is rationing by HA limiting the uptake- talk about the policy for hours, the lack of communication with clients about entitlement
10. Are excluded services limiting the uptake- talk about hskp, meals, transportation, respite.
11. What changes are needed
    a. Increase the scope of services: include hskpg, transportation etc. Link to collateral positive impact on jobs for home support workers
    b. Examine co-payment. Update the formula to reflect inflationary lifts on cost and exempt SAFER as well as GIS.
    c. Target Respite – provincial entitlement is 8 hours per week, outside of personal care hours.
    d. Liberate CSIL- make client direct funding easier and more accessible
    e. Provincially Standardized printed information for clients and their family members outlining the home support program, the assessment process and the entitlements. This would be used by all health authorities (we may want to include a sample).

I will connect your through email with Bruce Ronayne, s.22
s.22

Thanks
Isobel

From: Vivian Smith [mailto:vmsmithvictoria@gmail.com]
Sent: Sunday, August 26, 2018 8:18 PM
To: Mackenzie, Isobel HLTH:EX
Subject: Monday update

Hi Isobel,
As soon as possible, I'd like to have the Home Support Review sent to me as a word document. Way easier to move stuff around that way.
I also need a brief outline of the data-gathering methodology. How was the study done, who took part? How long did it take, etc? I see that on page 8, that "including the voice of seniors and their caregivers in assessing the services they receive provides an additional lens etc etc," so I wonder if seniors comments were included in the data capture or are you

saying that is coming up in some other report? Earlier, on page three, you note that government funding means that "an opportunity presents itself to incorporate the perspectives of those receiving home supports services in redesigning and enhancing the services." So I'm confused; is that what this report is doing in part, with seniors having been consulted? Or is it a straight-up quantitative analysis response to the Action Plan to Strengthen Home and Community Care for Seniors that gives the province a blueprint for change? Neither? Thanks for clearing that up.
I look forward to receiving, at your earliest convenience, your email that outlines the issues arising from our meeting.
s.22

Thanks again for this opportunity.
Cheers,
Vivian

Home Support Review

Draft January 18, 2018

Revision History

Filename date	Author(s)	Description	Notes
October 18, 2017	Nancy/Rob	Home Support Review	Updated with 2015/16 data
October 20, 2017	Nancy/Rob	Incremental draft	
November 1, 2017	Nancy/Rob	Incremental draft	
December 1, 2017	Nancy	Incremental draft	
January 18, 2017	Heather	Incremental draft	

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Introduction

British Columbia's home support system has remained relatively unchanged for more than two decades and has been the subject of numerous reports by a variety of organizations. The content and critiques of these reports have varied, however a consistent theme has emerged – while the home support system is achieving many of its intended functions and goals, there is no question that the home support system must evolve to address the needs of a growing and increasingly frail and complex seniors population.

The provincial government has recognized this need and in March, 2017, released its Action Plan to Strengthen Home and Community Care for Seniors. This plan recognized the need to not only deliver more hours of service to the growing home support client base, it also recognized the need to expand the scope of service as well as refresh existing home support policies in the province. Additional funding has been directed towards home support from both the provincial and federal governments, and an opportunity presents itself to incorporate the perspective of those receiving home support services in redesigning and enhancing the service.

An effective home support program achieves two primary objectives. First, with ongoing support, seniors can live in their own homes for as long as possible and delay or eliminate the need for admission to residential care. Second, it reduces the strain on the acute care system by reducing the risk of hospitalization for its clients through proactive intervention and monitoring, and allowing for quicker discharge from hospital. These objectives support the desire of the majority of seniors to live independently and to receive supports and care, if needed, in their home. With these objectives in mind, the intent of the Office of the Seniors Advocate (OSA) in undertaking a review of home support is to understand the current state and trends over time of home support services and engage users of the service in providing feedback on their experience of the services they receive. Finally, to identify potential opportunities for innovation and service delivery enhancement. In conducting the review, the OSA drew upon many sources of data and information including the results of a province-wide standardized survey of all home support clients in BC, and administrative and clinical data from the Ministry of Health and the five regional health authorities.

This report makes recommendations in three key areas:

- Ensuring the hours of home support are optimized to meet the needs of an increasing seniors population and that the model of service is responsive to the needs of the senior;
- Improving flexibility and choice in seniors' access to home support services by ensuring it is client and family-centered; and
- Introducing innovative and cost effective solutions for home support to the health care system.

Home Support in British Columbia

How the Home Support System Works

As we age, some of us will find it more difficult to manage tasks that allow us to live independently. We may experience challenges bathing, getting dressed, or managing medications—collectively referred to as the Activities of Daily Living, or ADLs. In British Columbia, subsidized[1] home support is available to help individuals who face these daily challenges.

B.C.'s home support is governed by provincial policies and guidelines and is managed and delivered by each of the province's five regional health authorities. It is delivered as part of the provincial Home and Community Care (HCC) program, which also offers professional supports such as nursing, physiotherapy, occupational therapy, nutrition, and social work.

Activities of Daily Living (ADLs)

- Basic self-care
- Feeding
- Toileting
- Dressing
- Grooming
- Maintaining continence
- Bathing
- Walking
- Transferring

The B.C. Ministry of Health defines the scope of home support services in its Home and Community Care Policy Manual as follows:

> ***"Home support services*** are direct care services provided by unregulated care providers to clients who require personal assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, bathing, cueing, grooming and toileting, and may include safety maintenance activities as a supplement to personal assistance when appropriate, as well as specific nursing and rehabilitation tasks delegated under Policy 1.C, Delegation of Tasks.
>
> ***"Safety maintenance activities*** are identified through the care plan and focus on reducing, eliminating or monitoring risk or potential risk to a client. As part of the authorized services, these activities may include clean-up, laundry of soiled bedding or clothing, and meal preparation."

B.C. Ministry of Health policy states that home support services are meant to *supplement*, rather than replace the efforts of individuals and their caregivers to meet their health needs. Subsidized home support is available to clients on an ongoing regular basis (long term home support) or on a short term basis that is expected to be temporary (short term home support). Short term home support is typically put in place to facilitate hospital discharge where a patient is able to recover in their own home with the assistance of home support.

[1] "Subsidized" indicates partially or fully funded by a health authority

Health authorities deliver home support either through staff directly employed by the health authority or through an agency that is funded to provide the service. In either case, the guidelines, supervision and training requirement for home support staff are the same.

Long term home support services are provided in two ways – either directly by the health authority (or contracted provider) or through a specialized program known as Choices in Supports for Independent Living (CSIL). Individuals who are part of the CSIL program receive funds from the health authority in lieu of home support hours, allowing the client (or a proxy) to hire and direct their own caregivers. This arrangement is one type of self-directed care, and one of the focus areas of this report.

Clients who do not require home support but need stand-alone support for activities such as transportation, shopping, financial management, housekeeping and meal preparation (referred to as Instrumental Activities of Daily Living - IADLs) are directed to community resources, such as the United Way's Better at Home program, as these services are not part of the array of services available through the Ministry of Health funded program. In some exceptional circumstances where an individual is eligible for home support on the basis of their need for assistance with ADLs, some housekeeping service may be available where it meets the criteria of "hazard reduction". Additionally, in some instances limited meal preparation may also be available. There is variation across the health authorities in the extent to which these additional services may be available.

A number of criteria are used to assess eligibility for home support and the clinician will complete the assessment and consider:

- Client's ability to manage, including risk assessment
- Unique needs and strengths of the client
- Other supports, including that provided by family and friends
- If there are other community services to address the client's needs

Clinicians work with the client and their family to determine what services will best support the client to remain independent in their home.

Most health authorities have set a guideline of a maximum of 120 hours of home support per month for individual clients. This translates to 4 hours per day of daily service for a client. If a client is assessed to require more than 120 care hours per month, approval processes are in place to make exceptions to the 120 hour maximum.

Clients receiving long term home support are required to pay a client contribution toward the cost of the support they receive. The amount of the contribution is based on the client's assessed income on their most recent tax return. The client contribution is called the "daily rate," and is charged for each day the client receives service, regardless of the number of hours received per day. For example, a client with a $20 daily rate would pay $7,300 per year for daily service; a client receiving service every other day would pay $3,640 per year.

A senior in receipt of the federal Guaranteed Income Supplement (GIS) will have the client contribution waived. Approximately 70% of B.C. long term home support clients receive GIS, and therefore have no client contribution for home support services.

The Guaranteed Income Supplement—commonly referred to by its acronym, GIS—is a federal benefit paid to seniors who are eligible for Old Age Security (OAS) but whose overall annual income *including OAS* falls below a certain threshold ($24,486 for singles, $35,668 combined for couples). The GIS payment decreases as income approaches this threshold.

Who receives Home Support?

In the course of a year, about 40,000 people in BC use the home support program, with approximately 22,000 receiving service at any given time. Data derived from the RAI-HC (Resident Assessment Index – Home Care) assessments of clients allows us to paint a picture of the characteristics of home support clients as (see Table X below).

Table X: Characteristics of B.C. home support clients (RAI assessment) 2015/16

Average age	82
Female	67%
Married	28%
Widowed	43%
Lives with primary caregiver	42%
Caregiver distress	31%
Dementia diagnosis	32%
Wandering	3%
Aggressive behaviours	12%
Activities of Daily Living 3+	20%
Cognitive Performance Scale 3+	21%
MAPLe 4/5	52%
Bladder incontinence	26%

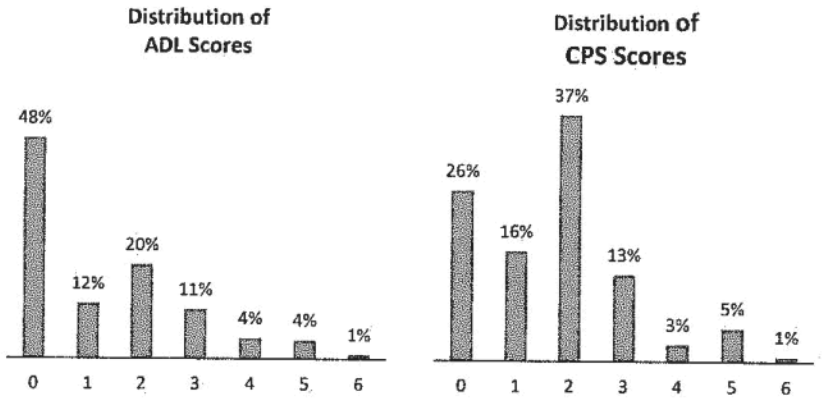
Activities of Daily Living
a score of 3 or more describes a person who is not fully independent and must have physical assistance to complete tasks such as bathing, toileting and activities related to their personal care.

Cognitive Performance Scale

a score of 3 or more indicates that the person needs close supervision and direction to carry out daily tasks.

Method for Assigning Priority Levels
the (MAPLe) score, an algorithm that uses dozens of items within the RAI-HC assessment tool to assign a numerical value to the overall complexity of a client's needs. Scores of 4 and 5 demonstrate high complexity

Because seniors receiving home supports vary in their individual range of physical and cognitive capabilities, each person is assessed and a home support plan is tailored to best meet the needs of that individual. In reviewing the data for Activities of Daily Living (ADL) function and the Cognitive Performance Scale (CPS), we are able to see the broad range of client needs being met in the home support program. One-fifth of clients have an ADL score of 3 or higher, which means they need significant to complete assistance with the activities of daily living. Over one-fifth of clients have a CPS score of 3 or higher, which would be typical of moderate to advanced dementia. Increasing values on the CPS scale indicate more significant cognitive impairment, including difficulty with short term memory, difficulty making oneself understood, and the need for cueing to complete tasks.



Commented [CHGH1]: I suggest removing this and converting it into bullet points...69% have a score of 2 or less in CPS scale....something like that

What this variation in client characteristics demonstrates is that the home support program is capable of successfully supporting seniors throughout the process of aging and that, as clients' needs increase, the program is able to support their continued ability to live at home. As well, this variation speaks to the complex task home support staff have in managing the needs of a large and diverse population.

Review of the Home Support Program

As stated in the introduction to this report, B.C.'s home support service has two primary objectives:

- To support seniors to live in their own homes for as long as possible and delay or eliminate the need for admission to residential care.
- To reduce strain on the acute care system by reducing the risk of hospitalization for home support clients through proactive intervention and monitoring, and allowing for timely discharge from hospital.

While it is difficult to directly evaluate how efficiently or effectively these objectives are being met, there are several markers we can examine which, when bundled together, can paint an overall picture of

the home support program. Importantly, including the voice of seniors and their caregivers in assessing the service they receive provides an additional lens to aspects of effectiveness and efficiency in service delivery.

Is home support keeping pace with population growth and increasing complexity?

The ability of the home support program to achieve the objective of keeping seniors living independently and reducing length of stay in hospital and/or delaying or eliminating admission to residential care can be approached in a number of ways. One way is to assume that the current delivery of home support services, in terms of number of clients served and number of service hours per client, is appropriate and that we only need to ensure it keeps pace with the population growth. If so, what one should see, at a minimum, is the number of clients growing at a rate that is keeping pace with the population growth and that the number of hours per client remains constant. In fact, analysis shows that home support services are not keeping pace.

BC has experienced a growth in the population > 65 years of age AND has seen an increase in the total volume of home support hours. BUT the rate of growth of the >65 population has outstripped the increase in total volume of hours. This means that service levels have fallen in comparison to service levels in 2006/07.

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% over the previous year. This doesn't sound like a large decrease, but in fact, it is 11,089.55 hours, which is equivalent to 42 fewer clients receiving support at the average of 263 hours of care annually. This overall decrease in the amount of service delivery took place despite an increase in the number of clients.

Table: Client counts and hours delivered by home support program (including CSIL clients)

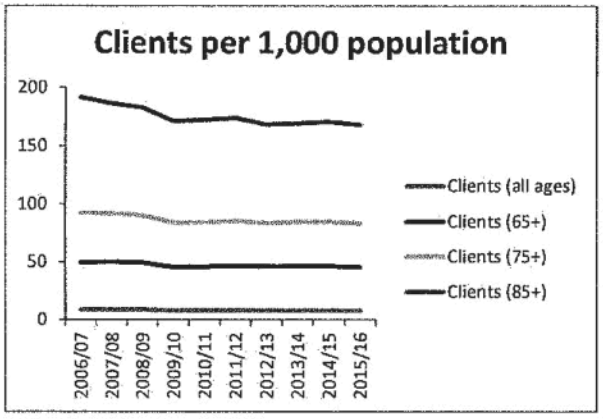
INCL CSIL	Clients	Hours	Population, 65+
2006/07	34,471 (17% of pop>65)	8,383,447 (243.2 hours/client)	611,211
2015/16	42,170 (20% of pop>65)	11,089,553 (262.97 hours/client)	850,424
% change 06/07-> 15/16	+ 22%	+ 32%	+ 39%

As the table above shows, while there has been an absolute increase in the number of clients and the volume of hours delivered to these clients, the population growth among B.C.'s seniors has outstripped service increases. The graphs below illustrate, on a per-population basis, service levels have fallen relative to 2006/07. The overall number of clients receiving home support and the number of hours of home support has not kept up with population growth.

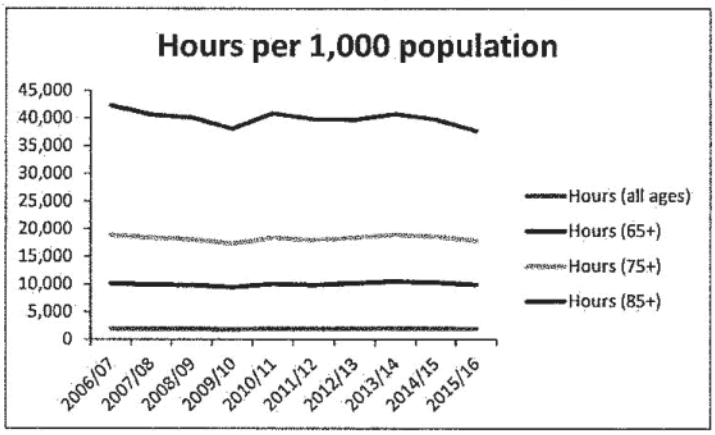
The following graphs plot a relative measure of services levels: the number of clients and hours per 1,000 population. Since 2006/07, the data demonstrates a downward trend in the number of clients and the hours they receive relative to the size of the overall population in B.C. Intuitively, the likelihood of needing home support services is associated with increased age, so we have developed a graph demonstrating service levels against different age cohorts. Most home support clients are at least 75 years of age, and in fact fully one half are aged 85 or older. In relation to the general population aged 75 or older, home support service levels per 1,000 population have seen a moderate decline between 2006/07 and 2015/16; on a per population basis, the number of clients receiving home health services has declined by 10% and total service hours have declined by 6%. Most alarmingly, however, service levels for people aged 85 or older have declined markedly since 2006/07; on a per-population basis, the number of 85+ clients have declined by 12% and total service hours have declined by 11%.

Commented [CHGH2]: Need to add in the growth rate of this population

Graph: Number of clients on home support (including CSIL clients)



Graph: Number of hours of home support (including CSIL clients)



One of the measures of service intensity is hours per client per year. In 2015/16, the average hours delivered per client per year was 263, or 5.1 hours per week. This represents a provincial decrease of 2% in the average hours of service per client from 2014/15.

Table: Average hours per client, per year

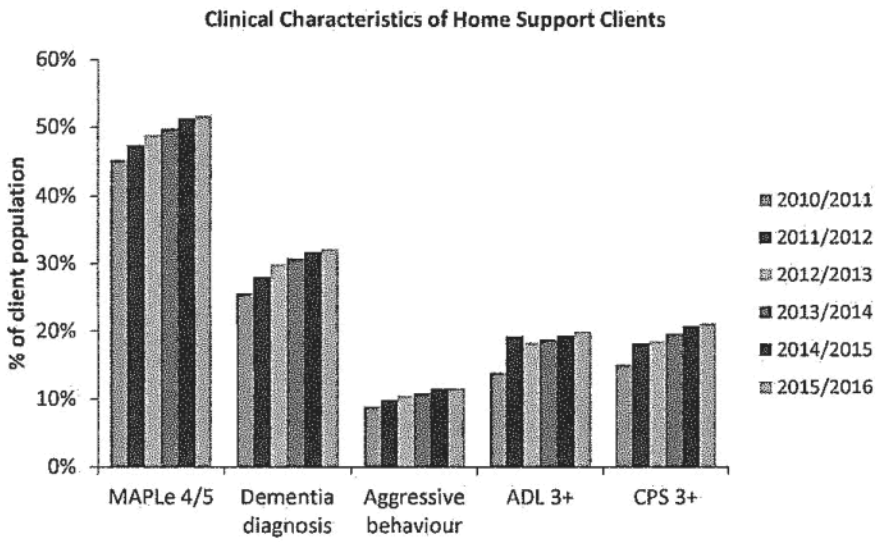
	w/ CSIL
2006/07	243
2008/09	239
2009/10	250
2010/11	262
2011/12	256
2012/13	267
2013/14	272
2014/15	268
2015/16	263

The decrease in average hours of service over the past 4 years is coupled with another trend: the health care needs of seniors receiving service are demonstrating increasing complexity. Seniors receiving home support are experiencing increasing levels of cognitive impairment, responsive behaviours, impairments in activities of daily living, increasing MAPLe scores, and increasing reports of caregiver distress.

Commented [CHGH3]: definition

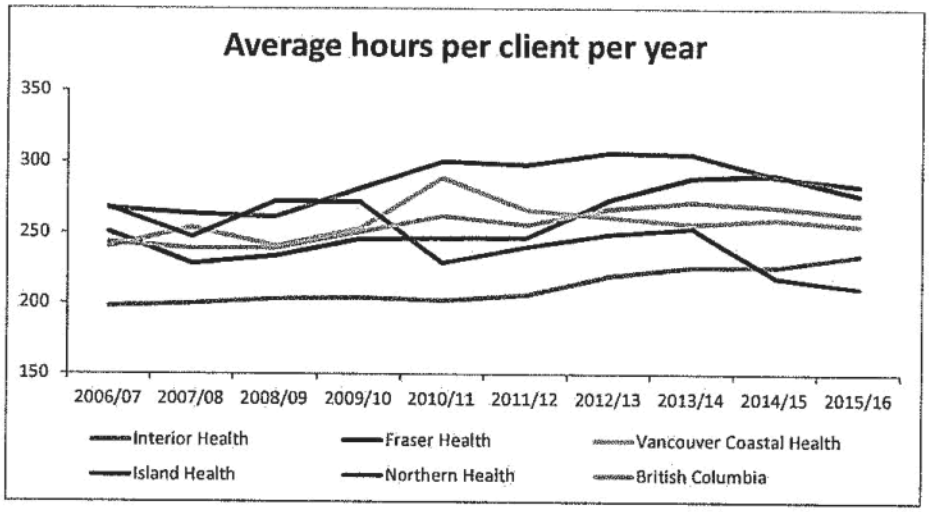
The chart below demonstrates the portion of clients with any of the six measures of complexity has increased by at least nine per cent over the past six years. This data suggests that despite the client base becoming increasingly complex each year, the intensity of service has been on the decline over the past four consecutive years. It is well understood that a more complex client requires a higher intensity of service for their needs to be adequately met.

Graph X: Clinical characteristics of home support clients (RAI assessment) from 2010/11 to 2015/16



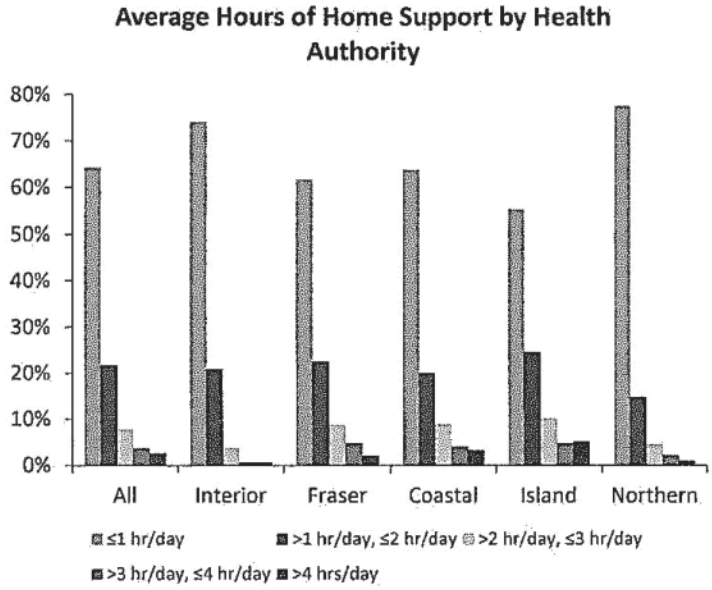
Ensuring service levels are equitable across health authorities

There is substantial variation in home support service delivery by health authorities across the province. The table below shows that Island Health, with approximately 283 average hours of service per client per year, consistently provides more home support hours per client than other health authorities. Fraser Health provides the second highest level of support with 277 average hours per client per year. Northern Health and Interior Health, on average, provide the lowest amounts of hours per client per year. Average hours increased in only one health authority, the health authority which, historically, had delivered the lowest levels of home support.



The variation in average hours per client is also reflected in the distribution of home support hours that an individual client receives across the Health Authorities. Two health authorities (Northern and Interior) have a greater percentage of clients with less than one hour of service per service day. Island Health demonstrates a greater percentage of its clients receiving services in the two to four hour range. Island Health also appears to be an outlier in terms of offering greater than four hours of service, including a number of clients receiving 24 hour live-in support, a service that does not appear available in other health authorities.

Commented [CHGH4]: awaiting data from Jeff for rate of or %accessing LTC for all HA's



Perhaps more interesting than the health authority differences in average hours of home support per client per year, is the inconsistency in terms of the time allocated to individual home support tasks (e.g. bathing). Each health authority has developed its own practice manual that specifies a time range for each activity in order to determine the number of hours of service a client will receive.

There is wide variation between health authorities in the time parameters allocated for each activity or group of activities. The minimum time allocated for personal care, including bathing, incontinence/toileting and catheter/bowel care, ranges from just over 30 minutes to over an hour. The range in the minimum time allocated to meals, including prep and eating/feeding, is even more varied, from 15 minutes to one hour. Finally, the minimum parameters for activities such as medication administration, ranges from five to fifteen minutes.

Suggested travel time allocations for home support workers ranges from 10-15 minutes across health authorities. While this may be sufficient in smaller urban communities, this is most certainly a challenge in British Columbia's larger cities and in the rural and rural remote areas. In areas with a high concentration of home support clients within close proximity, services may be delivered via a clustered care model. The care requirements of all clients in the cluster are used to allocate workers in an efficient manner by reducing travel and focusing work in one geographic area (neighbourhood). In this model the minimum authorized time home support workers may spend per client can be only 10-15 minutes, whereas for non-clustered services the minimum ranges from 15-30 minutes across health authorities.

Finally, there is significant inconsistency within health authorities in determining the range of hours of in-home respite care for caregivers. While two health authorities do not specify a time range, one health authority indicates a range of up to six hours of respite care. The importance of respite care in preventing caregiver distress cannot be understated as evidenced by our previous research which found the number of hours of care provided by the unpaid caregiver is the strongest predictor of caregiver distress.

Are we comparing apples to apples?

It is reasonable to ask whether the differences in service parameters are as a result of differences in the health characteristics of the seniors in each health authority. For example, if a given health authority has clients with more complicated health needs in comparison to another health authority, it would be reasonable to expect that the health authority would provide a higher intensity of service.

To understand if this is the case, an analysis was conducted that adjusted for various health characteristics considered likely to drive the need for home support including: the client's ability to conduct activities of daily living (ADL score); cognitive impairment (CPS score); wandering; co-residing with a caregiver; and levels of informal support available to the client. The analysis demonstrated that health characteristics did not explain all of the variation in the distribution of home support hours between health authorities. Some variation in service hour distribution was linked to in which geographic area the client lived and which health authority delivered the service. In other words, a client who lived in the interior of B.C. with identical characteristics to a client living on Vancouver Island, would generally expect to receive fewer hours of service.

In conclusion, the analysis of client assessment and service utilization data provides a picture of a complex system. While the number of seniors in B.C. is increasing rapidly, the number of home support clients while increasing, has done so at a slower rate than population growth. At the same time that the average home support hours provided annually to clients has reduced, the clinical complexity of clients has increased steadily. As a result of increasing complexity and reducing service hours, it is reasonable to assume that, because the home support system works within resource constraints, the threshold of need for receiving service must increase. At a very basic level, the home support program is not keeping pace with demand or the increasingly complex needs of home support clients.

As the complexity of the average home support client has increased, the hours per year delivered to the average client has decreased.

Recommendation: The Ministry of Health, in conjunction with health authorities, develop a home support capacity plan that is sustainable, standardizes the parameters of task and time allocation, and reinforces the need for standardization of service and equitable access for seniors across the province.

Potential for delaying admission to residential care

The financial and strategic importance of an efficient and effective home support program is most apparent than when looking at the role it plays in delaying or preventing admission to residential care. As part of the Office's November 2016 report *Making Progress: Placement, Drugs and Therapy Update*, three profiles of residents with low care needs were used to assess the degree to which seniors may be admitted seniors into residential care before they are truly ready.

The November 2016 review identified that some seniors whose physical and/or cognitive function was not sufficiently compromised to require 24-hour-a-day care, and who were potentially inappropriately placed in residential care. The review indicated that of the 28,000 residents living in residential care facilities approximately 10% may not require residential care placement and could be cared for in the community either in assisted living or with home supports. The population of residential care clients who may not require residential care placement met the following descriptions:

- having few or no impairments in either cognition or physical ability to meet care needs
- having mild to moderate symptoms of dementia, but no physical impairments
- having physical challenges and intact cognition, who might be better served in assisted living

The very personal impact of admission to residential care on residents and their families emphasizes the need to ensure that people enter into residential care only when necessary and only when all other available supports, including home support, have been exhausted.

The data reviewed in producing this report shows that 48% of residential care admissions were not preceded by publicly subsidized home support. Of those who did receive service, only 27% received three or more hours of home support service per day. This analysis highlighted concerns that community services such as home support are not being fully explored before a move to residential care is made.

This has system cost implications as well as quality of life implications for the individual who may wish to live at home. From a system perspective, in 2016 almost 2000 seniors were waiting placement, and a further 8,549 seniors were admitted to residential facilities. If 10% of residents in residential facilities

(2,800 individuals) could have their care needs met in their own home or in Assisted Living, individuals who do require residential care would no longer be delayed service as a result of waiting. Additional capacity would be available to develop innovative strategies for respite to continue to support individuals in remaining at home. Further, the cost of providing service in residential care for one day is approximately twice the cost of providing 3 hours of home support.

Taken together, these analyses suggest that home support is not being fully exhausted as a financially preferable alternative to residential care. From a quality of life perspective, the vast majority of seniors express a desire to remain in their homes for as long as possible. The need to fully exhaust the home support system is a quality measure for maintaining individuals in their own home and potentially delaying admission to residential care. While the impact to individuals and their families cannot be underestimated, we must also be look at the healthcare system impact.

If the premise is that of subsidizing seniors to live independently in the community to the level of cost of a care facility, then we must examine those costs. Currently in B.C. residential care costs range between $6,000 and $7,000 per month. The cost of 120 hours of home support varies between and within health regions based on whether the service is contracted or provided by health authority staff. For those health authorities who use contracted agencies, the amount is an average of $36 per hour, for a total of $4,320 a month, slightly higher when the service is provided by health authority staff.

The analysis completed for this report indicates the largest percent of individuals receive 1 hour of home support per day. The data does indicate that complex clients with a significant level of need can remain in their own home with robust home supports, and only the frailest seniors whose needs cannot be met at home should be living in residential care. Our review of the data indicates that many residents are living in residential care without having received home support services. Harnessing the full potential of home support services before admission to residential care will ensure that only seniors who cannot be supported in the community with home support services are admitted to residential care.

Additional analysis was conducted to determine if higher levels of home support (hours/day) would demonstrate a reduced risk of admission to RC. In fact, the data demonstrates that individuals who received up to 2 hours of home support per day had a 77% likelihood of being admitted to residential care (within the 2 year data window) than those who received no home support. The importance of home support hours in helping people to remain in their own home was even more evident when 3 hours of home support per day were provided, which reduced the risk of admission to residential care to 44%, again, in comparison to individuals who received no home support.

Commented [CHGH5]: Insert a graphic representation

There appears no question then that increasing home support hours and maximizing these hours to support individuals to remain in their own home is beneficial for individuals, but that it is also an efficient and effective way to manage our healthcare resources.

Recommendation: The Ministry of Health, in conjunction with health authorities, develop a home support strategy to ensure that home support hours are maximized to support individuals in remaining in their own home. Further that individuals admitted to residential care have exhausted home support services prior to their admission to residential care, and that home support services can meet the needs of those who require short term high intensity and/or overnight supports which may be greater than 120 hours of service in a month.

Alleviating pressure on acute care

Another way to determine whether home support is meeting its objectives is to examine hospital admissions in the province. Just as home support is an important tool for delaying or preventing admission to long term residential care it is also an important tool for alleviating pressures on acute care services. Home support has been shown to reduce emergency department (ED) visits and hospitalizations, reduce hospital admissions from the ED to inpatient, reduce hospital lengths of stay for seniors being discharged from hospital, and potentially avert admissions from hospital to residential care.

A review of how much home support seniors were receiving before and after being admitted to hospital showed that 97% of seniors came to the hospital having received no prior home support service. Of these seniors, 91% were discharged from hospital with no home and community care service in place. While it is likely that the majority of these seniors did not require home support, it is noteworthy to look more closely at some sub-sets of acute care admissions. For example, 32% of all seniors admitted to hospital came through the emergency department; they had an average age of 80, stayed in hospital for 10 days on average for a range of serious medical conditions including COPD, heart disease and pneumonia. This sub-set of seniors, despite their conditions, received no home support prior to hospitalization and were discharged from hospital with no home support. The question arises whether more can be done to identify seniors at risk of hospitalization in the primary care setting, in the community or when they arrive in hospital.

Analysis also showed that hospitalizations of home support clients differ across the health authorities, just as levels of home support service vary. When comparing intensity of home support (defined as hours per day) between health authorities, we see the health authority with the lowest intensity of service has a 15% higher risk of hospitalization for its long term home support clients when compared to the health authority with the highest intensity of service. Although factors influencing risk of hospitalization are complex, this suggests an association between higher service intensity and reduced hospitalizations.

Facilitating discharge from hospital

For seniors in hospital, home support can facilitate more rapid discharge from hospital to home or provide a transition for those awaiting placement to residential care. When a patient's care needs no longer require the intensity of services offered in the facility and the patient is not able to be discharged

home, the designation of a patient as Alternate Level of Care (ALC) is applied. ALC is typically associated with hospitals, where a patient's acute care or rehabilitation phase has ended, but they are not able to be discharged home or to a different care setting which offers other services and care or to their home. This might occur when a patient's family is unable to support their family member's care at home, home support is not yet in place, or when a patient is awaiting placement in a residential care facility.

In 2015/16, B.C. hospitals reported providing over 418,000 ALC days, most of which (89%) were provided to seniors. The issue of ALC is complex, but there are two primary concerns associated with ALC: first, if a patient no longer require acute care but is unable to be discharged from the bed, then a patient who does require the bed will experience delays in accessing the bed (as an example, experiencing a hospital stay in a corridor or other less than optimal space). Perhaps more importantly, acute hospitals are designed to provide acute care, and are not adept at providing residential-type care. The impact for the patient can be significant, including increasing frailty and being subject to hospital acquired infections.

In an effort to in part mitigate the number of ALC days in hospitals in B.C. the provincial government announced in 2013, that regional health authorities would receive $50 million, over three years, for targeted primary and community care initiatives. This funding was intended to help expand or roll out innovations such as the Home is Best (Home First) program across all five health authorities. The Home is Best philosophy was based on evidence that home is the best place for seniors to live and convalesce following hospitalization.

The initial "Home First" service was designed to provide intensive short-term support immediately following hospital discharge, at which point the services are gradually reduced until clients are able to be supported with regular home and community care services. "Home First" was introduced following successful pilots in both Fraser Health and Vancouver Coastal Health. Each pilot reported sizeable reductions in emergency department visits (69% and 25%, respectively) and acute care admissions (50% and 30%). The funding for the initiation of "Home First" program was time limited, and health authorities were expected to integrate principles and practices into their service models.

The "Home First" program targeted services to support seniors with complex care needs return to and remain living at home, avoiding future hospital admissions or transfers to residential care. This can include bathing, washing, dressing, grooming, taking medications and other personal care needs. The program's target audience were those seniors waiting for a residential care bed or a residential care eligibility assessment, in hospital.

Scenario
Using home support to expedite discharge from hospital

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A successful example of Home First was Island Health's initiative in the South Island health service delivery area. The project was built on the philosophy that even those who are assessed as needing placement may find they can function in the community if they receive the appropriate level of support. The data show that, over a two year period, 707 seniors who were in acute care awaiting placement were returned home. For three months, there were intense supports in place. This included support from occupational therapists to ensure the home was accessible (ramps, slip/trip hazards removed) and overnight or live in caregiving where necessary. The goal was to ensure that clients could remain at home after three months with four hours per day of home support or less. The results showed that, after three months, only 28% proceeded to residential care as planned; 31% remained at home with home support as per provincial guidelines (at or below four hours per day) and the remainder were no longer on the program.

While all health authorities may have "Home First" strategies, they differ in the guidelines for enhanced home support, and consequently comparison of services is challenging. For example, health authorities may offer enhanced service as short as 12 hours or 2 weeks of support whichever comes first (although more can be authorized if necessary) or as much service as required within a three month period. Data shows that, in practice, the average short term home support client, with service initiated within one week of discharge from hospital, received 54 days of service with an average of 1.03 hours per day.

Our review of the data revealed that the level of home support delivered to clients varied by health authority, with clients in Island Health receiving the most home support per day and those in Northern Health receiving the least. Clients in Inland Health received short term support from an average of 88 days after discharge (the highest), while those in Interior Health received it for an average of 42 days post-discharge (the lowest). A separate analysis showed that Island Health had the highest proportion of clients receiving four hours or more per day of short term service, and the lowest proportion of clients receiving one hour per day or less. This variation across the health authorities and the low intensity of service per day suggests there is room for not only for standardizing home support allocation but additionally for increasing home support.

Commented [CHGH6]: awaiting new data from Jeff

It is clear from both the evidence and the experiences of seniors and their families that more can and should be done to ensure all home support options and resources are being fully exhausted for seniors being discharged from hospital, both those who are awaiting residential care, and those who are intending to remain at home.

Alleviating burden on family caregivers. Needs to be updated with new data. Check duplication on page 7.

One of the consequences of seniors living as independently as possible for as long as possible is the increasing strain on unpaid caregivers, and family caregivers in particular. It is estimated that the value of unpaid caregiver labour in B.C. is approximated $3.5 billion. According to the Office of the Seniors Advocate's 2017 report *Caregivers in Distress: A Growing Problem*, 96% of B.C. seniors eligible for home support also receive support from an unpaid caregiver. This report found that 31% of caregivers were assessed as experiencing actual distress meaning they were angry, depressed or in conflict because of caring for their loved one and/or believe they would not be able to keep performing their care activities.

B.C. has one of the highest rates of caregiver distress in the country at 30%. The OSA analysis showed that while 54% of caregivers would benefit from respite services such as adult day programs, home support or respite beds only 7% had used an adult day program, only 11% had used a respite bed and only 53% had received home support. Evidence supports a strong correlation between caregiver distress and the number of hours of care being provided by the caregiver. Caregiver distress reduces when a robust home support service is in place. We compared B.C. to Alberta and found some notable differences:

- A higher percentage of caregivers reported distress (B.C. 29%; Alberta 14%)
- A lower percentage of clients received home support services in the last 7 days (B.C. 53%, Alberta 65%)
- The complexity of client needs was higher (B.C. 53%, Alberta 37%)

To summarize, clients in B.C. have higher needs and more caregiver distress, but received less home support than their counterparts in Alberta. While the home support program is intended to supplement unpaid caregiver support (family caregivers), it is also intended to reduce reliance on more costly healthcare resources (hospital and residential care). B.C. data indicates that robust home support services are necessary to support individuals in remaining in their own home, and that the services provided in the community need to be responsive to the needs of the population. Home support has significant capacity to support individuals in their own homes, and to perform an important role in reducing length of stay in hospital.

Recommendation: Health Authorities must ensure home support services are designed to smoothly and quickly transition individuals from hospital to home with sufficient resources for success, inclusive of flexible and innovative respite services and overnight care.

Meeting clients' needs by improving choice and flexibility

An important step in the OSA's review of B.C.'s home support program was to understand how clients and their family members view the program. Client satisfaction is an important component in understanding whether the home support being delivered is meeting clients' needs. In the fall of 2015, the OSA sent a standardized survey to all current B.C. home support clients and their family members. The OSA released the results of the survey, with almost 10,000 responses, in its report, *Listening to Your Voice: Home Support Survey Results*.

The responses showed that the majority of respondents (78%) felt the program was meeting their needs most or all of the time, however clients with higher complexity of needs were more likely to rate home support services as sometimes, rarely or never meeting their needs. Those who responded to the survey showed a higher level of physical and cognitive function than the home support population in general. Overall the survey highlighted the following areas for improvement:

> **Skill of workers** – less than half of clients (47%) report their workers have all of the necessary skills to provide good care
>
> **Number of workers and use of substitute workers** – 48% of respondent felt they had too many different regular home support workers or different substitute workers.
>
> **Additional services** – 28% of respondents would like help with housekeeping. Clients assessed as having great difficulty in performing ordinary housework are much more likely to respond that home support services did not meet their needs.

Expanding suite of services available through home support

In addition, two important themes in the comments made by survey respondents were identified – the inflexibility of the home support system in B.C., and the fact that it was not providing all of the services they need.

The OSA's home support survey clearly revealed that many clients want services that are not currently offered; most notably 33% expressed a desire for housekeeping services, a service that was removed from the suite of home supports services in the 1990s. Currently, if a senior is seeking assistance with Instrumental Activities of Daily Living such as shopping, housework or yard work, they have to find help themselves or are referred to the Better at Home program administered through the United Way of the Lower Mainland. For many seniors, this fragmentation of services is not ideal.

It is important to understand that the burden of IADLs falls to unpaid caregivers much of the time, often becoming part of the caregiver burden and stress. Perhaps the time has come to consider further innovative strategies (in addition to the United Way Better at Home program) to provide assistance with household chores. For example, if individuals receiving home support (who are generally low income) received a stipend from government in response to caregiver burden such that the home support client could purchase services to alleviate stress from their family member (for example some housekeeping services, yard work, snow shoveling etc.). This strategy could be designed such that Home Support Case Managers provided assessment of caregiver burden and "approved" a stipend based on a pre-determined income sliding scale.

Modification of the current home support system would allow for a more family-centred approach. In this model, similar to the home support approach in Ontario, the family becomes the "client." Recognizing the importance of family caregivers means giving them the flexibility to design home support service that optimizes their input, recognizing that non-clinical supports such as homemaking, meal preparation, supportive housing, transportation and respite are often essential to supporting an individual at home.

Recommendation: Ministry of Health and Health Authorities jointly design an innovative self-directed and family-centred approach to address the importance of addressing non-clinical supports such as housekeeping and meal preparation have in reducing caregiver burden.

Supporting self-directed care

In addition to encouraging more flexibility in the existing system, some seniors are telling us that they would like to direct their care themselves in conjunction with their families and caregivers. When reviewing literature and research from other jurisdictions, it is clear that the most effective home support systems are those that allow clients, their families and caring networks, the ability to tailor a full suite of services that best fits their needs.

As stated earlier, there is one self-directed model of care that exists in B.C. called the Choice in Supports for Independent Living program or CSIL. This is a self-directed model of care designed for a specific population and used by a small percentage of home support clients (3%). Similar models are utilized in home support systems around the world. In the CSIL program, health authorities provide the client or their designated representative with funding (based on their care needs) to employ their own workers directly. In effect, the client becomes their own employment agency for the purpose of managing their

support workers. This program is targeted to individuals with moderate to high care needs who have met all other criteria required for subsidized home support.

The overriding advantage to self-directed care is that the person requiring care has much more control over their day to day care and can devise a system of care that works for them, improving personalization and consistency of care. The current CSIL program has some complex requirements for the client or family caregiver to implement in order to access the program, and improving these processes could result in more people accessing the program. There may also be clients who would benefit from utilizing a combination of both health authority delivered service and self-directed service, again a hybrid delivery model that exists in many other jurisdictions world-wide.

Scenario
s.22

Recommendation: Ministry of Health and Health Authorities jointly design an innovative self-directed care option that reduces blends the best aspects of case management and CSIL. This innovative program would provide funding to caregivers to hire home support workers, have oversight and support from Case Managers, and result in a hybrid model of home support better meeting the needs of our aging and frail population.

Ensuring access by low income seniors

Depending on their income, home support clients in B.C. may be required to contribute to the cost of the home support services they receive via a client contribution. In many circumstances, the client contribution can present a significant cost barrier to clients. B.C. is one of the few provinces in Canada that requires clients to pay a per diem rate for service. A comparison between B.C.'s home support program and Ontario's home support program found that a significantly greater proportion of Ontario seniors access that province's home support program; while there are many differences between the programs, it is likely that Ontario's lack of a client contribution amount is one factor influencing this finding.

Approximately one third of home support clients are required to pay a client contribution rate for home support. The remaining two thirds do not pay a client contribution are in receipt of the Guaranteed Income Supplement (GIS). Recipients of GIS, and other federal income-tested benefits like the Allowance for spouses of GIS recipients, do not have a client contribution for home support.

The formula for determining the client contribution amount is based on the client's income. If a home support client is married or part of a common law relationship, the partner's income is included in the calculation. If both partners receive home support, only one client contribution is required, and it will be equal to the client contribution that would prevail were only one partner receiving home support.

The client contribution is calculated as a daily rate. The monthly client contribution is the daily rate times the number of days on which service was received. The formula is as follows:

Net income (line 236 of CRA Income Tax submission)
(-) Income tax paid
(-) Universal child care benefit amount
(-) RDSP payment amount
(-) Earned income up to $25,000 (lines 101, 104, 135, 137, 139, 141 and 143)
(-) Basic deduction amount ($10,284 for singles, $16,752 for couples)
(=) Remaining annual income
(÷) 720
(=) Daily rate

The assessed client contribution is independent of the number of hours, per day, of service; that is, a client will pay the same, per day, regardless of whether they receive one hour or eight hours of service in that day.

If the service delivered to a client is less than the assessed client contribution, they are billed only for the actual cost of service delivery. The following table outlines the cost per hour of home support service provided by the health authorities that would be used to determine the actual service delivery cost:

		NHA	IHA	FHA	VCH	VIHA
Cost per Hour of Long term Home Support	Owned and Operated	$50	$37.95	$35.16	$34.34-$37.00	$35
	Contracted			$33.65	$34.38-$36.38	$36.50

While the lowest income clients—those on GIS—are exempt from client contributions, moderate income clients may face prohibitively high client contributions.

Consider a single senior with an income of $25,000 per year—just above the threshold for receiving GIS...

> This client would be assessed a monthly client contribution of $550 for daily home support, leaving them with $1,400 per month of after-tax income. If this senior faces the rental market in Metro Vancouver, with an average rent of $1,080 per month for a one bedroom, they have very little left over for other living expenses, such as groceries, utilities, and transportation to medical appointments.

Now consider a single senior with an income of $35,000 per year...

> This client would be assessed a monthly client contribution of $880 for daily home support, leaving them with $1,740 per month of after-tax income—an extra $10,000 per year of gross income translates to only $340 per month of extra income after deducting the increased income taxes owed and higher client contribution.

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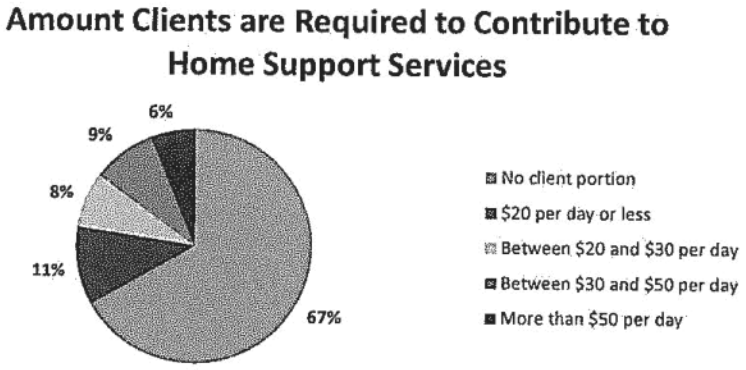
In the OSA's housing report, *Seniors' Housing in B.C.: Affordable, Appropriate, Available*, the routine living expenses of a senior in Victoria or Vancouver were estimated at $1,000 per month. When factoring in rent, it is clear that the client contribution for home support can be prohibitively expensive for seniors receiving daily or near-daily home support visits.

Whether the client contribution is potentially a barrier to receiving home support is greatly dependent on individual circumstances. Some seniors may be living mortgage-free, but 40% of senior households in B.C. with an income below $30,000 are renters. While not all parts of the province face the high market rents seen in Vancouver, cost of living is much more uniform. Lower rents outside of B.C.'s large metropolitan areas may be offset by higher utility costs, higher transportation costs (particularly in areas with underdeveloped transit systems), and higher grocery costs. Even seniors who are living without a mortgage may still find the cost of a home support client contribution to be too high, as their ability to save for home repairs could be eroded.

Although the majority of home support clients do not have a client contribution, the majority of clients with a client contribution must pay in excess of $20 per day. Nine percent of home support clients (29% of those with a client contribution) pay up to $20 per day; these clients would see the largest relative benefit of a revised basic deduction amount.



The basic deductions used in the calculation of the client contribution, has not changed since 1997. The basic deduction amount is intended to "protect" some of a client's income for basic living expenses such as rent, food, and utilities; by remaining unchanged for 19 years, the basic deduction has failed to keep pace with the actual cost of living, leaving clients with too high of a bill for home support.

Increasing the basic deduction amount from $10,284 to $14,500 for singles (with a corresponding increase for couples) would bring down the daily client contribution by $5.86, which, on an annual basis, translates to savings of $2,110 for a client receiving daily home support and $609 for a client receiving twice-weekly home support. This change would update the basic deduction amount to reflect the rate of inflation over the last 19 years.

For clients whose income is just over the threshold for receiving the Guaranteed Income Supplement (and, therefore, not obligated to contribute to the cost of home support), updating the basic deduction amount to reflect inflation since 1997 would reduce by one third the client contribution for home support services.

Recommendation: Ministry of Health adjust the rate setting calculation by adjusting the basic deduction amount from $10,284 to $14,500. Further the Ministry of Health commit to reviewing the basic deduction amount every two years to ensure that low income seniors are not losing ground economically in their ability to access home support services.

Allowing seniors access to equity in their homes to help fund their home support needs

Maintaining autonomy in direction our own affairs for as long as possible is an important tenet of independence. Ensuring clients have flexibility to meet the costs of the care they need to stay in their own homes is important. The Seniors Advocate proposes a program that allows homeowners to access equity in their home to pay for care needs.

While the median income for B.C. seniors is less than $27,000, the majority of seniors—80%—own their own home. A significant number of low-income seniors, particularly those living in regions with strong housing markets, may have substantial equity established in their homes. In the Seniors Advocate's first housing report, a recommendation to the provincial government was made to create a Homeowner Expense Deferral Account program, modelled after the Property Tax Deferment program currently in place. This program would allow low or moderate income seniors to use the equity in their home to offset the costs of housing by deferring some, or all, of the major ongoing and exceptional expenses associated with home ownership.

A similar home equity account program is proposed for seniors eligible for home support services, allowing for deferral of home support costs against home equity. Interest would accumulate on an annual basis, and the balance would be payable upon a client ceasing to receive any home support services, either because of death or initiation of private-pay services. All seniors eligible for home support, and with sufficient equity in their home (at least 25%), would be eligible.

This type of program would ensure that seniors who have wealth established in their homes but a limited, fixed income would be able to afford home support services while remaining in the home of their choosing. While one-quarter of all senior home owners have a household income of less than $30,000 per year, the majority of seniors with a household income of less than $30,000 per year are home owners. For a senior right at the $30,000 per year point, the annual deductible, incorporating the proposed $14,000 basic income amount, would be around $13,000. Deferring this amount against home equity would allow this senior to receive the home support services they require while keeping money aside for expenses such as home repairs or home modifications to allow for continued independence.

The home equity account would function like a line of credit against the home owner's equity. To balance financial fairness to both the government (lender) and home owner (borrower), the interest rate would be set at the prime rate. This would be far below what is available from commercial home equity loans or reverse mortgages, which are generally in excess of a 5% interest rate. Eligible expenses for the home equity account would include the annual home support deductible as well as any private services a client may wish to purchase in excess of what the health authority has assessed as necessary. Giving seniors the choice about where best to allocate their money when it comes to what they know they need to remain living independently is crucial in ensuring home support works and is able to grant independence.

Recommendation: Ministry of Health review and adopt a home owner health expense deferral program to allow those individuals 65 years and older to leverage equity in their homes to pay for health care costs.

Conclusion

The needs and desires of British Columbia's 850,000 seniors are as diverse as the communities in which they live; however, one goal that unites them is the fact that, overwhelmingly, they want to remain in their own homes as they age. The provision of publicly-subsidized home support is a key service in enabling seniors to live independently in their homes for as long as possible. Ensuring that all seniors have equitable access to the services no matter where they live in the province is imperative.

When we look at the evidence, it is important to highlight the efficient and effective work that is being done by health authorities and individual home support workers. However, when we look at the goals of home support in preventing admission to both residential and acute care, it is clear that the home support system is not being fully exhausted before moving to the more costly option of residential care. The efficiency and effectiveness of our health system would be significantly improved with adjustments to include care options that are flexibly administered, self-directed and supported through case management services.

At the same time, it is important to ensure that all seniors are able to access a fair and equitable home support system. While the majority of seniors on home support don't directly pay for the service, approximately one third of clients have a client contribution based on an outdated calculation. Updating the funding formula to reflect cost of living increases would ensure that limited income is not a barrier to accessing home support services, and would ensure an accessible and equitable approach for B.C.'s seniors.

The Seniors Advocate spends significant time reaching out to B.C.'s seniors and listening to their concerns. A recurring theme the Advocate has encountered is that seniors desire more choice and flexibility in deciding what services they need to allow them to remain in their own homes. Allowing clients to choose how to spend the money that would otherwise go to their publicly-provisioned care increases flexibility, convenience, and quality of life with the additional benefit of a lower cost per hour for the government. Self-directed care is increasingly becoming a key tool in many countries' home support programs.

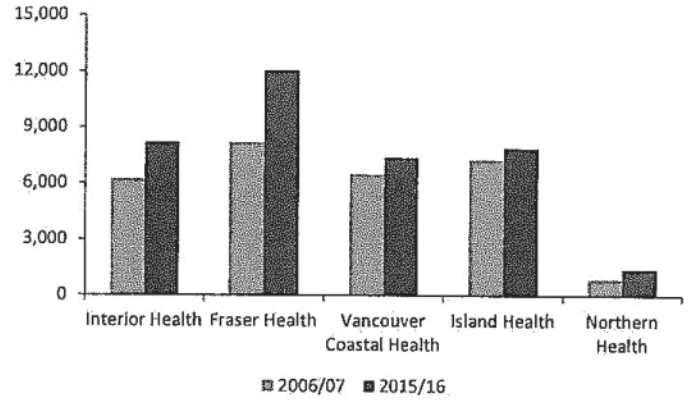
Similarly, home support clients desire access to a broader suite of services, particularly when it comes to housekeeping. While limited housekeeping services may be available to certain clients under the goal of hazard reduction services, most health authorities provide very limited if any housekeeping services. The Advocate recommends allowing all clients to access the ADL and IADL services in a more flexible and self-directed manner that meets the needs of clients and families who are providing care.

The recommendations outlined in this report speak to ensuring that more seniors are able to benefit from home support, and that clients of home support have fairer access to a broader suite of services

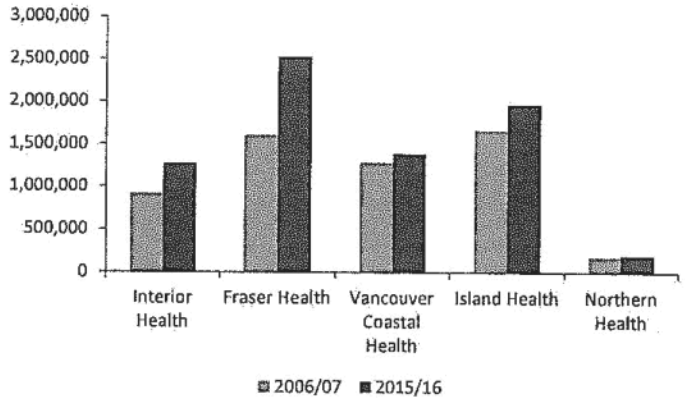
not only today but into the future. Enabling seniors to stay in their own homes as they age is not only important from a quality of life perspective, but also from a health system perspective. Home support is significantly more cost effective than residential care and extended hospitalizations. With British Columbia's seniors population projected to grow significantly in the coming two decades, it is vitally important that the home support system is ready to respond to the increase in clients and more effectively work in conjunction with the long term care and acute care systems in place in the province.

Appendix: Breakdown of Analysis by Health Authority

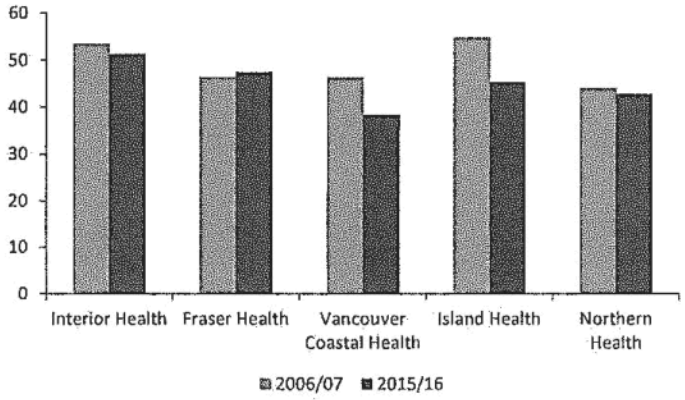
Graph: Client counts, by Health Authority, 65+



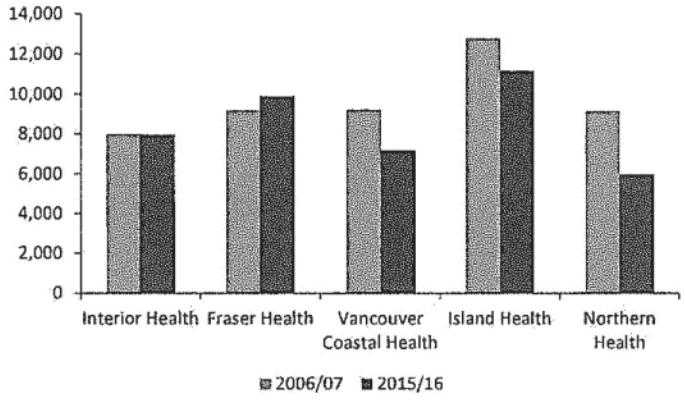
Graph: Hours, by Health Authority, 65+



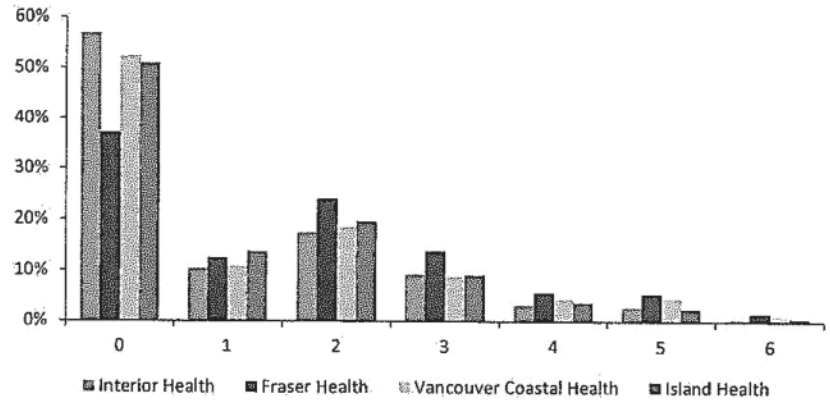
Graph: Clients per 1,000 population, by Health Authority, 65+



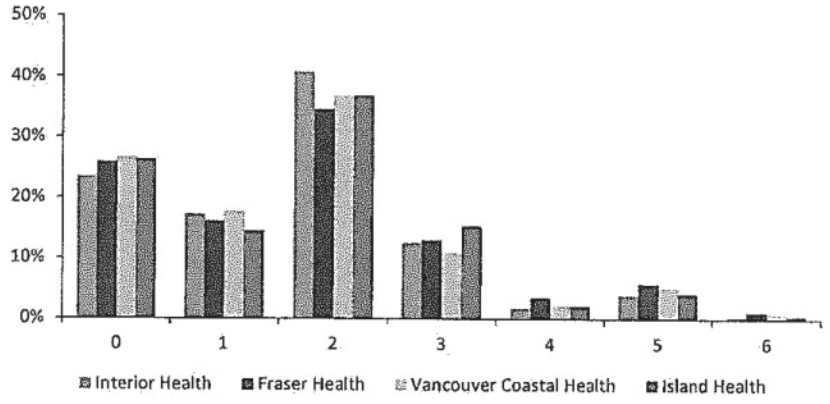
Graph: Hours per 1,000 population, by Health Authority, 65+



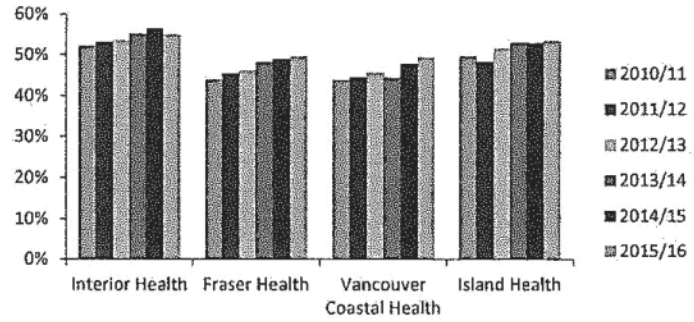
Graph: Distribution of ADL scores, by Health Authority



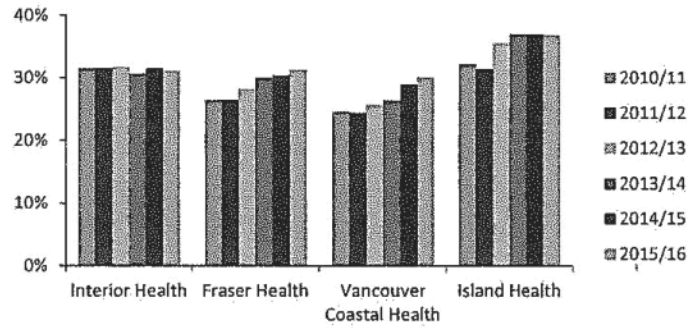
Graph: Distribution of CPS scores, by Health Authority



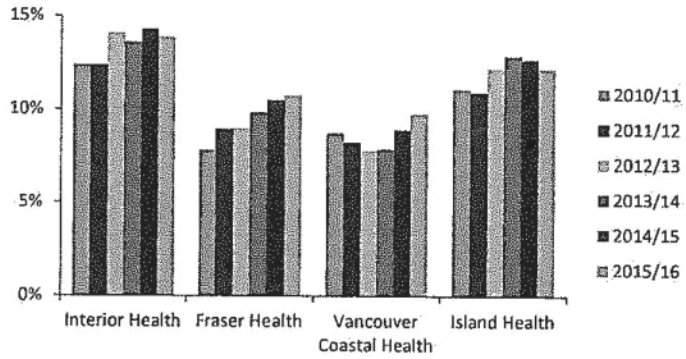
Graph: Distribution of MAPLe 4/5 Scores, by Health Authority



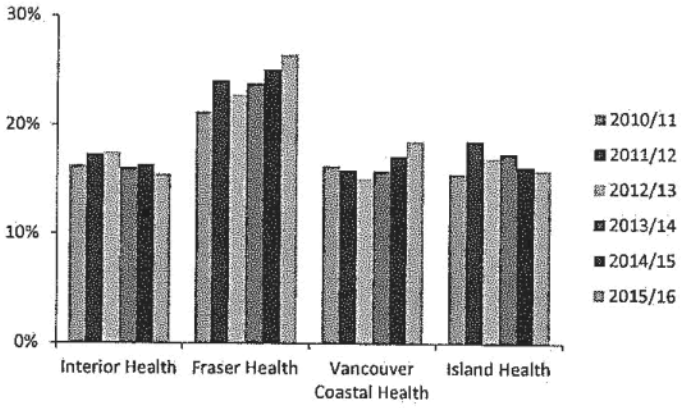
Graph: Distribution of dementia prevalence, by Health Authority



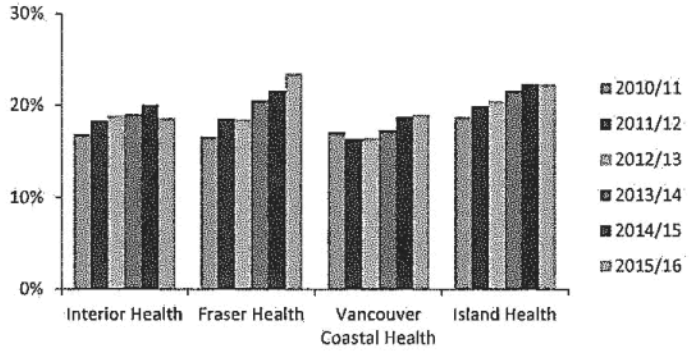
Graph: Distribution of aggressive behaviours, by Health Authority



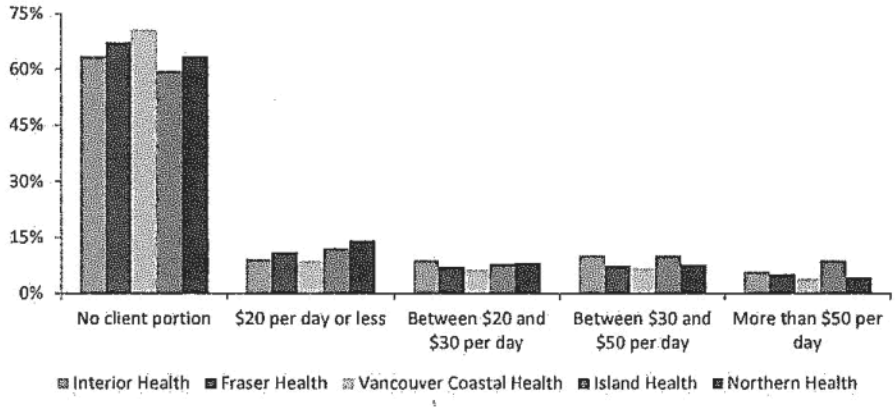
Graph: Distribution of ADL Score 3 or higher, by Health Authority



Graph: Distribution of CPS Score 3 or higher, by Health Authority



Graph: Amount clients are required to contribute to home support services, by Health Authority



Ronayne, Bruce HLTH:EX

From: Mackenzie, Isobel HLTH:EX
Sent: September 19, 2018 7:52 AM
To: 'vmsmithvictoria@gmail.com'
Cc: Marquis, Yvette HLTH:EX; Cowan-Douglas, Rob J HLTH:EX; Cook, Heather G HLTH:EX
Subject: RE: Home Support first draft

Hi Vivian,

s.22

At the moment we are updating the data to the latest numbers. I have had a brief review but need a bit more focus on it to give feedback for the next iteration. I think our deadline will get pushed back a bit. s.22
s.22 I think we should schedule some time together in the office next Thursday or Friday if that works for you. I have copied Yvette on this and we will set up a time. In the interim I have also copied Rob Cowan on this email and you and he can communicate on how we might right up an example or two of the money issues. What we want to illustrate here two different money issues.

First, the co-payment. So we want to talk about the lower income but above GIS threshold and we want it to represent a homeowner and a renter. The point to make is the copayment makes staying at home receiving daily home support more expensive than long term care. We would outline the various costs to the senior when they live at home and receive daily home support on a certain income, I propose using either the median or the average single income (most HS client and RC clients are single).
Then contrast that with what they would pay in RC. We need to remember all the costs that are covered in RC such as drugs, supplies etc.

The second financial picture we want to paint is CSIL funding at the maximum of 4 hours per day. The point we want to make here is the affordability of a live in worker under CSIL for both the client and the system. We want to contrast it both to the cost of hourly care through the existing health authority delivery system and to the cost of long term care.

I have also copied Heather Cook on this as she can help if there are questions about the actual service and Rob can help with the numbers. Looking for both narrative and imagery that can convey this in a way the public can easily understand.

Cheers
Isobel

From: Vivian Smith [mailto:vmsmithvictoria@gmail.com]
Sent: Tuesday, September 18, 2018 1:31 PM
To: Mackenzie, Isobel HLTH:EX
Subject: Re: Home Support first draft

Hi Isobel,
s.22

How is your review of the first draft going?

Cheers,
Vivian

On Mon, Sep 3, 2018 at 7:16 PM Mackenzie, Isobel HLTH:EX <Isobel.Mackenzie@gov.bc.ca> wrote:

Great thanks Vivian, I will have a look at it and get back to you in a few days.

Sent from my iPad

On Sep 3, 2018, at 5:18 PM, Vivian Smith <vmsmithvictoria@gmail.com<mailto:vmsmithvictoria@gmail.com>> wrote:

Isobel,
s.22
Please find attached my first draft of the rewritten report. What a ton of work you folks have done; congratulations and may it bear lots of fruit.
Things to note:
First, the report follows the rough outline you sent to me by email, with some variation as themes seemed to warrant. I have incorporated the elements of the draft report from your office, as well as from my notes from our meeting. I have used new material for which I have attached links. In some places, whatever statement was being made needed a source or evidence to back it up. Some areas need expansion and are marked as such.
Second, I have left in all the charts and graphs that you may or may not want to incorporate as we move through the drafts, except for those in the appendix, which can be added later as needed. Those in the body of the report need renumbering at least.
Third, you will see (Goddess of technology willing) that the draft does not show individual corrections or changes, as the amount would make it difficult to read. You should see only notes at the side – mostly my queries, some additional requests from you for Heather - and some queries in yellow highlight that appear now as part of the report. These are for your office to address, either with more information or an explanation that helps me to understand a contradiction or something I just don't get.
Fourth, in going after redundancies, contradictions and institutional jargon, I may have misinterpreted things and introduced mistakes. Happy to fix those and any errors of sloppiness immediately.
I am curious why you don't mention any aspects of home care for Indigenous people, unless that is handled separately by the Office of Indigenous Health. In that case, perhaps a note on that would be helpful. I wonder, too, if aspects of BC's increasingly diverse population might affect home care delivery. For instance, what happens when non-English speakers need care – are paid translators needed? etc.
Depending on your schedule, I hope you and your staff can review the draft in detail over the next week or two s.22
s.22

Thank you again for the opportunity to be part of this exciting report.
Best,
Vivian
<OSA Home Support Report First Draft .doc>

Ronayne, Bruce HLTH:EX

From: AHCook <ah-cook@shaw.ca>
Sent: January 4, 2019 11:43 AM
To: Marquis, Yvette HLTH:EX; Carey, Linda HLTH:EX; Cook, Heather G HLTH:EX
Subject: email message to go out

Hello Yvette/Linda;

The following email needs to go out from your email address, on behalf of Isobel. She would like it to go out today, but it may have to wait til Monday if I don't get NHA and FHA info this afternoon:

Subject: Hold the date request – Office of the Seniors Advocate

Message:

Isobel Mackenzie, the Seniors Advocate, is requesting that you hold January 23, 2019 from 1030 a.m. – 1:30 p.m. for a meeting in Vancouver. The meeting will take place at (can you please put in the address/coordinates of the PENDER room in Vancouver?, and note that it is on the skytrain (whichever line) route?). Coffee/tea and a light lunch will be provided.

The Seniors Advocate would like to share with you, in advance of a public release, outcomes from her review of Home Support services in British Columbia. She will be sharing data and her key findings and is looking forward to a discussion with you.

Isobel would like to meet with up to two Home & Community Care operational leads from each Health Authority. You have been identified as one of those leads, and you may invite a second operational lead (Director level) from your Health Authority. Isobel would ask that consideration be given for an urban and rural operational perspective. While an in-person meeting is preferred, a web-ex type access will be available. Further details on the web-ex access will be forwarded closer to the date of the meeting.

thank you
Yvette Marquis

The email should go to the following people:

- Shannon Hopkins, VCHA shannon.hopkins@vcha.ca
- Deborah Cracknell, VIHA deborah.cracknell@viha.ca
- Deborah Preston, IHA deborah.preston@interiorhealth.ca

I am missing NHA and FHA, but should have them later today, and I'll send them as soon as I have them. Can you also secure the Pender Room for the 23rd (better do that before you send the email??), and arrange for food for about 20 people. Isobel also wants to invite some care providers, I don't have their contact information yet and won't have that til Monday. I'll craft a second email for the care providers on Monday. Isobel will also require travel arrangements. Not sure if she is taking Shelley with her or taking Rob to manage the technology?

thanks
Heather C

Ronayne, Bruce HLTH:EX

From: Cowan-Douglas, Rob J HLTH:EX
Sent: March 12, 2019 10:58 AM
To: Mackenzie, Isobel HLTH:EX
Cc: Cook, Heather G HLTH:EX
Subject: RE: request for data

I need to update the below to exactly mirror Jeff's approach. He looks at home support numbers only for those clients *not* admitted from hospital, which I think is a better way to do this, so I've redone my numbers.

Comparing with Jeff's numbers from 2014/15:

- % admitted to LTC with NO home support AND who were NOT admitted from hospital:
  - 39% (was 47% in 2014/15)
- % admitted from hospital:
  - 45% (was 48% in 2014/15)
- % admitted to LTC with home support AND who were NOT admitted from hospital
  - <3 hrs per day: 84% (was 73% in 2014/15)
  - >=3 hrs per day: 16% (was 27% in 2014/15)

We're getting better at getting people on HS before admission BUT with fewer hours. Hospital admissions ticked down a bit. Hours per day is based on days on which service was received, which reflects Jeff's approach in his 2014/15 analysis.

To put it another way (breaking the LTC admission pie out):

- 45% of admissions come from hospital
- 55% of admissions come from community
  - 33% of admissions come from community with HS
    - 28% of admissions come from community with <3 hrs of HS/day
    - 5% of admissions come from community with >= 3 hrs of HS/day
  - 21% of admissions come from community with no HS (rounding means these don't sum quite to 55%)

One in twenty LTC admissions had >=3 hrs/day of HS. One in five had none. We don't know private home support #s of course, but there's a roughly 4x higher incidence of no HS than intensive HS.

Rob

From: Cowan-Douglas, Rob J HLTH:EX
Sent: Tuesday, March 12, 2019 10:33 AM
To: Mackenzie, Isobel HLTH:EX
Cc: Cook, Heather G HLTH:EX
Subject: RE: request for data

Answers in red.

- % of individuals admitted to ltc having without having received home support:
  - 54%
- % admitted from hospital:

    - I constructed an analysis where we look at people whose first day in LTC is abutting a hospital discharge. The average LOS is 64 days, so I'm confident this is capturing LTC admissions from hospital, as we would expect to see a high LOS.
    - **45%** of individuals admitted to LTC were admitted from a hospital.
- Those admitted who have had home support....how many hours of support were they receiving
    - This depends on whether we look at *eligible* days or *service* days as the denominator.
        - For the days on which clients received service, the **average is 2.04 hours and 19% of clients received 3+ hours.**
        - If we look at all days a client was eligible for service, the average is 0.98 hours and 4% of clients received 3+ hours.

A more nuanced analysis of the hours received could look at a ~90 day window preceding admission to get "peak" hours. Let me know how far we want to take this.

From: Cook, Heather G HLTH:EX
Sent: Thursday, March 7, 2019 2:02 PM
To: Cowan-Douglas, Rob J HLTH:EX
Subject: request for data

Hello Rob,

Isobel may be catching up with you on the following, but in case she doesn't:

Her goal is to release the Home Support report (for circulation to select individuals) on week of March 18th. She would like to have refreshed data on the following to place in her report:

- % of individuals admitted to ltc having without having received home support
- % admitted from hospital
- Those admitted who have had home support....how many hours of support were they receiving

She indicates this data was pulled previously, but would like to have refreshed (current data).

Heather Cook, RN, MScN
Director, Systemic Review and Research
Office of the Seniors Advocate
Province of British Columbia
T: 1-778-698-9132
Heather.g.cook@gov.bc.ca

Cowan-Douglas, Rob J HLTH:EX

From: Mackenzie, Isobel HLTH:EX
Sent: January 3, 2019 12:07 PM
To: Cowan-Douglas, Rob J HLTH:EX
Subject: FW: second draft of home support report, replaces first
Attachments: OSA Home Support Report Second Draft.doc

Hi Rob,

When I look at the track changes, it seems to indicate it is still pending, so I think this is the most recent version. Could you please update with the lates data.

Thanks
Isobel

From: Vivian Smith [mailto:vmsmithvictoria@gmail.com]
Sent: Wednesday, September 26, 2018 11:19 AM
To: Mackenzie, Isobel HLTH:EX
Subject: second draft of home support report, replaces first

September 26, 2018

Isobel,

Please find attached my second draft of the rewritten report. Please delete the first.

As with the first, it follows the outline you sent. You will still see the main elements of the draft report from your office, as well as additions and changes from our meeting. This draft revises some material and adds elements to the co-pay section that come from my meeting with Rob, who was very helpful. Rob has provided the new income profile. He also feels the hospital analysis is not as strong as it could be; I leave that to your office to sort out.

I left in most of the charts and graphs as before, but my strong opinion is that the more of those we can put in the appendix, the more powerful the report will be. I know you want the data support to be front and centre. It still would be, but the complex numerical breakdowns would not distract readers from the crucial facts that the numbers support.

I've taken out all the editing marks so you don't get caught up in those if you use a printout. You should just see the comments at the side.

As well as my question about Indigenous issues not being raised, which I mentioned last time, I think the report should also talk about why LGBTQ2 citizens may prefer home support over institutional care, for reasons relating to the stigma around their sexuality.

Finally, nothing in the draft report from your office refers to home-care workers, who provide the support to seniors. Is there anything to add about their working conditions, problems, experiences or recommendations? Or at least should we say that this would be another report topic?

I look forward to our conversation on October 2.

s.22

Best,

Vivian

Home Advantage

By Expanding B.C.'s Home Support Program,
We Improve Seniors' Lives and Reduce Health Costs

A report from the Office of the Seniors Advocate

October, 2018

Letter from IM

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Acknowledgements

Summary?

Introduction:

British Columbia's 850,000 seniors are as diverse as the communities in which they live.

Yet they share the same desire: to live in homes of their own choosing.

In fact, that's what we all want. Just because our health needs become more complex as we age should not mean that we have to leave our familiar surroundings and loved ones.

In British Columbia, the government has created the publicly-subsidized Home Support program to enable citizens age 65 and over to continue to live independently in their own homes. Ensuring that all seniors have equitable access to these services, no matter where they live in the province, is key to achieving this purpose.

This review of Home Support by the Office of the Seniors Advocate examines whether the program is meeting its goals of equitable access, keeping seniors out of long-term care residences and contributing to an effective, efficient and financially sound delivery of health care.

We find it does not.

Evidence-based analysis and recommendations

This OSA report is part of our mandate to monitor important seniors' services, address systemic issues that affect care and accessibility, provide recommendations for improvement, and to engage seniors and their families. In conducting our review, the Office sought to understand the current state of home support and tease out trends over time, asking users of the services to provide feedback on their experiences so that we could identify possible opportunities to improve them. We drew on many sources of data and information, including the results of a province-wide survey of all home support clients in B.C., and administrative and clinical data from the Ministry of Health and five regional health authorities.

This is not our first report on this topic. We, along with a variety of other organizations, have studied the home support system for the more than 20 years it has been in operation. In 2016, for example, the Office released a landmark review of the program that drew on the responses of nearly 10,000 seniors and their caregivers. While most respondents (nine out of 10) felt care workers in the program showed respect and compassion, they also reported what they saw as gaps in service and training. That review and others show consistently that home support must evolve to address the needs of a growing number of seniors who are increasingly frail and have more complex needs than when the system was established.

This review shows that the home support system currently does not meet its own objectives. British Columbians do not receive enough - or the kinds - of care they need to live at home for as

long as possible. Vulnerable seniors are not getting the help they need when and in what ways they need it. The government is spending more money than it needs to on health care for seniors.

Commented [VS1]: Should this be in boldface?

Today, the largest percentage of clients in the home care program receives just one hour of help a day. Four hours a day is considered appropriate for effective at-home care. If more hours are needed, a care facility may be better.

Commented [VS2]: Define this percentage.

The data we collected and analysed clearly show that health authorities and individual home support workers are doing efficient, effective work. But when we looked at the goals of home support in preventing or delaying admission to both residential and acute care facilities, we saw that the home support system is not being used to its fullest extent before British Columbians are moved to the costlier option of residential care. The health system – and citizens' lives – will improve significantly when we make changes to the home support system that allow users to self-direct their own program; administer supports with more flexibility, including respite care and housekeeping hours; and support people through a case-management approach.

We also need to update the calculations that determine clients' contributions to their care, known informally as "co-pay." While most seniors currently using support don't directly pay for the service, approximately one-third of clients contribute, based on an outdated calculation.

The funding formula itself has become unworkable, a barrier to deserving British Columbians who should receive home care support but can't afford it and so do not apply. The formula prevents seniors from getting the care they need at home.

Specifically, the review found that:

- Nearly half of those British Columbians admitted to residential care (48%) did not have any hours of publicly funded home support beforehand that might have kept them at home longer. Of those who did get services, less than a third (27%) received three or more hours per day.
- Insufficient home support is part of why long-term care facilities have wait lists. In 2016, almost 2,000 people were waiting to be placed and over 8,500 were admitted to residential facilities. If one in 10 residents of those facilities (2,800 people) could be cared for at home or in assisted living (where personal and hospitality care is provided for those who can make their own decisions), people who truly do need residential care would not be kept waiting by those who don't.
- Seniors who are admitted to hospital with serious illnesses and conditions (97% of cases reviewed) usually have no prior home support. Despite having medical problems such as COPD, heart disease and pneumonia, about a third of seniors who arrive in hospital via the emergency ward are later discharged without any support to go home to.

- Seniors want more flexibility to decide what services they need to remain in their homes. Allowing clients to choose themselves how to allocate the money that would otherwise go to their publicly provisioned care would increase flexibility, convenience, and quality of life. Self-directed care, which is increasing in many countries' home support programs, increases the odds of staying at home longer, which saves health care dollars. Home support is significantly more cost effective than residential care and extended hospitalizations.
- Home support clients want a broader range of services, particularly housekeeping and respite care, which are currently very limited. Since unpaid caregivers (mostly family members, mostly women), provide so much of informal home care, respite is key to preventing caregiver burnout and keeping seniors at home.
- B.C.'s five regional Health Authorities offer varying levels of home support service, both in terms of the number of hours and kinds of services, as well as inconsistent hours of respite support for caregivers. This means we are not offering universality of access and service delivery across the province.

Commented [VS3]: Reference?

A list of specific recommendations to address the problems with the current home support program appears at the end of this review. They speak to ensuring that more seniors benefit from home support and that clients have fairer access to a broader suite of services not only today but in the future.

With British Columbia's seniors' population projected to grow significantly in the coming two decades, the home support system must respond to the increase, both in client numbers and needs, and work more effectively in conjunction with the long-term care and acute-care systems in the province.

How the home support system works – and doesn't

To show how we came to the conclusions we did, this report offers readers a step-by-step accounting of what the home support program is and what it is not; who currently receives what services and why; and who pays for what and why. With this information in mind, readers will have a clear picture of what changes to the program are necessary as the senior population ages faster than the rest. According to the most recent Canadian census data, the number of people 85 and older grew nearly four times the rate of the overall population from 2011 to 2016. B.C. leads the country in the percentage of people by province who are 65 or older, at 18.3%, compared to the national rate of 16.9%. By 2031 almost one in four people in B.C. will be over age 65. Seven

Commented [VS4]: https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016004/98-200-x2016004-eng.cfm

Commented [VS5]: https://www2.gov.B.C..ca/gov/content/family-social-supports/seniors/health-safety/active-aging

Commented [VS6]:

of the top 10 municipalities with the largest proportion of residents over 85 are in B.C.; four are on Vancouver Island alone.

In the context of home support, it is helpful to look at the "dependency ratio," where a select group such as seniors is quantified in relation to 100 workers aged 20-64. The percentage of seniors who will need economic support from any given 100 workers will increase from 26% currently to 43.5% in 2036. In other words, over the next two decades, B.C. will have more seniors relying on the workforce to support their care.

Commented [VS7]: add stats here that show the workforce shrinking

What is home support?

As we move into old age, many of us find it more difficult to manage daily, bodily tasks that we've always done with ease. For instance, it may become difficult to bathe, dress or manage medications. (Clinicians call these Activities of Daily Living, or ADLs.) In British Columbia, subsidized[1] home support is available to help people who face these basic, self-care challenges.

In B.C., provincial policies and guidelines govern home support and each of the province's five regional health authorities manage and deliver it as part of the provincial Home and Community Care (HCC) program. This program also offers professional supports such as nursing, physiotherapy, occupational therapy, nutrition, and social work.

Activities of Daily Living

- Basic self-care
- Feeding
- Toileting
- Dressing
- Grooming
- Maintaining continence
- Bathing
- Walking

The B.C. Ministry of Health defines the scope of home support this way:

> "***Home support services*** are direct care services provided by unregulated care providers to clients who require personal assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, bathing, cueing, grooming and toileting, and may include safety maintenance activities as a supplement to personal assistance when appropriate, as well as specific nursing and rehabilitation tasks delegated under Policy 1.C, Delegation of Tasks.
>
> "***Safety maintenance activities*** are identified through the care plan and focus on reducing, eliminating or monitoring risk or potential risk to a client. As part of the authorized services, these activities may include clean-up, laundry of soiled bedding or clothing, and meal preparation."

[1] "Subsidized" indicates partially or fully funded by a health authority

Home support does not mean 24-hour nursing care. These services' goals are to supplement, rather than replace, the efforts of individuals and their caregivers to meet their health needs. Subsidized home support is available to clients on an ongoing, regular basis (long-term home support) or on a temporary basis (short term or episodic home support). Short-term support is typically put in place so that a patient can be discharged from hospital as soon as possible, allowing them to recover at home.

Health authorities deliver home support either through staff directly employed by the health authority or through an agency that is funded to provide the service. In either case, the guidelines, supervision and training requirement for home support staff are the same.

Long-term home support services are provided in two ways, either directly by the health authority (or contracted provider) or through a specialized program known as Choices in Supports for Independent Living (CSIL). People who are part of the Choices program receive funds from the health authority in lieu of home support hours, allowing the client (or a proxy) to hire and direct their own caregivers. This arrangement is one type of self-directed care and one of the focus areas of this report.

Clients who do not require home support but need outside help with such things as transportation, shopping, financial management, housekeeping and meal preparation (referred to as Instrumental Activities of Daily Living or IADLs) are directed to community resources, such as the United Way's Better at Home program, as these services are not available through the Ministry of Health funded program. Occasionally, where someone is eligible for home support because they need help with the activities of daily living, some housekeeping services may be available to reduce the possibility of hazard or injury. Seniors may also receive limited meal preparation. The availability of these additional services varies across the health authorities.

Clinicians use these criteria to assess eligibility for home support:

- A client's ability to manage, including a risk assessment
- Unique needs and strengths of the client
- Other supports, including those that family and friends provide
- If other community services can address the client's needs

Commented [VSB]: An example?

Once an assessment is made, clinicians work with the client and their family to determine what services will best support the client to remain in their home.

Most health authorities have set a guideline of a maximum of 120 hours of home support per month for individual clients, or four hours of service per day. Approval processes are in place to allow for more if needed.

Who receives home support?

About 40,000 people in B.C. use the program annually, with approximately 22,000 receiving services at any given time. As the table below shows, a typical client is a woman in her early 80s, perhaps still married but more likely widowed and living with a primary caregiver, such as a daughter. This demographic data comes from what is known as the Resident Assessment Index – Home Care (RAI-HC), which allows us to paint a picture of the characteristics of clients. Three boxes below the table show definitions of characteristics requiring a clinical assessment.

Table X: Characteristics of B.C. home support clients (RAI assessment) 2015/16

Commented [VS9]: To be updated

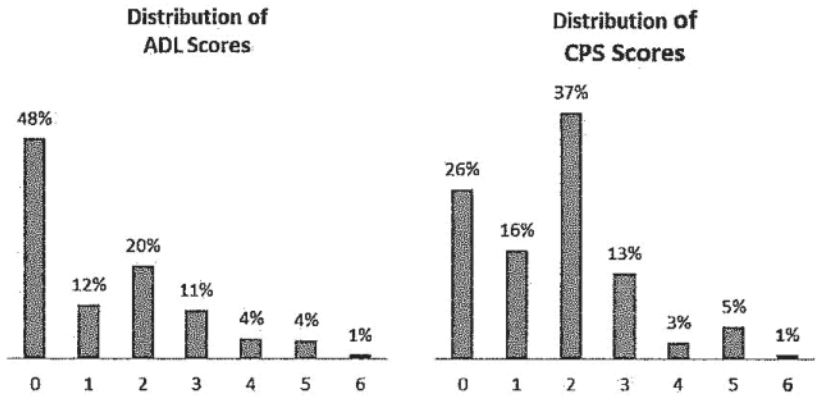
Average age	82
Female	67%
Married	28%
Widowed	43%
Lives with primary caregiver	42%
Caregiver distress	31%
Dementia diagnosis	32%
Wandering	3%
Aggressive behaviours	12%
Activities of Daily Living 3+	20%
Cognitive Performance Scale 3+	21%
MAPLe 4/5	52%
Bladder incontinence	26%

Activities of Daily Living
A score of 3 or more describes a person who is not fully independent and must have physical assistance to complete tasks such as bathing, toileting and activities related to their personal care.

Cognitive Performance Scale
A score of 3 or more indicates that the person needs close supervision and direction to carry out daily tasks.

Method for Assigning Priority Levels
The (MAPLe) score is an algorithm that uses dozens of items to assign a numerical value to the overall complexity of a client's needs. Scores of 4 and 5 demonstrate high complexity.

Because clients vary in their physical and cognitive capabilities, each person is assessed and a plan is tailored to best meet their needs. In reviewing the data for Activities of Daily Living function and the Cognitive Performance Scale (CPS), we see the program meets a broad range of needs. One-fifth of clients have an ADL score of 3 or higher, which means they need from significant help to complete assistance with the activities of daily living. Over one-fifth of clients have a CPS score of 3 or higher, which is typical of moderate to advanced dementia. Increasing values on the CPS scale indicate more significant cognitive impairment, including difficulty with short-term memory, difficulty making oneself understood, and the need for cueing to complete tasks.



Commented [CHGH10]: I suggest removing this and converting it into bullet points...69% have a score of 2 or less in CPS scale....something like that

Commented [VS11R10]: I agree, make it so the reader doesn't have to scratch their heads to figure out what it means.

This variation in client characteristics demonstrates how the program can support seniors as they age and how its responsiveness allows clients to remain at home as their needs increase. It also shows the high level of complexities that home support staff deal with as they support a large, diverse population.

Note from Isobel: I think it will also be helpful to show a time comparison and I a m thinking 2017/18 compared to the first year we have good data for (Heather to advise)

Commented [VS12]: Isobel comments, my query

Commented [VS13]: Isobel's comments. To be addressed.

Note from Vivian: Can we break down how much each service is used, maybe by percentage from most common to least requested??

How much support do clients receive?

B.C.'s population of residents who are 65 and older has grown. The total number of home support hours has also increased, but not as fast as the senior population. This means that over the past 10 years, service levels have fallen as the number of clients increased.

Specifically, the total number of service hours delivered to all clients in 2015/16 was 11,089,553, which is a decrease of 0.1% over the previous year. Taken as a percentage, this doesn't sound like much of a loss. But when we look at how many fewer actual hours are spent (11,089.55 hours), that is the same as 42 fewer clients receiving support (at the average of 263 hours annually). Our analysis shows a particularly troubling number: the largest percent of people in the program receive just one hour of home support per day.

The following charts provide a detailed breakdown of who gets home support and how much clients receive, including Choices in Support for Independent Living (CSIL) clients, who can self-direct aspects of their plan. The first one shows that the number of clients and the volume of hours delivered have increased, but population growth among B.C.'s seniors has outstripped service increases.

Commented [VS14]: https://www.theglobeandmail.com/news/national/census-2016-statscan/article34882462/

Commented [VS15]: across the province?

Commented [VS16]: This is an important number, so I moved it up from page 17. Since it is such a meaningful number, we need to provide the exact percentage here. A large per cent can be small if there are a lot of different amounts to compare, as with an election where there are a lot of candidates.

Commented [VS17]: to be updated as needed

Commented [VS18]: to be updated

Commented [VS19]:

Table insert correct number: Client counts and hours delivered by home support program (including CSIL clients)

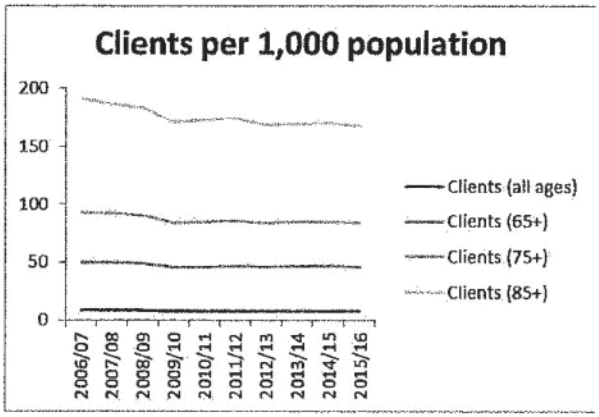
% change over time	Clients	Hours	Population, 65+
2006/07	34,471 (17% of pop>65)	8,383,447 (243.2 hours/client)	611,211
2015/16	42,170 (20% of pop>65)	11,089,553 (262.97 hours/client)	850,424
% change 06/07-> 15/16	+ 22%	+ 32%	+ 39%

The graphs below illustrate, on a per-population basis, how service levels have fallen over the past decade. They plot a relative measure of service levels based on the number of clients and hours per 1,000 population.

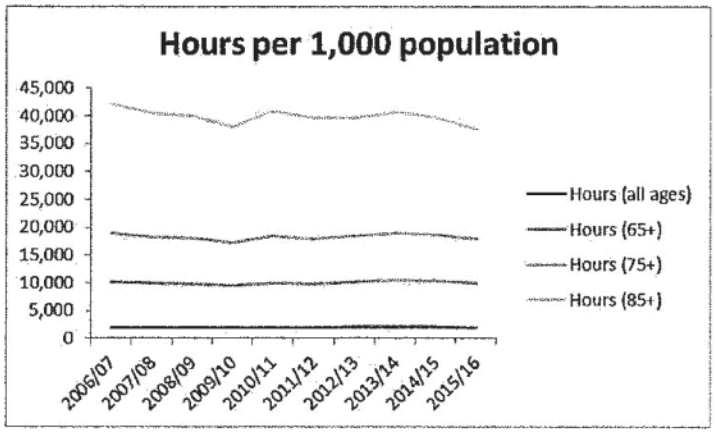
The older someone is, the more likely they will need home support services, so we have developed a graph demonstrating service levels against different age cohorts. Most home support clients are at least 75 and fully one half are 85 or older. In relation to the general population aged 75 or older, home support service levels per 1,000 population have seen a moderate decline between 2006/07 and 2015/16. On a per population basis, the number of clients has dropped by 10% and total service hours have declined by 6%. Most alarmingly, however, service levels for people aged 85 or older have declined markedly since 2006/07; on a per-population basis, the number of 85+ clients has dropped by 12% and total service hours have declined by 11%.

Commented [CHGH20]: Need to add in the growth rate of this population

Graph #: Number of clients on home support (including CSIL clients)



Graph #: Number of hours of home support (including CSIL clients)



Commented [VS21]: does it matter if the CSIL patient are excluded? How does their inclusion affect the results or analysis?

Commented [VS22R21]: te

The number of hours received by a client per year is one measure of service. In 2015/16, the average was just over five hours per week. This represents a provincial decrease of 2% from 2014/15.

Table: Average hours per client, per year

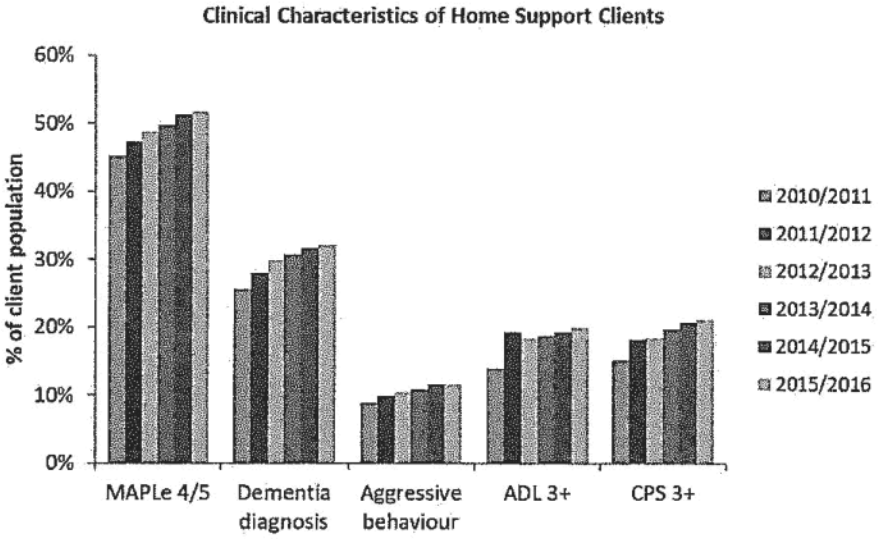
	w/ CSIL
2006/07	243
2008/09	239
2009/10	250
2010/11	262
2011/12	256
2012/13	267
2013/14	272
2014/15	268
2015/16	263

Another trend that amplifies the decrease in average hours is the growing complexity in the health needs of seniors receiving service. These include increasing levels of cognitive impairment, responsive (aggressive) behaviours, impairments in activities of daily living and increasing MAPLe scores (the numerical needs assessment tool). Caregivers also report increasing distress.

Commented [CHGH23]: definition

A more complex client clearly requires a higher intensity of service, yet the data show that the opposite is happening. The chart below demonstrates that the portion of clients with any of six measures of complexity has increased by at least 9% over the past six years. Despite the client base becoming increasingly complex, the intensity of service has been dropping.

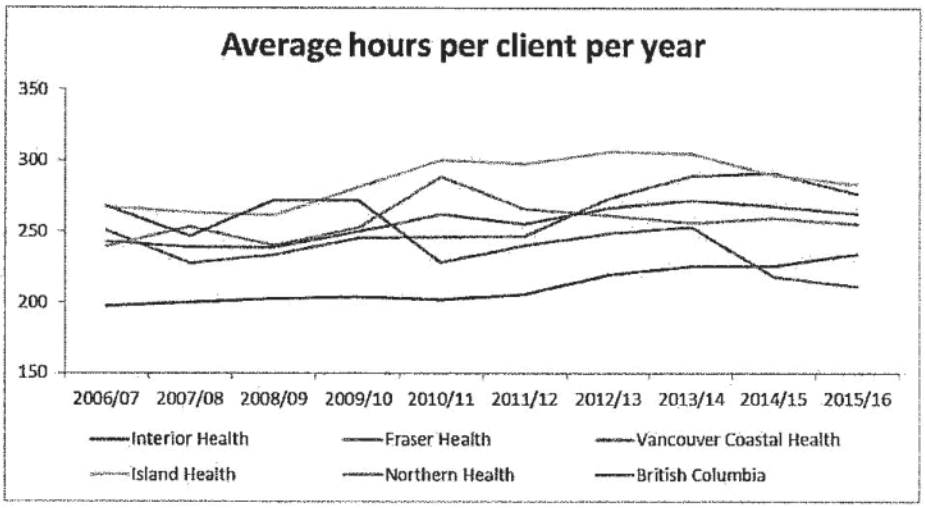
Graph X: Clinical characteristics of home support clients (RAI assessment) from 2010/11 to 2015/16



Who gets what depends on where home is;
support varies across health authorities

Home support service delivery varies dramatically across the province. For example, the table below shows that Island Health, with 283 average hours of service per client per year, consistently provides more home support hours per client than other health authorities. Fraser Health provides the second highest level at 277 average hours per client per year. Northern Health and Interior Health, on average, provide the lowest amounts of hours per client per year. Average hours increased in only one health authority, the health authority which, historically, had delivered the least home support.

Commented [VS24]: If that is Interior Health, we should so here. I can't tell the colour on my laptop.



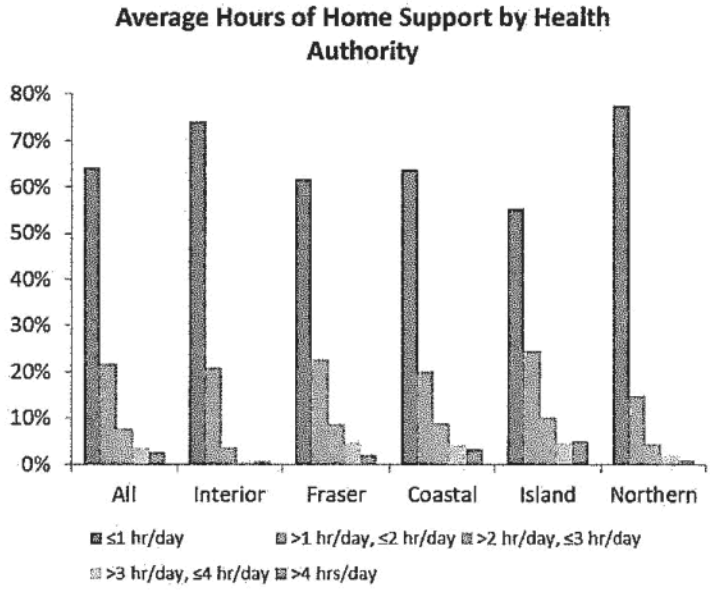
Two authorities (Northern and Interior) have a greater percentage of clients with less than one hour of service per service day. Island Health demonstrates a greater percentage of its clients receiving services in the two- to four-hour range. Island Health also appears to be an outlier in terms of offering more than four hours of daily service, including a small? number of clients receiving 24-hour live-in non-nursing support, a service that does not appear to be available in other health authorities.

Commented [VS25]: I think we need to say more clearly how many hours are offered. What is a greater or larger percentage? Relative to what? If the goal is to get more hours per client, then provide current hours per person, not just as a percentage that we don't even provide. Farther down, you say the average is one hour a day. Pretty skimpy and an important number. Try something like "Four out of 10 clients in the North and Interior receive only half an hour of service a day" or whatever it is. That provides a much clearer picture of the problem you're tackling.

Commented [CHGH26]: awaiting data from Jeff for rate of or %accessing LTC for all HA's

Commented [VS27]:

Commented [VS28R27]: We said earlier that this is not 24-hour nursing care. Maybe explain difference.



Who gets what kind of care and for how much time?

Inconsistencies in time allotted for specific tasks (such as bathing) are perhaps more telling than variations in numbers of hours of support. Each health authority has its own practice manual that specifies a time range for each activity to determine the number of hours of service a client will receive. These vary widely, with some authorities allotting two, three or even four times the number of minutes for a given task than others do.

For example, the minimum time allocated for personal care, including bathing, incontinence/toileting and catheter/bowel care, ranges from just over 30 minutes to over an hour. The range for meals, including preparation and eating/feeding, is even more varied, from just 15 minutes to one hour. The range for medication administration is five to 15 minutes.

Suggested travel time allocations for home support workers range from 10 to 15 minutes across health authorities. In this case, the variation is small and does not reflect differences in actual travel times. Ten minutes may be enough time to drive to a client's home in smaller urban communities, but certainly would not be enough in British Columbia's larger cities or rural and remote areas. In areas with a high concentration of home support clients living near each other, services may be delivered via a clustered care model. The care requirements of all clients in the

cluster are used to allocate workers efficiently by reducing travel and focusing work in one geographic area (neighbourhood). In this cluster model the minimum authorized time workers may spend per client can be only 10-15 minutes; for non-clustered services the minimum ranges from 15-30 minutes across health authorities.

Finally, the number of hours for in-home respite care for caregivers swings widely among health authorities. While two do not specify a time range, one indicates a range of up to six hours of respite care. The importance of respite care in preventing caregiver distress cannot be overstated. Our previous research found the number of hours of care provided by the unpaid caregiver is the strongest predictor of caregiver distress, which manifests itself in give examples here.

Are we comparing apples to apples?

We wondered if differences in the health profiles of seniors within each authority could account for the wide range in levels of service provision among them. For example, if Health Authority A has clients with more complicated health needs than Authority B, we would expect Authority A to provide a higher intensity of service.

To find the answer, we conducted an analysis that adjusted for various health characteristics that are commonly considered drivers of the need for home support, including a client's ability to conduct activities of daily living; cognitive impairment; wandering; living with a caregiver; and levels of informal support available to the client. The analysis demonstrated that health characteristics did not explain all the variation in home support among health authorities. Some variation was linked to the geographic area where the client lived and which health authority delivered the service. In other words, a client who lived in the Interior with identical characteristics to a client living on Vancouver Island would generally receive fewer hours of service.

What do clients say about the home supports they currently receive?

An important step in the OSA's review was to understand how clients and their family members view the program. Client satisfaction is key to assessing whether the support being delivered is meeting the program's – and the client's – goals. In the fall of 2015, we sent a standardized survey to all B.C. home support clients and their family members and received almost 10,000 responses. Our report, called *Listening to Your Voice: Home Support Survey*, showed that more than three quarters of respondents (78%) felt the program was meeting their needs most or all the time. However, clients with a higher complexity of needs were more likely to rate home support services as sometimes, rarely or never meeting their needs. Those who responded to the survey showed a higher level of physical and cognitive function than the home support population in general. Overall the survey highlighted the following areas for improvement:

1. **Skill of workers** – Nearly half of respondents (47%) reported their workers had all the necessary skills to provide good care

Commented [VS29]: I don't get this. If the non- cluster range is consistent across B.C. at 15-30 minutes, why does it say at the top of the paragaph that it is half that.

Commented [VS30]: Per week? And what about the other health authorities? Does not having a time range mean you can get a lot more or is there a practice of not supplying it because there is no minimum? We should name the authorities and their time allotments here.

Commented [VS31]: give reference.

Commented [VS32]: I'm not following this. So some health characteristic variation was at play? Or do you mean to say that if you strip away all the variations in health characteristics, there is still inconsistency in service delivery? If you are trying to find out if the health profile of seniors is a factor causing variation, then I am not sure how comparing seniors with exactly the same profile answers the question. I think you would need to say that more seniors in Health Authority A have a complex profile than in Health Authority B, and they were found to get more hours, which caused a variation. Simply put, we did (or did not) see that more intensive services came with more complicated health needs.

Commented [VS33]: "Nearly," being an adverb, denotes judgement, which is more than plain description. We could just as easily say "more than half of the respondents didn't think their workers could do their jobs" and be just as correct. It depends what you want out of this number.

2. **Number of workers and use of substitute workers** – Nearly half (48%) of respondents felt they had too many different regular workers or substitute workers.
3. **Additional services** – Almost three in 10 (28%) of respondents would like help with housekeeping. Clients assessed as having great difficulty doing ordinary housework were much more likely to respond that support services did not meet their needs.

Factors Limiting Uptake:

What might prevent people from taking advantage of home support?

As we have seen so far at the "what the program is" or systemic level, demand for home support services is increasing while supply is not. When we examine factors at the "what the program isn't" level, we start to see the specific ways in which people may be prevented from receiving home support. Their access may be thwarted by costs they can't afford; necessary services not being offered such as respite, transportation, housekeeping and meals; and insufficient amounts of time to fill needs. This next section looks in more detail at these limits because we want to know what about the system itself may prevents its use.

Cost: How much do people pay? The answer shows the system needs repair

Commented [VS34]: Isobel notes we need to use data on co-payment. Is that not included here yet?

About one-third of clients in B.C. contribute to the cost of home support; how much depends on their income. But in many circumstances, having to pay can prevent a potential client from applying for support or getting the amount they need. B.C. is one of the few provinces in Canada that requires clients to pay a per diem rate for service. In Ontario, a significantly greater proportion of seniors access that province's program, likely because it is free, although there are other differences.

Commented [VS35]:

Commented [VS36R35]: Significantly greater means what?

Most clients are low-income and don't contribute, or "co-pay," as they receive a Guaranteed Income Supplement (GIS) or other federal income-tested benefits, like the allowance for spouses of GIS recipients.

For example, a single senior will receive some amount of GIS up to around $25,000 a year in income (including the GIS). They may receive a very small amount of GIS if their income is close to $25,000, since the payment is reduced as income increases. But even getting as little as $100 a year in GIS still counts as getting it, so there would still be no co-pay for home support at that income level.

It's important to look here at the context of how income is assessed in B.C. The province ties many programs, such as the subsidized senior's bus pass, to the receipt of GIS. This means that a senior whose income is just over the GIS threshold would be better off with *less* income.

Now imagine you are a senior who is just a few dollars over that income threshold and you stop receiving GIS. Suddenly, you must contribute to your home support, since it is based on your income. For a $25,000-a-year person, that co-pay is about $20 a day, which is $600 a month if you're getting daily service. That's nearly a third of your total income.

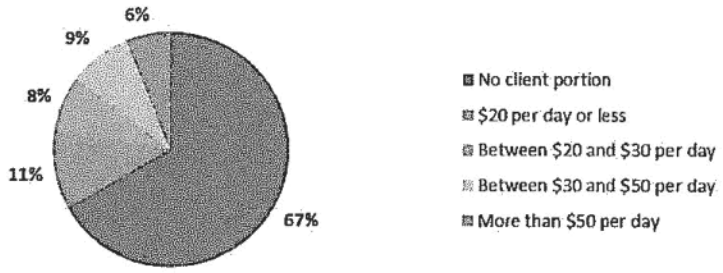
Since two-thirds of home support clients in B.C. are on GIS but only one-third of seniors overall are on GIS, people who receive the supplement are over-represented among clients. Some of this has to do with the fact that home support clients are 80+ on average, and older seniors have lower incomes. Also, a lot of home support clients are women who spent most of their working lives as unpaid homemakers, so they have little to no pension (and survivor pensions are often reduced).
But our research suggests that moderate-income seniors — those in the $25,000 to $40,000 range — find home support to be too expensive and don't sign up. This can mean that moving to a long-term care facility is a financially smart move for the senior in some situations, even if it is not what they need or want. It is not financially smart for the government.

At the same time, a quirk in the program may mean that people with higher incomes are getting home support for a low cost. Those with earned income (as defined by the Canada Revenue Agency) have a maximum monthly cap of $300 for home support. The intent was to help working-age people who need home support (because of illness or disability) remain on the job by not making these services take a big chunk of their income. But also included in this capped group are seniors with skillsets that allow them to work part-time well past retirement age. The client contribution formula factors in a spouse's income as well, so couples have an even better chance of being covered by the earned income cap.

Commented [VS37]: Possible example or stats?

According to Statistics Canada, seniors with earned income have a higher average income than those without. So, we end up with a home support system that has two large groups of clients on either end of the income spectrum, and not a lot in the middle.

Amount Clients are Required to Contribute to Home Support Services



As noted above, the formula for determining the contribution is based on the client's income. If a client is married or part of a common-law relationship, the partner's income is included in the calculation. If both partners receive home support, only one contribution is required and it will be equal to the client contribution that would prevail if only one got support.

The client contribution is calculated as a daily rate. The monthly client contribution is the daily rate times the number of days on which service was received. (See the Appendix for the formula.)

The assessed client contribution is independent of the number of hours, per day, of service; that is, a client will pay the same, per day, regardless of whether they receive one hour or eight hours of service in a day. While the lowest income clients — those on GIS — are exempt from client contributions, moderate income clients may face prohibitively high client contributions.

Consider a single senior with an income of $25,000 per year, just above the threshold for receiving the GIS.

> This client would be assessed a monthly client contribution of $550 for daily home support, leaving them with $1,400 per month of after-tax income. If this senior faces the rental market in Metro Vancouver, with an average rent of $1,080 per month for a one bedroom, they have very little left over for other living expenses, such as groceries, utilities, and transportation to medical appointments.

Now consider a single senior with an income of $35,000 per year.

> This client would be assessed a monthly client contribution of $880 for daily home support, leaving them with $1,740 per month of after-tax income — an extra $10,000 per year of gross income translates to only $340 per month of extra income after deducting the increased income taxes owed and higher client contribution.

Commented [CHGH38]: put in a box as per the patient story above

Commented [VS39R38]: And if we add an income profile as suggested above, this could move or be shorter or incorporated.

Scenario:

Commented [VS40]: To be put in a box, like the others.

This typical couple lives in Vancouver and has a joint income of $38,400. This puts them just over the cut-off to receive GIS if both receive the OAS benefit. The clause requiring both to get OAS would cover the almost all senior couples.

This couple pays the market rent ($1,223) for a one-bedroom apartment. (They do not qualify for the SAFER subsidy because their income is too high.)

Monthly income	**$ 3,200**
Rent	$ 1,223
Food	$ 400
Utilities	$ 80
Cable, phone, Internet	$ 100
Clothing and personal care	$ 200
Transportation	$ 8
Other costs	$ 300
MSP	$ 35
PharmaCare (monthly)	$ 123
Over the counter medications	$ 150
Subtotal of above expenses	**$ 2,619**
Monthly cost for daily home support	$ 900
Income left after all expenses	**$ (319)**

This couple's income would need to rise to around $45,000 per year to afford home support. As their income rises, the co-pay will also rise, as will MSP and PharmaCare expenses.

For a couple, the co-pay is assessed on a household basis. That means if both spouses need home support, they don't pay any more than if only one spouse needed it. Similarly, if one spouse has earned income, the cap of $300 a month for the co-pay will apply.

In the OSA's housing report, *Seniors' Housing in B.C.: Affordable, Appropriate, Available*, the routine living expenses of a senior in Victoria or Vancouver were estimated at $1,000 per month. When factoring in rent, the client contribution clearly can be prohibitively expensive for seniors receiving daily or near-daily home support visits.

Whether the contribution is a barrier to receiving home support depends on individual circumstances. Some seniors may live mortgage-free, but 40% of senior households in B.C. with an income below $30,000 are renters. While not all parts of the province face the high market rents seen in Vancouver, lower rents outside of B.C.'s large metropolitan areas may be offset by higher utility, transportation (particularly in areas with underdeveloped transit systems), and grocery costs. Even mortgage-free seniors may find the cost of a home support client contribution to be too high, as their ability to save for home repairs could be eroded.

If the service costs less than the assessed client contribution, they are billed only for the actual cost of service delivery. The following table outlines the cost per hour of home support service provided by the health authorities that would be used to determine the actual service delivery cost: the cheapest is Vancouver Coastal Health and the most expensive is Northern Health.

		NHA	IHA	FHA	VCH	VIHA
Cost per Hour of Long term Home Support	Owned and Operated	$50	$37.95	$35.16	$34.34-$37.00	$35
	Contracted			$33.65	$34.38-$36.38	$36.50

Commented [VS41]: IH? Maybe spell out....

Commented [VS42]: Total cost?

Commented [VS43]: Update?

A 20-year-old calculation

Formulas, like people, get old. The basic deductions used to calculate the client contribution have not changed since 1997. The amount is intended to protect some of a client's income for basic living expenses such as rent, food, and utilities. By remaining unchanged for more than 20 years, the deduction has failed to keep pace with the actual cost of living, leaving clients with too high a bill for home support.

Increasing the basic deduction amount (from $10,284 to $14,500 for singles with a corresponding increase for couples) would bring down the daily client contribution by $5.86, which translates to annual savings of $2,110 for a client receiving daily home support and $609 for a client receiving twice-weekly home support. This change would update the basic deduction amount to reflect the rate of inflation over the past 20 years.

For clients whose income is just over the threshold for receiving the Guaranteed Income Supplement (and who are therefore not obliged to contribute to the cost of home support), updating the amount to reflect inflation would reduce their payment by one-third.

Inflexibility: Clients are not getting the range of services they want

Survey respondents identified two key themes regarding the system: its inflexibility and lack of necessary services.

Many clients want services that are not offered; most notably, a third (33%) want housekeeping services, which were removed from the program in the 1990s. Currently, if a senior seeks help with Instrumental Activities of Daily Living (IADLs) such as shopping, housework or yard work, they have to find help themselves or are referred to the Better at Home program administered through the United Way of the Lower Mainland. For many seniors, this fragmentation of services is not ideal.

The burden of doing the shopping, housework or shovelling snow falls to unpaid caregivers much of the time, often becoming part of their stress. The time is overdue to consider further innovative strategies (in addition to the United Way Better at Home program) to provide help with household chores now done by family members who are burning out. For example, if people receiving home support (who are generally low income) received a stipend from government, they could buy services that would alleviate stress on their family member This strategy could be designed so that Home Support Case Managers assess caregiver burden and approve a stipend based on an income sliding scale.

Modification of the current home support system would allow for a more family-centred approach. In this model, as with the home support approach in Ontario, the family becomes the "client." Recognizing the importance of family caregivers means giving them the flexibility to design home support service that optimizes their input, recognizing that non-clinical supports such as homemaking, meal preparation, supportive housing, transportation and respite are often essential to supporting an individual at home.

Another aspect of inflexibility is a lack of direct funding for seniors to create their own care plan in conjunction with their families and caregivers. When reviewing the literature and research from other jurisdictions, we found that the most effective home support systems are those that do just that; they allow clients, their families and caring networks the ability to tailor a full suite of services that best fits their needs. This is what seniors told us they want.

As mentioned earlier, one self-directed model of care exists in B.C., called the Choice in Supports for Independent Living program or CSIL. It is designed for a specific population and is used by a small percentage (3%) of clients. Similar models are in use around the world. In the CSIL program, health authorities provide the client or their representative with funding directly, based on their needs, to employ their own workers. In effect, the client becomes their own employment agency for managing their support workers. This program is targeted to individuals with moderate to high care needs who have met all other criteria required for subsidized support.

The overriding advantage to self-directed care is that the client has much more control and can devise a daily plan that is tailor-made and consistent. The current CSIL program has complex

requirements for the client or family caregiver; streamlining these processes could result in more people accessing the program. There may also be clients who would benefit from a combination of health authority-delivered service and self-directed service. This hybrid delivery model also exists in many jurisdictions world-wide.

Scenario: How direct funding could improve quality of life and cost the system less

s.22

The burden on family caregivers

Needs to be updated with new data.

An increasing strain on unpaid caregivers, especially family caregivers, is a consequence of seniors living as independently as possible for as long as possible. The value of unpaid caregiver labour in B.C. is approximated $3.5-billion. According to the Office of the Seniors Advocate's 2017 report *Caregivers in Distress: A Growing Problem*, almost all (96%) of B.C. seniors eligible for home support also receive support from an unpaid caregiver. This report found that

Commented [VS44]: annually?

about a third (31%) of caregivers were assessed as experiencing actual distress, meaning they were angry, depressed or in conflict because of caring for their loved one and/or believe they would not be able to keep performing their care activities.

B.C. has one of the highest rates of caregiver distress (30%) in the country. The OSA analysis showed that while more than half (54%) of caregivers would benefit from respite services such as adult day programs, home support or respite beds, only 7% had used an adult day program, 11% had used a respite bed and just over half (53%) had received home support. Evidence supports a strong correlation between caregiver distress and the number of hours of care they provide. When a robust home support service is in place, distress declines.

Commented [VS45]: Below it is 29%.

We compared B.C. to Alberta and found some notable differences: clients in B.C. have higher needs and more caregiver distress but received less home support than their counterparts in Alberta. Specifically:

- A higher percentage of caregivers reported distress (B.C. 29%; Alberta 14%)
- A lower percentage of clients received home support services in the last seven days (B.C. 53%, Alberta 65%)

Commented [VS46]: Above, it's 30%.

The complexity of client needs was much higher (B.C. 53%, Alberta 37%).

Hours and communication.

Isobel's item #9 on her email to me says "Is rationing by HA limiting the uptake: talk about the policy for hours, lack of communication with clients about entitlement."

I'm not seeing communication issues mentioned in the draft report, or a full explanation of what lies behind the policy for how hours are rationed. We have mentioned the number of hours above and talked about four hours as the cut-off before a move to an LTC facility is deemed best. So I need more info for this section about limiting factors if you want to talk about communication, or lack thereof.

My notes from our meeting refer to clients having to go through exhausting hoops to get home support, so they give up and go into long-term care homes. This could go under this section on limits, with more information.

Commented [VS47]: Here is where we may want to insert a section that talks about the possible lack of uptake from First Nations people, if we can quantify that or provide anecdotal evidence. Another group that may want to stay out of residential care, for various reasons, would be members of the LGBTQ2 communities. Would they feel safe or comfortable in LTC, especially when much of the staff are from cultures that don't necessarily embrace differing sexualities?

The final aspect to assess if the home support program is meeting its goals is to examine whether the program keeps seniors out of long-term care facilities and hospitals.

The high cost of moving to residential care

As part of the Office's November 2016 report *Making Progress: Placement, Drugs and Therapy Update*, profiles of three residents with low care needs were used to assess the degree to which seniors may be admitted into residential care before they truly must be.

That review found that some seniors - those whose physical and/or cognitive function was not sufficiently compromised to require 24-hour-a-day care - were potentially inappropriately placed in residential care. Of the 28,000 residents living in residential care facilities in B.C., approximately one in 10 could be cared for in the community instead, either in assisted living residences or with home supports. The population of residential care clients who may not require residential care placement met the following descriptions:

- having few or no impairments in either cognition or physical ability to meet care needs
- having mild to moderate symptoms of dementia, but no physical impairments
- having physical challenges and intact cognition but might be better served in assisted living facilities

The data reviewed in producing this 2018 report shows that nearly half (48%) of residential care admissions were not preceded by publicly subsidized home support. Of those who did receive service, only 27% received three or more hours of home support service per day. We conclude that community services such as home support are not being fully explored before a move to more expensive residential care is made.

Commented [VS48]: Correct???

This has implications for both health system costs and the quality of life for those who wish to live at home. From a system perspective, in 2016 almost 2,000 seniors were waiting placement, and a further 8,549 seniors were admitted to residential facilities. If 10% of residents in residential facilities (2,800 individuals) could have their care needs met in their own home or in assisted living residences, people who do need residential care would not have to wait so long for it, if at all. Additional capacity doesn't just make room for those who need long-term care in residences; it also means creating the space to develop innovative strategies for respite so that those remaining at home receive the support they need without their caregivers burning out. In straight budgetary terms, the cost of residential care for one day is twice the cost of three hours of support at home. The analysis completed for this report indicates the largest percent of individuals receives just one hour of home support per day.

Commented [VS49]: What is the number?

Currently in B.C., residential care costs between $6,000 and $7,000 per month. The cost of 120 hours of home support (30 hours a week) varies between and within health regions based on whether the service is contracted or provided by health authority staff. For those health authorities who use contracted agencies, the amount is an average of $36 per hour, for a total of $4,320 a month, slightly higher when the service is provided by health authority staff.

Commented [VS50]: So does this square with the "twice as much" cost described elsewhere?

The data indicate that complex clients, even with a significant level of need, can safely remain in their own homes with appropriate supports, and that only the frailest seniors should be living in residential care. Harnessing the full potential of home support will ensure that only seniors who must be admitted to residential care, will be.

We also wanted to determine if more hours of home support per day would show a reduced risk of admission to residential care rates. They do. In fact, the data demonstrate that people who

received up to two hours of home support per day had a reduced likelihood (from 100% to 77%) of being admitted to residential care (within the two-year data window) than those who received no home support. When three hours of home support per day were provided, the risk of admission to residential care fell to 44%, again, in comparison to individuals who received no home support.

Commented [VS51]: Is this correct? I found the original percentage was not clearly explained.

Commented [CHGH52]: insert a graphic representation

There appears no question then that increasing home support hours and maximizing these hours to support individuals to remain in their own home benefits individuals and is an efficient and effective way to manage our healthcare resources.

What about four hours a day Isobel? See above re query about rationing policy?

The high cost of hospital admissions

Commented [VS53]: Rob has some concerns about the hospital analysis section not being as strong as it could be. What other factors might be at play? To discuss and amend as needed.

As well as looking at long-term care admissions, an examination of hospital admissions can determine whether home support meets its goals. Just as home support is an important tool for delaying or preventing admission to long term residential care, it is key to alleviating pressures on acute care services. Home support has been shown to reduce emergency department (ED) visits and hospitalizations, reduce hospital admissions from the ED to inpatient, reduce hospital lengths of stay for seniors being discharged from hospital, and potentially avert admissions from hospital to residential care.

Commented [VS54]: inpatient?

A review of how much home support seniors were receiving before and after being admitted to hospital showed that nearly all seniors (97%) came to the hospital having received no prior home support service. Of these seniors, nearly as many (91%) were discharged from hospital with no home and community care service in place. While it is likely that most of these seniors did not require home support, it is worth looking more closely at some sub-sets of acute care admissions. For example, 32% of seniors admitted to hospital came through the emergency department; they had an average age of 80 and stayed in hospital for 10 days on average for a range of serious medical conditions, including COPD, heart disease and pneumonia. This sub-set of seniors, despite their conditions, received no home support before hospitalization and were discharged from hospital with no home support. The question arises whether more can be done to identify seniors at risk of hospitalization in the primary care setting, in the community or when they arrive in hospital.

Hospitalizations of home support clients differ across the health authorities, just as levels of home support service vary. When comparing the intensity of home support (defined as hours per day) among health authorities, we see the authority with the lowest intensity of service has a 15% higher risk of hospitalization for its long-term home support clients when compared to the health authority with the highest intensity of service. Although factors influencing risk of hospitalization are complex, this suggests an association between higher service intensity and reduced hospitalizations.

For seniors in hospital, home support can mean a faster discharge from hospital to home or provide a transition for those awaiting placement to residential care. When a patient's care needs no longer require the intensity of services offered in the facility and the patient is not able to be discharged home, the designation of a patient as Alternate Level of Care (ALC) is applied. ALC is typically associated with hospitals, where a patient's acute care or rehabilitation phase has ended, but they are not able to be discharged home or to a different care setting that offers other services and care, or to their home. This might occur when a patient's family can't support their family member's care at home, home support is not yet in place, or when a patient is awaiting placement in a residential care facility.

In 2015/16, B.C. hospitals reported providing over 418,000 ALC days, most of which (89%) were provided to seniors. The issue of ALC is complex, but there are two primary concerns associated with it: first, if a patient no longer requires acute care but is unable to be discharged, then a patient who does require the bed will experience delays getting it. They may end up spending part of their hospital stay in a corridor or other less than optimal space. Perhaps more importantly, acute hospitals are designed to provide acute care; they are not adept at providing residential-type care. The impact on the patient can be significant, including increasing frailty and being subjected to hospital acquired infections. Across Canada, about 10% of adults in hospital at any given time have a hospital acquired infection and more than 8,000 people a year die because of them.

In part to reduce the number of ALC days in hospitals in B.C., the provincial government announced in 2013 that regional health authorities would receive $50-million over three years for targeted primary and community care initiatives. This funding was intended to help expand or roll out innovations such as the Home is Best (Home First) program across all five health authorities. The Home is Best philosophy was based on evidence that home is the best place for seniors to live and convalesce following hospitalization.

The initial Home First service was designed to provide intensive, short-term support immediately following hospital discharge, at which point the services are gradually reduced until clients can be supported with regular home and community care services. Home First was introduced following successful pilots in Fraser Health and Vancouver Coastal Health. Each pilot reported sizeable reductions in emergency department visits (69% and 25%, respectively) and acute care admissions (50% and 30%). The funding for the initiation of the program was time limited, and health authorities were expected to integrate principles and practices into their service models.

The Home First program targeted seniors with complex care needs so they could return to and remain living at home, avoiding future hospital admissions or transfers to residential care. Services can include bathing, washing, dressing, grooming, taking medications and other personal care needs. The program's target audience were those seniors waiting for a residential care bed or a residential care eligibility assessment, in hospital.

Commented [VS55]: So two groups of seniors targeted, those who could go home and those awaiting placement?

Scenario

Using home support to expedite discharge from hospital

s.22

A successful example of Home First was Island Health's initiative in the South Island health service delivery area. The project was built on the philosophy that even those who are assessed as needing placement may find they can function in the community if they receive the appropriate level of support. The data show that, over a two-year period, 707 seniors who were in acute care awaiting placement were returned home. For three months, intense supports were in place. This included support from occupational therapists to ensure the home was accessible (ramps, slip/trip hazards removed) and overnight or live-in caregiving where necessary. The goal was to ensure that clients could remain at home after three months with four hours per day of home support or less. The results showed that, after three months, only 28% proceeded to

residential care as planned; 31% remained at home with home support as per provincial guidelines (at or below four hours per day) and the remainder were no longer on the program.

Commented [VS56]: As compared to what if the supports were not in place, 100% in LTC?

While all health authorities may have Home First-type strategies, they differ in the guidelines for enhanced home support, and consequently comparison of services is challenging. For example, health authorities may offer enhanced service as short as 12 hours or two weeks of support, whichever comes first (although more can be authorized if necessary), or as much service as required within a three-month period. Data shows that, in practice, the average short-term home support client, with service initiated within one week of discharge from hospital, received 54 days of service with an average of one hour and three minutes per day.

Our review of the data revealed that the level of home support delivered to clients leaving hospital varied by health authority, with clients in Island Health receiving the most home support per day and those in Northern Health receiving the least. Clients in Inland Health received short term support from an average of 88 days after discharge (the highest), while those in Interior Health received it for an average of 42 days post-discharge (the lowest). A separate analysis showed that Island Health had the highest proportion of clients receiving four hours or more per day of short term service, and the lowest proportion of clients receiving one hour per day or less. This variation across the health authorities and the low intensity of service per day suggests there is room for not only for standardizing home support allocation but additionally for increasing home support.

Commented [CHGH57]: awaiting new data from Jeff

The evidence and the experiences of seniors and their families tell us clearly that more can and should be done to ensure all home support options and resources are being fully exhausted for seniors being discharged from hospital, both those who await residential care and those who intend to remain at home.

The home as a financial resource

For most British Columbians, our homes are where we strive to life as fully and as independently as we can in our communities of choice. Homes also have financial value.

While the median income for B.C. seniors is less than $27,000, eight out of 10 seniors (80%) own their own home. A significant number of low-income seniors, particularly those living in regions with strong housing markets, may have substantial equity established in their homes. In the Seniors Advocate's first housing report, a recommendation to the provincial government was made to create a Homeowner Expense Deferral Account program, modelled after the Property Tax Deferment program currently in place. This program would allow low- or moderate-income seniors to use the equity in their home to offset the costs of housing by deferring some, or all, of the major ongoing and exceptional expenses associated with home ownership.

Commented [VS58]: date

Commented [VS59]: Did anything come of that proposal? If so, we should say so. If not, why mention it in such detail here?

We now propose a program that allows homeowners to access equity in their home to pay for home support care needs, allowing for deferral of costs. Interest would accumulate annually, and the balance would be payable upon a client ceasing to receive any home support services, either because of death or initiation of private-pay services. All seniors eligible for home support with enough equity in their home (at least 25%) would be eligible.

This type of program would ensure that seniors who have wealth established in their home but who are on a limited, fixed income would be able to afford home support services. For a senior right at the $30,000 per year income point, the annual deductible, incorporating the proposed $14,000 basic income amount, would be around $13,000. Deferring this amount against home equity would allow this senior to receive the home support services while keeping money aside for expenses such as home repairs or home modifications to allow for continued independence.

The home equity account would function like a line of credit against the home owner's equity. To balance financial fairness to both the government (lender) and home owner (borrower), the interest rate would be set at the prime rate. This would be far below what is available from commercial home equity loans or reverse mortgages, which are generally over 5%. Eligible expenses for the account would include the annual home support deductible as well as any private services a client may wish to buy above what the health authority has assessed as necessary. Giving seniors the choice about where best to allocate their money when it comes to what they know they need to remain living independently is crucial in ensuring home support works.

To conclude

Our review shows that most seniors and their caregivers who receive home support are satisfied with the services they receive. But the evidence presented in this review also shows clearly that the system falls short of its goals as clients needs become more complex. Seniors are not being cared for how they want, as much as they want. Their caregivers are still distressed and burning out. Seniors are being placed in care homes before they need to be. The health care system is spending more than it should by not fully exploring and offering expanded home care supports for a growing population of seniors in B.C.

So, what can we do? Plenty. Opportunities abound for the home support system to expand, to be more flexible and to improve lives. What follows is a list of recommendations that show how creativity, fiscal responsibility and efficiency can combine to make the system work as well for individuals needing home support as it would for the health care system itself. These recommendations should stand as a Bill of Rights for home care clients and their families.

Commented [VS60]: IM, we can obviously rewrite this list, make it smaller or larger. It comes from the priorities we discussed and the draft report.

We recommend that the Ministry of Health, in conjunction with Health Authorities:

1. Develop a system in which clients are entitled to four hours a day or equivalent of care, to be spent as they see fit, with a funding formula that puts power in their hands. This self-directed care option blends the best aspects of case management and personal choice. Clients would not have to spend precious energy going through the hoops currently needed to receive care, which often sends them exhausted into long-term care before they need to. Direct-to-client funding would be easy and accessible, so they could, for instance, hire their own health workers with support from case managers. This system mirrors the Choices in Support for Independent Living model (CSIL) that now allows a small group of clients to direct some aspects of their care.
2. Develop a capacity plan that means people will first exhaust home support services before applying for admission to residential care. Ensure services are flexible enough to meet the needs of those who require short-term, high-intensity and/or overnight supports that may exceed 120 hours of service in a month.
3. Standardize the range of tasks included in home care and the amount of time to do them; increase the scope of services (housekeeping, transportation, respite care); and provide equitable access to the same services for seniors across the province.
4. Provide respite care whenever a caregiver wants it, in whatever form they need, to equal one eight-hour day a week, outside of personal care hours. To develop this part of the program, respite care needs to be tracked and coded as an essential service. Another benefit to this change would be that it will create more fulltime jobs for home support workers, who generally work on a casual, part-time basis.
5. Update the funding formula. Adjust the rate-setting calculation by increasing the basic deduction amount, and review that amount every year to ensure that low-income seniors are not losing service because inflation makes it unaffordable. As well as clients receiving the Guaranteed Income Supplement (GIS), those in the SAFER program – or Shelter Aid for Elderly Renters, which helps make rents affordable for seniors with low to moderate incomes – should be exempt from home care service payments. Review the cap on co-payment for earned income so that those seniors who can afford to pay more, do.
6. To review and adopt a home care expense deferral program to allow those 65 years and older to leverage equity in their homes to pay for home support costs.
7. Provide, in print, provincially standardized information for clients, families and caregivers that outline the home support program, the assessment process and a list of what they are entitled to receive. All five health authorities would use this pamphlet.

Commented [VS61]: is that right? As in, one eight-hour day a week, but however they want it?

Commented [VS62]: IM, do we have any data on this aspect of care or is it an assumed benefit?

Commented [VS63]: The original draft said health care costs, but that seems too general. I think you mean just home support, right?

Commented [VS64]: Is there an example we could use?

All British Columbians want to live as independently as possible, with privacy and dignity intact. As we age, none of us would gladly choose to exhaust our caregivers and families, only to be moved prematurely into a "facility," no matter how safe and warm it may be.

The Home Support system was created to keep British Columbians safely at home as our health needs increase. The time has come to update and expand that program and to put its powerful tools in the hands of those who need it most. We all deserve the advantages of home.

Appendix graphs and charts; should more be moved here?

Add footnotes, references, acronyms, etc.

Cowan-Douglas, Rob J HLTH:EX

From:	Cook, Heather G HLTH:EX
Sent:	April 16, 2018 8:27 AM
To:	Cowan-Douglas, Rob J HLTH:EX
Subject:	FW: #'s we need for Leadership presentation
Attachments:	for our call; RE: questions from Isobel re: Home Support; home support - good news in a new model; Hospitalization trend; Home Support Review Draft Report 2018-01-18.docx; Home Support Data Slides 2017-02-17.pptx

Hello Rob,

I've attached the above emails from Jeff because they are not yet on the LAN. The information in the emails may be helpful in responding to Isobel's ask for data.

I have multiple versions of the Home Support report on my computer (again not on the LAN), and I've attached the most recent one that went to Isobel in February and which she has not yet completed her review...

We should catch up today or tomorrow regarding how far you've progressed with her data ask. We will need to engage Edward so that he can pull the presentation together for her.

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From: Mackenzie, Isobel HLTH:EX
Sent: Thursday, April 12, 2018 6:03 PM
To: Cook, Heather G HLTH:EX
Cc: Cowan-Douglas, Rob J HLTH:EX
Subject: #'s we need for Leadership presentation

Heather/Rob:
Can we start pulling these numbers together, hoping we can have them all before end of the day Monday. Some are in the PDT Reports and Jess Poss likely has others.

1. % of residents in LTC who could be in the community. Look at the CIHI numbers from their report as well as the numbers that Jeff did for us
2. Last 5 years – the number of new residential care beds and the number of new subsidized A/L units- see if you can also find out how many new beds are on the books to come on stream and if we are losing any AL – I know we are losing some AL capacity in Coastal with the attrition at Terraces on 7th and VIHA lost some units at Lions Cove.
3. Home Support Last 2 years: Acuity level (I know it is rising but cannot remember how we measured that)- the average hours per client; the number of clients vs growth in population 75 plus , further breakdown of hours – how a many getting one hour/two etc.

4. The data from Jeff about admissions to RC and the % who were on HCC (I think about 50%). Of those 50% on home support, how many hours a month they were getting
5. Heather – whatever source you have that talks about 3 hours a day being protective for admission to residential care.
6. CSIL program – see how far back we can chart for increase in the clients in hopefully at least the last two years and better yet 5 years. The average hours per client on CSIL, but see if we can break that down to find the minimum number of hours for a client on CSIL.
7. ADP- number of spaces, number of clients, average days per client – see last Caregiver Distress Report
8. Latest numbers on Caregiver Distress

That should be lots to work on. I will be tied up a good part of tomorrow over in Abbotsford but available around 3pm or so for a check in and a chat, I assume with Rob s.22

Thanks
Isobel

Cowan-Douglas, Rob J HLTH:EX

From: Jeff Poss <jwposs@uwaterloo.ca>
Sent: March 9, 2018 11:41 AM
To: Cook, Heather G HLTH:EX
Subject: home support, updated material
Attachments: RC placement models 2March2018.xlsx; Placement Models March 2018_HS_only.docx

Heather, attached are the updated report and figures. Let me know if you want to discuss or have questions.

Adding language to the models was interesting, and important, as expected. Dichotomized as English/non-English suggests that non-English provides a significant protective effect, and when applied in the models brings the hazard of Northern and Interior lower (although still significantly elevated) where non-English speaking clients are much more rare. Economic trade-offs or other markers of SES did not show an effect, interestingly.

Good to have the update and know that the home support document won't be out until the summer. Curious as to what ideas Isobel s.22

- Jeff

Jeff Poss, PhD
Associate Adjunct Professor
School of Public Health and Health Systems
University of Waterloo

Health Services Research Consultant
Vancouver

Analysis of BC RAI-HC/MRR – March 2 2018, for OSA – J. Poss

Questions:

1. Is there evidence that provision of home support keeps people in their own homes longer (i.e., delays placement to residential care or assisted living)?
2. Are there differences in the HA's effectiveness in this?
3. Does need for help with IADL's predict placement in residential care?

Approach and considerations:

Measurements in the RAI-HC are required to adjust for individual differences, as well as to supply IADL measures for question #3.

In addition to challenges of availability of a RAI-HC close to an episode where possible RC transitions can be observed, timing of that RAI-HC (start of case, clinical change, return from hospital, prior to placement) is not a randomized event. In a time-to-event model, the date of the RAI-HC may be biased as a starting time. Selecting new cases only in a period (and starting time at the episode beginning) is also problematic, since RAI-HC measures are not available for all historic periods, and it's not possible to adjust for policy or other differences in place where clients started service.

Here I have chosen to take a cross-section of community adult cases that are all active on a (somewhat) arbitrarily chosen date: September 12, 2014. As of this day, there will be a variety of types of cases (new and long-standing) and should be representative of what might be observed on any other day around that time. September 12 is the start of a fiscal reporting period, allowing home support services in the next 3 complete fiscal reporting periods to be summed. This period avoids summer as well as the Christmas holiday period, where service provision may be different than usual. It also supports a 21 month period (18 months prior, 3 months after) around which RAI-HC assessments are available for all five health authorities.

Case eligibility is based on being active in case management and receiving home support, on the index date. In addition to having a non-hospital RAI-HC available, I removed cases that, on the index date, were waiting for placement in Assisted Living or Residential Care. The rationale for this is that these individuals will be transitioning when a suitable bed is available, and so will experience the event, or be censored, differently than those who have are not waiting for placement.

Note that this approach allows the effect of home support levels to be seen, among those who receive any home support. Investigations were performed including individuals who were case managed and assessed, but did not receive home support, but this presented challenges in being able to conduct a fair comparison: some, perhaps a significant proportion, of those not receiving public home support may be receiving private home support – however it is not possible to understand who these individuals are, or to know their actual home support amounts, something necessary to be able to include them in this analysis. So instead of being able to answer the question around whether home support effects the risk of future placement, it became the question of do <u>different levels of home support</u> effect the risk of future placement among those receiving some home support.

Dataset Creation Steps

Step	Count
Active cases on a chosen index date (September 12, 2014 – start of a fiscal reporting period), based on HCC MRR, either case managed or receiving long-term home support	40,536
Had RAI-HC in a non-hospital setting in prior 18 months or next 3 months (use closest one to September 12, 2014)	31,278
Remove those waiting for placement in either AL or RC on September 12, 2014	26,341
Remove CSIL clients (not typical of home support, younger, etc.)	25,672
Add average home support per day from MRR home support and remove cases not receiving any home support	14,328
Using MRR and CCRS episodes, identify Residential Care placement dates	

Descriptive Characteristics of the sample

	Interior	Fraser	Coastal	Island	Northern	**BC**
N	2,993	3,988	3,891	2,987	469	**14,328**
Female	69.9%	68.3%	68.6%	69.0%	68.7%	**68.9%**
Over 85	45.1%	41.7%	41.9%	45.8%	33.7%	**43.1%**
Primary language not English	3.3%	34.5%	36.3%	16.6%	5.4%	**22.7%**
Dementia	23.1%	23.2%	21.3%	26.9%	17.9%	**23.3%**
Wandering	1.8%	1.1%	1.0%	2.0%	1.9%	**1.4%**
Aggressive behaviour	7.9%	7.5%	6.5%	7.2%	9.0%	**7.3%**
Prim. caregiver co-resides	33.8%	52.3%	39.4%	36.7%	33.9%	**41.0%**
MAPLe high or very high	45.8%	41.5%	40.0%	42.0%	37.8%	**42.0%**
up to 1.5 hrs/day	84.7%	69.0%	73.9%	67.1%	84.2%	**73.7%**
>1.5 up to 3 hrs/day	13.3%	21.0%	16.7%	22.5%	10.9%	**18.25**
>3 hrs/day	2.0%	9.9%	9.4%	10.5%	4.9%	**8.1%**
Placed Res Care or AL in next year	7.7%	5.7%	5.5%	6.8%	6.8%	**6.3%**

Some notable differences by HA are coloured in the table above. Among the most notable is the proportion of primary caregivers who co-reside with the resident, with Fraser as the high outlier, and Interior and Northern as the two low HA's. Despite this similarity between Northern and Interior, they differ the most in the proportion of high and very high MAPLe (indicative of more clients at high risk of placement). It is of interest that, after adjustments, Interior and Northern are the two HA's with the highest risk of placement, although this could be from any number of factors in the model, including primary caregiver co-residing.

Time-to-event multivariable regression: time here begins on September 12, 2014 when all cases were not in residential care or assisted living. The event of interest is placement in RC **or** AL from September 13, 2014 to September 11, 2015. Cases are censored when long-term home support or case management ends (whichever is later). All cases censored on September 11, 2015.

Covariate effects are of some interest on their own, all adjusted for other factors in the model (meaning two people who measure as the same, except they differ in that characteristic alone):

- Older age much more likely to be placed, sex/gender no difference
- Situations with live-in caregivers lower likelihood
- Where the caregiver cannot continue, or shows the strains of caregiving, more likely
- Behaviours and wandering, rare but very powerful
- Cognitive impairment to a very high degree, ADL impairment not as much

The ability to see the effects of home support intensity on future placement requires some choice of grouping by home support level. Several variations were tried. Presented here is where HS is assigned as:

- any up to 1.5 hrs/day
- >1.5 up to 3 hrs/day [the reference, allowing significance to be understood for lower and higher levels]
- >3 hrs/day

It is found that lower HS levels are associated with higher risk of placement, and higher HS levels are associated with lower risk (at the .05 significance level).

1. **Version 1** adjusts with sex, age, primary caregiver, caregiver distress, ADL, IADL, cognition, wandering, aggressive behaviour. Home support levels at or below 1.5 hrs/day are associated with a 20.2% additional hazard, and those with more than 3 hrs/day are associated with a 33.6% lower hazard, compared to those receiving more than 1.5 hrs up to 3 hrs per day.
2. **Version 2** adds HA to the model. The HS hazards narrow slightly: 16.3% higher hazard for the up to 1.5 hr group just fails to meet .05 statistical significance; the 30.7% lower hazard for the highest HS group, compared to the middle HS group is statistically significant.
3. **Version 3** adds primary language as an additional covariate, here it is dichotomized as English and non-English. When the client's primary language is not English, the adjusted hazard is almost 30% less, consistent with the idea that some cultural groups are more likely to live as multi-generational where cultural values and informal supports help in living in one's home for a longer period of time. Also of interest is that the higher hazard for Interior and Northern Health seen in Version 2 moderates somewhat (1.61 to 1.38, and 1.69 to 1.47, respectively), suggesting that some of the difference is associated with much lower proportions of non-English primary language in these two HA's. This adjustment did not significantly alter

→Also examined were any available measures of socio-economic status, since it may provide a protective effect including the purchase of private care in addition to public home support. Three available albeit crude measures were tried: education and economic trade-offs (RAI-HC), and home support co-payment (MRR), and none of them were significant in the models.

Discussion regarding questions:

1. Is there evidence that provision of home support delays placement in residential care?
    - There is evidence that among those receiving home support, adjusting for needs and risk of placement, that higher amounts of home support are protective of placement, and that lower amounts are related to higher risk of placement.
        - However, the models have significant amounts of unexplained variance – which means that unmeasured factors, if they were known, could produce results that are different. As we see here, adding the HA to the model changed the average effects of home support, suggesting the effect is not highly robust.
2. Are there differences in the HA's effectiveness in delaying placement in residential care?
    - Compared to Coastal (the reference), and adjusting for client and home support differences in the samples, Fraser and Island were no different. Interior and Northern had elevated risk of placement, about 40% higher after adjustment.
        - Similar caution here about large amounts of unexplained variance. Similar to above, adding non-English language to the model changed the HA effects.
3. Does need for help with IADL's predict placement in residential care?
    - Yes, adjusting for other things in the model, including functional characteristics of ADL and cognition. Here a hierarchical scale of IADL difficulty is used whereby three IADLs are used ranging from early to late loss (housework, meal preparation, and telephone use). Compared to those with no difficulty in all of these:
        - Those with great difficulty in one or more of these 3 IADL's had a statistically significant hazard ratio of 2.23 (more than twice the risk).
    - Additional analysis suggests that among the 7 IADL's measured, meal preparation and medication management are the two areas where difficulty is most highly related to placement risk. Both are related to a significantly elevated risk. Hazard ratios for great difficulty compared to no difficulty (95% confidence of hazard):
        - Meal preparation: 2.26 (1.44 – 3.53)
        - Medication management: 1.77 (1.38 – 2.26)
    - Similar caution here about large amounts of unexplained variance

Cowan-Douglas, Rob J HLTH:EX

From: Cook, Heather G HLTH:EX
Sent: January 18, 2018 8:37 AM
To: 'Jeff Poss'; Cowan-Douglas, Rob J HLTH:EX
Subject: RE: questions from Isobel re: Home Support

Hello Jeff,

Thanks for the update...and yes, I understand the challenge of comparing health authorities...but I agree...I think it's worth a look.

ROB – can you assist Jeff with the data ask?

Thank you!

Heather Cook, RN, MScN
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From: Jeff Poss [mailto:jwposs@uwaterloo.ca]
Sent: Wednesday, January 17, 2018 3:45 PM
To: Cook, Heather G HLTH:EX
Cc: Cowan-Douglas, Rob J HLTH:EX
Subject: RE: questions from Isobel re: Home Support

Heather,

Regarding these questions, you will appreciate that it's challenging to compare health authorities, in general, and Northern Health in particular since it's distinct in geography, size, and health status, compared to the other four. But that doesn't mean it's not worth having a look.

I can assemble LTC beds and population as well as light care proportions in ResCare, am having trouble finding reliable numbers for ALC and hospital readmission – can the OSA obtain these?

And I've drafted a brief analytic report on home support, IADL, and risk of ResCare Entry. Have sent to Kim McGrail for a second set of eyes, expect to hear back from her shortly. - Jeff

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From: Cook, Heather G HLTH:EX [mailto:Heather.G.Cook@gov.bc.ca]
Sent: January-10-18 3:56 PM
To: Jeff Poss
Cc: Cowan-Douglas, Rob J HLTH:EX
Subject: questions from Isobel re: Home Support

Hello Jeff,

Found my sheet of paper as soon as you left... The questions from Isobel regarding Home support:

VIHA has the highest intensity home support compared to NH. Are there outcomes we can tie that to?

- # of LTC beds per 1000 of target population (look at parameters of age 75 and age 85)
- ALC, both in terms of percentage of beds and the LOS
- Re-admission to hospital rates
- The percentage of LTC residents who do not meet guidelines

Now...although Isobel's question is specifically to compare these two health authorities, it would make more sense to me to run the same date for all health authorities and then see if there is anything that falls out of the data as far as "evidence".

Is this something you can do?

Thanks
H

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Cowan-Douglas, Rob J HLTH:EX

From: Cowan-Douglas, Rob J HLTH:EX
Sent: March 2, 2018 10:07 AM
To: 'Jeff Poss'
Cc: Cook, Heather G HLTH:EX
Subject: RE: questions from Isobel re: Home Support

Hi Jeff,

As far as I can tell from the (many, many) emails we had back and forth with the IT people, Lisa's VPN was created; my apologies if we didn't communicate this to you. Can you get her to try logging in with the instructions and software I previously sent to you? The username and password are the same as her IDIR (usual login) for the SAE. If it's not working, I'll get Bruce to escalate this ASAP.

Regards,

Rob

From: Jeff Poss [mailto:jwposs@uwaterloo.ca]
Sent: Friday, March 2, 2018 10:00 AM
To: Cook, Heather G HLTH:EX
Cc: Cowan-Douglas, Rob J HLTH:EX
Subject: RE: questions from Isobel re: Home Support

Hi Heather,

Too bad we just overlapped the Thursday morning and didn't have a chance to chat!

I do have something, and I'm hoping it will be worth waiting for.. yes, I now have server access again. I had some back-and-forth with Kim McGrail about these questions and she had some good suggestions. In a nutshell I have abandoned the question of can you test if any home support is beneficial – the challenge is that those assessed cases receiving no home support are a very challenging (analytically) group, some we know receive private home support (unknown and unmeasurable), but we don't know which ones. Instead, what I am now concentrating on is whether an effect can be seen around the intensity of home support received, among those who receive it. Looks like there is something there. And it will incorporate the IADL and health authority questions.

I would like to run these latest findings by Kim, and get them to you early next week.

Am copying Rob as he had helped with the server access for me (thank you) – we have some tidying up on the residential care work for the planned academic paper (note that this additional analysis will not be part of the billed hours to the OSA), and wanted to understand where things are at for server access for Lisa – has a VPN request gone in for her, or were we looking at sharing the VPN (floated at some point)? - Jeff

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From: Cook, Heather G HLTH:EX [mailto:Heather.G.Cook@gov.bc.ca]
Sent: March-01-18 12:32 PM
To: Jeff Poss
Subject: RE: questions from Isobel re: Home Support

Hi Jeff,

We didn`t have a chat to catch up in Edmonton...but I`m wondering if you have any update to the below? And...is your VPN issue resolved?

Thanks
Heather C

Heather Cook, RN, MScN
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From: Jeff Poss [mailto:jwposs@uwaterloo.ca]
Sent: Wednesday, January 17, 2018 3:45 PM
To: Cook, Heather G HLTH:EX
Cc: Cowan-Douglas, Rob J HLTH:EX
Subject: RE: questions from Isobel re: Home Support

Heather,

Regarding these questions, you will appreciate that it's challenging to compare health authorities, in general, and Northern Health in particular since it's distinct in geography, size, and health status, compared to the other four. But that doesn't mean it's not worth having a look.

I can assemble LTC beds and population as well as light care proportions in ResCare, am having trouble finding reliable numbers for ALC and hospital readmission – can the OSA obtain these?

And I've drafted a brief analytic report on home support, IADL, and risk of ResCare Entry. Have sent to Kim McGrail for a second set of eyes, expect to hear back from her shortly. - Jeff

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From: Cook, Heather G HLTH:EX [mailto:Heather.G.Cook@gov.bc.ca]
Sent: January-10-18 3:56 PM
To: Jeff Poss
Cc: Cowan-Douglas, Rob J HLTH:EX
Subject: questions from Isobel re: Home Support

Hello Jeff,

Found my sheet of paper as soon as you left... The questions from Isobel regarding Home support:

VIHA has the highest intensity home support compared to NH. Are there outcomes we can tie that to?

- # of LTC beds per 1000 of target population (look at parameters of age 75 and age 85)
- ALC, both in terms of percentage of beds and the LOS
- Re-admission to hospital rates
- The percentage of LTC residents who do not meet guidelines

Now...although Isobel's question is specifically to compare these two health authorities, it would make more sense to me to run the same date for all health authorities and then see if there is anything that falls out of the data as far as "evidence".

Is this something you can do?

Thanks
H

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Cowan-Douglas, Rob J HLTH:EX

From: Cook, Heather G HLTH:EX
Sent: January 15, 2018 8:37 AM
To: 'Jeff Poss'
Subject: RE: home support - good news in a new model

Hi Jeff,

Thanks for this...it is interesting, and I think your thought that perhaps new cases are more volatile is spot-on. Experience tells me that newly case-managed folk are time-consuming for Case Managers, often require adjustment to service, additional time with family caregivers, etc...as opposed to longer term case managed clients...who have a plan of care that is meeting their needs and the needs of their family caregivers...less time for case managers, often the service bucket doesn't change much (if at all) over time...until a further change happens (fall with injury; caregiver frailty etc...).

I think a 2 pager would be all that is required...methods/results will work well....

Thanks
H

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From: Jeff Poss [mailto:jwposs@uwaterloo.ca]
Sent: Friday, January 12, 2018 3:53 PM
To: Cook, Heather G HLTH:EX
Subject: home support - good news in a new model

Hi Heather,

Good to see you Wednesday. Today I've been conducting some analysis on the BC data to address the question of IADL needs and risk of residential care placement. Sorry for the length of this email.

In doing so, I think I've got some evidence you can use for showing home support is protective regarding res care entry.

In the earlier analysis I ran for Nancy, I had used a cohort of clients who were new as case managed cases, and it tended to show that either home support had no association for RC entry, or it increased the likelihood (because of unadjusted higher needs among those getting more home support). I don't recall why I settled on the new cases only, probably to remove any effect of changing policies over time that tend to influence cohort and service matching that you subsequently see.

What I changed this time was to use a cross-sectional cohort of all clients who had a RAI-HC assessment at home, so new and ongoing cases assessed in a 2 year window, were case managed, not in AL, and not waiting for a RC bed at the time of their assessment. If a client had more than 1 assessment I used the earlier one. There is a mixture of clients getting

home support of various intensities, and 38% of these folks had no long or short term home support in the 3 fiscal periods after the RAI-HC.

What I see is that home support is protective of RC entry, and higher amounts tend to be the most protective (a dose/response). Here are the hazard ratios for risk of entry to RC (values less than 1 are protective):

no home support: 1.00 (reference)
up to and including 1 hour per day : 0.90 (not significant)
>1 and up to 2 hours per day: 0.77 (significantly different from none)
>2 and up to 3 hours per day: 0.73 (ditto)
>3 hours per day: 0.44 (ditto)

This is interesting and a bit surprising to me, actually.. there must be something different about cases newly on service, they are more volatile, compared to this mixture of new and ongoing ones.

I will double-check everything but wanted to let you know. There is always the question of those 38% who received no home support, did they opt for private service after seeing the co-payment estimate? Were they getting other services like adult-day?

And the IADL question, of the 7 IADL's, difficulty with medication management is the one that stands out as a risk factor for RC placement, after adjusting for everything else (including home support). The other six not so much, but I will continue to look at this.

What level of detail would you like around this? A brief (say 2 pages) analytic report with methods and results summarized? Think about it, let's touch base early next week.

Jeff Poss, PhD
Associate Adjunct Professor
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Health Services Research Consultant
Vancouver

Home Support Review

Draft January 18, 2018

Revision History

Filename date	Author(s)	Description	Notes
October 18, 2017	Nancy/Rob	Home Support Review	Updated with 2015/16 data
October 20, 2017	Nancy/Rob	Incremental draft	
November 1, 2017	Nancy/Rob	Incremental draft	
December 1, 2017	Nancy	Incremental draft	
January 18, 2017	Heather	Incremental draft	

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Introduction

British Columbia's home support system has remained relatively unchanged for more than two decades and has been the subject of numerous reports by a variety of organizations. The content and critiques of these reports have varied, however a consistent theme has emerged – while the home support system is achieving many of its intended functions and goals, there is no question that the home support system must evolve to address the needs of a growing and increasingly frail and complex seniors population.

The provincial government has recognized this need and in March, 2017, released its Action Plan to Strengthen Home and Community Care for Seniors. This plan recognized the need to not only deliver more hours of service to the growing home support client base, it also recognized the need to expand the scope of service as well as refresh existing home support policies in the province. Additional funding has been directed towards home support from both the provincial and federal governments, and an opportunity presents itself to incorporate the perspective of those receiving home support services in redesigning and enhancing the service.

An effective home support program achieves two primary objectives. First, with ongoing support, seniors can live in their own homes for as long as possible and delay or eliminate the need for admission to residential care. Second, it reduces the strain on the acute care system by reducing the risk of hospitalization for its clients through proactive intervention and monitoring, and allowing for quicker discharge from hospital. These objectives support the desire of the majority of seniors to live independently and to receive supports and care, if needed, in their home. With these objectives in mind, the intent of the Office of the Seniors Advocate (OSA) in undertaking a review of home support is to understand the current state and trends over time of home support services and engage users of the service in providing feedback on their experience of the services they receive. Finally, to identify potential opportunities for innovation and service delivery enhancement. In conducting the review, the OSA drew upon many sources of data and information including the results of a province-wide standardized survey of all home support clients in BC, and administrative and clinical data from the Ministry of Health and the five regional health authorities.

This report makes recommendations in three key areas:

- Ensuring the hours of home support are optimized to meet the needs of an increasing seniors population and that the model of service is responsive to the needs of the senior;
- Improving flexibility and choice in seniors' access to home support services by ensuring it is client and family-centered; and
- Introducing innovative and cost effective solutions for home support to the health care system.

Home Support in British Columbia

How the Home Support System Works

As we age, some of us will find it more difficult to manage tasks that allow us to live independently. We may experience challenges bathing, getting dressed, or managing medications—collectively referred to as the Activities of Daily Living, or ADLs. In British Columbia, subsidized[1] home support is available to help individuals who face these daily challenges.

B.C.'s home support is governed by provincial policies and guidelines and is managed and delivered by each of the province's five regional health authorities. It is delivered as part of the provincial Home and Community Care (HCC) program, which also offers professional supports such as nursing, physiotherapy, occupational therapy, nutrition, and social work.

Activities of Daily Living (ADLs)

- Basic self-care
- Feeding
- Toileting
- Dressing
- Grooming
- Maintaining continence
- Bathing
- Walking
- Transferring

The B.C. Ministry of Health defines the scope of home support services in its Home and Community Care Policy Manual as follows:

> "***Home support services*** are direct care services provided by unregulated care providers to clients who require personal assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, bathing, cueing, grooming and toileting, and may include safety maintenance activities as a supplement to personal assistance when appropriate, as well as specific nursing and rehabilitation tasks delegated under Policy 1.C, Delegation of Tasks.
>
> "***Safety maintenance activities*** are identified through the care plan and focus on reducing, eliminating or monitoring risk or potential risk to a client. As part of the authorized services, these activities may include clean-up, laundry of soiled bedding or clothing, and meal preparation."

B.C. Ministry of Health policy states that home support services are meant to *supplement*, rather than replace the efforts of individuals and their caregivers to meet their health needs. Subsidized home support is available to clients on an ongoing regular basis (long term home support) or on a short term basis that is expected to be temporary (short term home support). Short term home support is typically put in place to facilitate hospital discharge where a patient is able to recover in their own home with the assistance of home support.

[1] "Subsidized" indicates partially or fully funded by a health authority

Health authorities deliver home support either through staff directly employed by the health authority or through an agency that is funded to provide the service. In either case, the guidelines, supervision and training requirement for home support staff are the same.

Long term home support services are provided in two ways – either directly by the health authority (or contracted provider) or through a specialized program known as Choices in Supports for Independent Living (CSIL). Individuals who are part of the CSIL program receive funds from the health authority in lieu of home support hours, allowing the client (or a proxy) to hire and direct their own caregivers. This arrangement is one type of self-directed care, and one of the focus areas of this report.

Clients who do not require home support but need stand-alone support for activities such as transportation, shopping, financial management, housekeeping and meal preparation (referred to as Instrumental Activities of Daily Living - IADLs) are directed to community resources, such as the United Way's Better at Home program, as these services are not part of the array of services available through the Ministry of Health funded program. In some exceptional circumstances where an individual is eligible for home support on the basis of their need for assistance with ADLs, some housekeeping service may be available where it meets the criteria of "hazard reduction". Additionally, in some instances limited meal preparation may also be available. There is variation across the health authorities in the extent to which these additional services may be available.

A number of criteria are used to assess eligibility for home support and the clinician will complete the assessment and consider:

- Client's ability to manage, including risk assessment
- Unique needs and strengths of the client
- Other supports, including that provided by family and friends
- If there are other community services to address the client's needs

Clinicians work with the client and their family to determine what services will best support the client to remain independent in their home.

Most health authorities have set a guideline of a maximum of 120 hours of home support per month for individual clients. This translates to 4 hours per day of daily service for a client. If a client is assessed to require more than 120 care hours per month, approval processes are in place to make exceptions to the 120 hour maximum.

Clients receiving long term home support are required to pay a client contribution toward the cost of the support they receive. The amount of the contribution is based on the client's assessed income on their most recent tax return. The client contribution is called the "daily rate," and is charged for each day the client receives service, regardless of the number of hours received per day. For example, a client with a $20 daily rate would pay $7,300 per year for daily service; a client receiving service every other day would pay $3,640 per year.

A senior in receipt of the federal Guaranteed Income Supplement (GIS) will have the client contribution waived. Approximately 70% of B.C. long term home support clients receive GIS, and therefore have no client contribution for home support services.

The Guaranteed Income Supplement—commonly referred to by its acronym, GIS—is a federal benefit paid to seniors who are eligible for Old Age Security (OAS) but whose overall annual income *including OAS* falls below a certain threshold ($24,486 for singles, $35,668 combined for couples). The GIS payment decreases as income approaches this threshold.

Who receives Home Support?

In the course of a year, about 40,000 people in BC use the home support program, with approximately 22,000 receiving service at any given time. Data derived from the RAI-HC (Resident Assessment Index – Home Care) assessments of clients allows us to paint a picture of the characteristics of home support clients as (see Table X below).

Table X: Characteristics of B.C. home support clients (RAI assessment) 2015/16

Average age	82
Female	67%
Married	28%
Widowed	43%
Lives with primary caregiver	42%
Caregiver distress	31%
Dementia diagnosis	32%
Wandering	3%
Aggressive behaviours	12%
Activities of Daily Living 3+	20%
Cognitive Performance Scale 3+	21%
MAPLe 4/5	52%
Bladder incontinence	26%

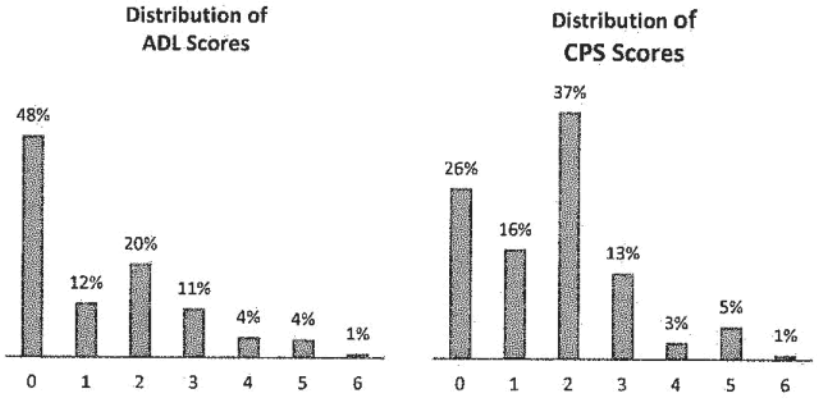
Activities of Daily Living
a score of 3 or more describes a person who is not fully independent and must have physical assistance to complete tasks such as bathing, toileting and activities related to their personal care.

Cognitive Performance Scale

a score of 3 or more indicates that the person needs close supervision and direction to carry out daily tasks.

Method for Assigning Priority Levels
the (MAPLe) score, an algorithm that uses dozens of items within the RAI-HC assessment tool to assign a numerical value to the overall complexity of a client's needs. Scores of 4 and 5 demonstrate high complexity

Because seniors receiving home supports vary in their individual range of physical and cognitive capabilities, each person is assessed and a home support plan is tailored to best meet the needs of that individual. In reviewing the data for Activities of Daily Living (ADL) function and the Cognitive Performance Scale (CPS), we are able to see the broad range of client needs being met in the home support program. One-fifth of clients have an ADL score of 3 or higher, which means they need significant to complete assistance with the activities of daily living. Over one-fifth of clients have a CPS score of 3 or higher, which would be typical of moderate to advanced dementia. Increasing values on the CPS scale indicate more significant cognitive impairment, including difficulty with short term memory, difficulty making oneself understood, and the need for cueing to complete tasks.



Commented [CHGH1]: I suggest removing this and converting it into bullet points...69% have a score of 2 or less in CPS scale...something like that

What this variation in client characteristics demonstrates is that the home support program is capable of successfully supporting seniors throughout the process of aging and that, as clients' needs increase, the program is able to support their continued ability to live at home. As well, this variation speaks to the complex task home support staff have in managing the needs of a large and diverse population.

Review of the Home Support Program

As stated in the introduction to this report, B.C.'s home support service has two primary objectives:

- To support seniors to live in their own homes for as long as possible and delay or eliminate the need for admission to residential care.
- To reduce strain on the acute care system by reducing the risk of hospitalization for home support clients through proactive intervention and monitoring, and allowing for timely discharge from hospital.

While it is difficult to directly evaluate how efficiently or effectively these objectives are being met, there are several markers we can examine which, when bundled together, can paint an overall picture of

the home support program. Importantly, including the voice of seniors and their caregivers in assessing the service they receive provides an additional lens to aspects of effectiveness and efficiency in service delivery.

Is home support keeping pace with population growth and increasing complexity?

The ability of the home support program to achieve the objective of keeping seniors living independently and reducing length of stay in hospital and/or delaying or eliminating admission to residential care can be approached in a number of ways. One way is to assume that the current delivery of home support services, in terms of number of clients served and number of service hours per client, is appropriate and that we only need to ensure it keeps pace with the population growth. If so, what one should see, at a minimum, is the number of clients growing at a rate that is keeping pace with the population growth and that the number of hours per client remains constant. In fact, analysis shows that home support services are not keeping pace.

BC has experienced a growth in the population > 65 years of age AND has seen an increase in the total volume of home support hours. BUT the rate of growth of the >65 population has outstripped the increase in total volume of hours. This means that service levels have fallen in comparison to service levels in 2006/07.

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% over the previous year. This doesn't sound like a large decrease, but in fact, it is 11,089.55 hours, which is equivalent to 42 fewer clients receiving support at the average of 263 hours of care annually. This overall decrease in the amount of service delivery took place despite an increase in the number of clients.

Table: Client counts and hours delivered by home support program (including CSIL clients)

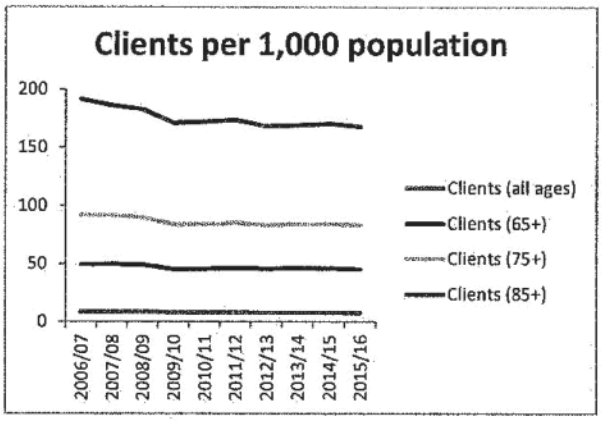
INCL CSIL	Clients	Hours	Population, 65+
2006/07	34,471 (17% of pop>65)	8,383,447 (243.2 hours/client)	611,211
2015/16	42,170 (20% of pop>65)	11,089,553 (262.97 hours/client)	850,424
% change 06/07-> 15/16	+ 22%	+ 32%	+ 39%

As the table above shows, while there has been an absolute increase in the number of clients and the volume of hours delivered to these clients, the population growth among B.C.'s seniors has outstripped service increases. The graphs below illustrate, on a per-population basis, service levels have fallen relative to 2006/07. The overall number of clients receiving home support and the number of hours of home support has not kept up with population growth.

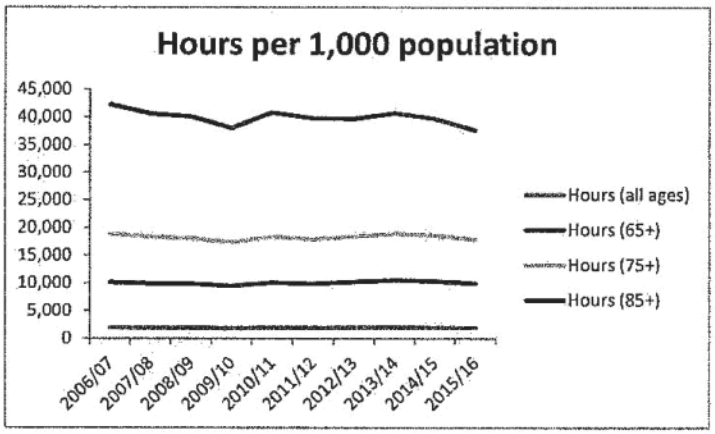
The following graphs plot a relative measure of services levels: the number of clients and hours per 1,000 population. Since 2006/07, the data demonstrates a downward trend in the number of clients and the hours they receive relative to the size of the overall population in B.C. Intuitively, the likelihood of needing home support services is associated with increased age, so we have developed a graph demonstrating service levels against different age cohorts. Most home support clients are at least 75 years of age, and in fact fully one half are aged 85 or older. In relation to the general population aged 75 or older, home support service levels per 1,000 population have seen a moderate decline between 2006/07 and 2015/16; on a per population basis, the number of clients receiving home health services has declined by 10% and total service hours have declined by 6%. Most alarmingly, however, service levels for people aged 85 or older have declined markedly since 2006/07; on a per-population basis, the number of 85+ clients have declined by 12% and total service hours have declined by 11%.

Commented [CHGH2]: Need to add in the growth rate of this population

Graph: Number of clients on home support (including CSIL clients)



Graph: Number of hours of home support (including CSIL clients)



One of the measures of service intensity is hours per client per year. In 2015/16, the average hours delivered per client per year was 263, or 5.1 hours per week. This represents a provincial decrease of 2% in the average hours of service per client from 2014/15.

Table: Average hours per client, per year

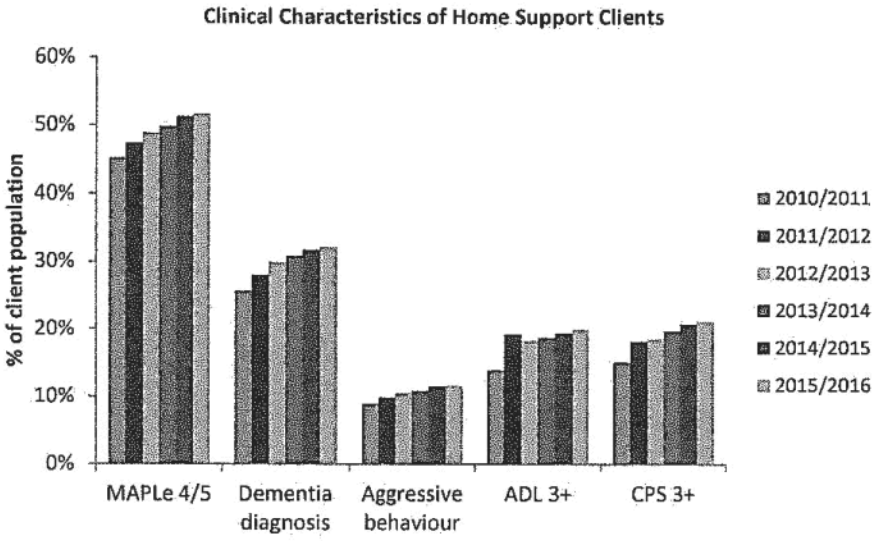
	w/ CSIL
2006/07	243
2008/09	239
2009/10	250
2010/11	262
2011/12	256
2012/13	267
2013/14	272
2014/15	268
2015/16	263

The decrease in average hours of service over the past 4 years is coupled with another trend: the health care needs of seniors receiving service are demonstrating increasing complexity. Seniors receiving home support are experiencing increasing levels of cognitive impairment, responsive behaviours, impairments in activities of daily living, increasing MAPLe scores, and increasing reports of caregiver distress.

Commented [CHGH3]: definition

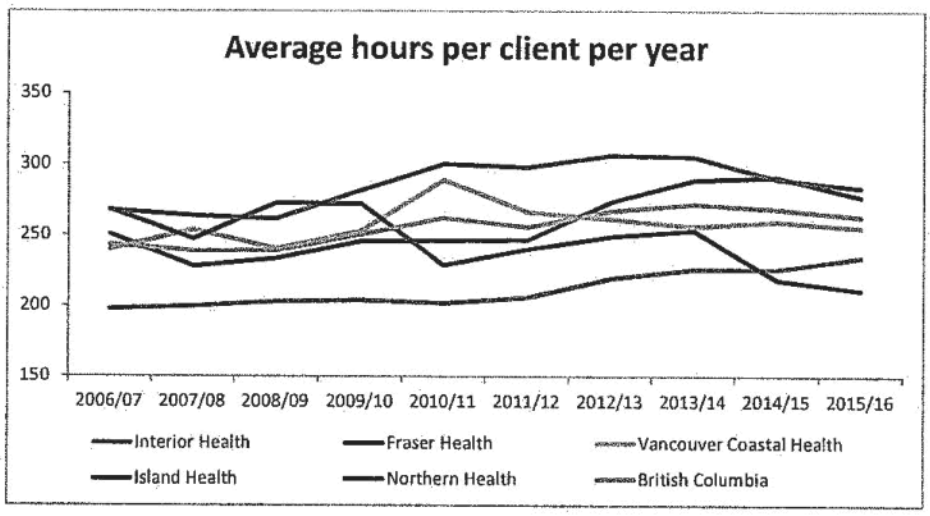
The chart below demonstrates the portion of clients with any of the six measures of complexity has increased by at least nine per cent over the past six years. This data suggests that despite the client base becoming increasingly complex each year, the intensity of service has been on the decline over the past four consecutive years. It is well understood that a more complex client requires a higher intensity of service for their needs to be adequately met.

Graph X: Clinical characteristics of home support clients (RAI assessment) from 2010/11 to 2015/16



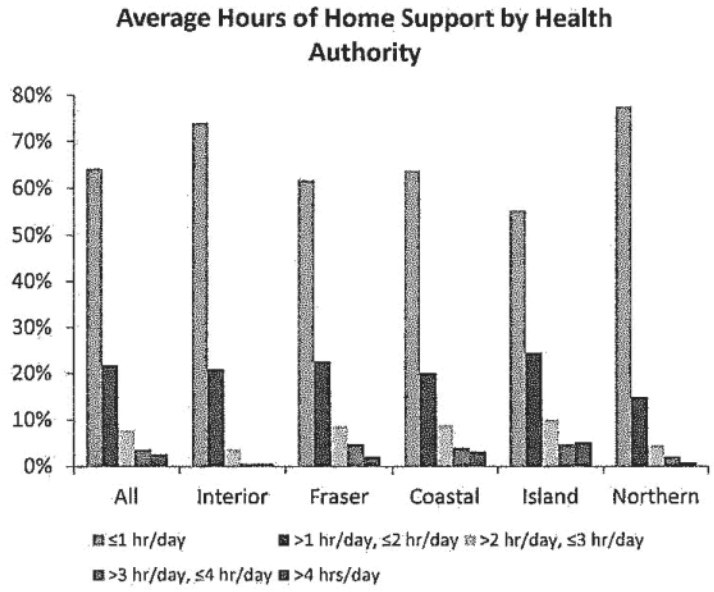
Ensuring service levels are equitable across health authorities

There is substantial variation in home support service delivery by health authorities across the province. The table below shows that Island Health, with approximately 283 average hours of service per client per year, consistently provides more home support hours per client than other health authorities. Fraser Health provides the second highest level of support with 277 average hours per client per year. Northern Health and Interior Health, on average, provide the lowest amounts of hours per client per year. Average hours increased in only one health authority, the health authority which, historically, had delivered the lowest levels of home support.



The variation in average hours per client is also reflected in the distribution of home support hours that an individual client receives across the Health Authorities. Two health authorities (Northern and Interior) have a greater percentage of clients with less than one hour of service per service day. Island Health demonstrates a greater percentage of its clients receiving services in the two to four hour range. Island Health also appears to be an outlier in terms of offering greater than four hours of service, including a number of clients receiving 24 hour live-in support, a service that does not appear available in other health authorities.

Commented [CHGH4]: awaiting data from Jeff for rate of or %accessing LTC for all HA's



Perhaps more interesting than the health authority differences in average hours of home support per client per year, is the inconsistency in terms of the time allocated to individual home support tasks (e.g. bathing). Each health authority has developed its own practice manual that specifies a time range for each activity in order to determine the number of hours of service a client will receive.

There is wide variation between health authorities in the time parameters allocated for each activity or group of activities. The minimum time allocated for personal care, including bathing, incontinence/toileting and catheter/bowel care, ranges from just over 30 minutes to over an hour. The range in the minimum time allocated to meals, including prep and eating/feeding, is even more varied, from 15 minutes to one hour. Finally, the minimum parameters for activities such as medication administration, ranges from five to fifteen minutes.

Suggested travel time allocations for home support workers ranges from 10-15 minutes across health authorities. While this may be sufficient in smaller urban communities, this is most certainly a challenge in British Columbia's larger cities and in the rural and rural remote areas. In areas with a high concentration of home support clients within close proximity, services may be delivered via a clustered care model. The care requirements of all clients in the cluster are used to allocate workers in an efficient manner by reducing travel and focusing work in one geographic area (neighbourhood). In this model the minimum authorized time home support workers may spend per client can be only 10-15 minutes, whereas for non-clustered services the minimum ranges from 15-30 minutes across health authorities.

Finally, there is significant inconsistency within health authorities in determining the range of hours of in-home respite care for caregivers. While two health authorities do not specify a time range, one health authority indicates a range of up to six hours of respite care. The importance of respite care in preventing caregiver distress cannot be understated as evidenced by our previous research which found the number of hours of care provided by the unpaid caregiver is the strongest predictor of caregiver distress.

Are we comparing apples to apples?

It is reasonable to ask whether the differences in service parameters are as a result of differences in the health characteristics of the seniors in each health authority. For example, if a given health authority has clients with more complicated health needs in comparison to another health authority, it would be reasonable to expect that the health authority would provide a higher intensity of service.

To understand if this is the case, an analysis was conducted that adjusted for various health characteristics considered likely to drive the need for home support including: the client's ability to conduct activities of daily living (ADL score); cognitive impairment (CPS score); wandering; co-residing with a caregiver; and levels of informal support available to the client. The analysis demonstrated that health characteristics did not explain all of the variation in the distribution of home support hours between health authorities. Some variation in service hour distribution was linked to in which geographic area the client lived and which health authority delivered the service. In other words, a client who lived in the interior of B.C. with identical characteristics to a client living on Vancouver Island, would generally expect to receive fewer hours of service.

In conclusion, the analysis of client assessment and service utilization data provides a picture of a complex system. While the number of seniors in B.C. is increasing rapidly, the number of home support clients while increasing, has done so at a slower rate than population growth. At the same time that the average home support hours provided annually to clients has reduced, the clinical complexity of clients has increased steadily. As a result of increasing complexity and reducing service hours, it is reasonable to assume that, because the home support system works within resource constraints, the threshold of need for receiving service must increase. At a very basic level, the home support program is not keeping pace with demand or the increasingly complex needs of home support clients.

As the complexity of the average home support client has increased, the hours per year delivered to the average client has decreased.

Recommendation: The Ministry of Health, in conjunction with health authorities, develop a home support capacity plan that is sustainable, standardizes the parameters of task and time allocation, and reinforces the need for standardization of service and equitable access for seniors across the province.

Potential for delaying admission to residential care

The financial and strategic importance of an efficient and effective home support program is most apparent than when looking at the role it plays in delaying or preventing admission to residential care. As part of the Office's November 2016 report *Making Progress: Placement, Drugs and Therapy Update*, three profiles of residents with low care needs were used to assess the degree to which seniors may be admitted seniors into residential care before they are truly ready.

The November 2016 review identified that some seniors whose physical and/or cognitive function was not sufficiently compromised to require 24-hour-a-day care, and who were potentially inappropriately placed in residential care. The review indicated that of the 28,000 residents living in residential care facilities approximately 10% may not require residential care placement and could be cared for in the community either in assisted living or with home supports. The population of residential care clients who may not require residential care placement met the following descriptions:

- having few or no impairments in either cognition or physical ability to meet care needs
- having mild to moderate symptoms of dementia, but no physical impairments
- having physical challenges and intact cognition, who might be better served in assisted living

The very personal impact of admission to residential care on residents and their families emphasizes the need to ensure that people enter into residential care only when necessary and only when all other available supports, including home support, have been exhausted.

The data reviewed in producing this report shows that 48% of residential care admissions were not preceded by publicly subsidized home support. Of those who did receive service, only 27% received three or more hours of home support service per day. This analysis highlighted concerns that community services such as home support are not being fully explored before a move to residential care is made.

This has system cost implications as well as quality of life implications for the individual who may wish to live at home. From a system perspective, in 2016 almost 2000 seniors were waiting placement, and a further 8,549 seniors were admitted to residential facilities. If 10% of residents in residential facilities

(2,800 individuals) could have their care needs met in their own home or in Assisted Living, individuals who do require residential care would no longer be delayed service as a result of waiting. Additional capacity would be available to develop innovative strategies for respite to continue to support individuals in remaining at home. Further, the cost of providing service in residential care for one day is approximately twice the cost of providing 3 hours of home support.

Taken together, these analyses suggest that home support is not being fully exhausted as a financially preferable alternative to residential care. From a quality of life perspective, the vast majority of seniors express a desire to remain in their homes for as long as possible. The need to fully exhaust the home support system is a quality measure for maintaining individuals in their own home and potentially delaying admission to residential care. While the impact to individuals and their families cannot be underestimated, we must also be look at the healthcare system impact.

If the premise is that of subsidizing seniors to live independently in the community to the level of cost of a care facility, then we must examine those costs. Currently in B.C. residential care costs range between $6,000 and $7,000 per month. The cost of 120 hours of home support varies between and within health regions based on whether the service is contracted or provided by health authority staff. For those health authorities who use contracted agencies, the amount is an average of $36 per hour, for a total of $4,320 a month, slightly higher when the service is provided by health authority staff.

The analysis completed for this report indicates the largest percent of individuals receive 1 hour of home support per day. The data does indicate that complex clients with a significant level of need can remain in their own home with robust home supports, and only the frailest seniors whose needs cannot be met at home should be living in residential care. Our review of the data indicates that many residents are living in residential care without having received home support services. Harnessing the full potential of home support services before admission to residential care will ensure that only seniors who cannot be supported in the community with home support services are admitted to residential care.

Additional analysis was conducted to determine if higher levels of home support (hours/day) would demonstrate a reduced risk of admission to RC. In fact, the data demonstrates that individuals who received up to 2 hours of home support per day had a 77% likelihood of being admitted to residential care (within the 2 year data window) than those who received no home support. The importance of home support hours in helping people to remain in their own home was even more evident when 3 hours of home support per day were provided, which reduced the risk of admission to residential care to 44%, again, in comparison to individuals who received no home support.

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There appears no question then that increasing home support hours and maximizing these hours to support individuals to remain in their own home is beneficial for individuals, but that it is also an efficient and effective way to manage our healthcare resources.

Recommendation: The Ministry of Health, in conjunction with health authorities, develop a home support strategy to ensure that home support hours are maximized to support individuals in remaining in their own home. Further that individuals admitted to residential care have exhausted home support services prior to their admission to residential care, and that home support services can meet the needs of those who require short term high intensity and/or overnight supports which may be greater than 120 hours of service in a month.

Alleviating pressure on acute care

Another way to determine whether home support is meeting its objectives is to examine hospital admissions in the province. Just as home support is an important tool for delaying or preventing admission to long term residential care it is also an important tool for alleviating pressures on acute care services. Home support has been shown to reduce emergency department (ED) visits and hospitalizations, reduce hospital admissions from the ED to inpatient, reduce hospital lengths of stay for seniors being discharged from hospital, and potentially avert admissions from hospital to residential care.

A review of how much home support seniors were receiving before and after being admitted to hospital showed that 97% of seniors came to the hospital having received no prior home support service. Of these seniors, 91% were discharged from hospital with no home and community care service in place. While it is likely that the majority of these seniors did not require home support, it is noteworthy to look more closely at some sub-sets of acute care admissions. For example, 32% of all seniors admitted to hospital came through the emergency department; they had an average age of 80, stayed in hospital for 10 days on average for a range of serious medical conditions including COPD, heart disease and pneumonia. This sub-set of seniors, despite their conditions, received no home support prior to hospitalization and were discharged from hospital with no home support. The question arises whether more can be done to identify seniors at risk of hospitalization in the primary care setting, in the community or when they arrive in hospital.

Analysis also showed that hospitalizations of home support clients differ across the health authorities, just as levels of home support service vary. When comparing intensity of home support (defined as hours per day) between health authorities, we see the health authority with the lowest intensity of service has a 15% higher risk of hospitalization for its long term home support clients when compared to the health authority with the highest intensity of service. Although factors influencing risk of hospitalization are complex, this suggests an association between higher service intensity and reduced hospitalizations.

Facilitating discharge from hospital

For seniors in hospital, home support can facilitate more rapid discharge from hospital to home or provide a transition for those awaiting placement to residential care. When a patient's care needs no longer require the intensity of services offered in the facility and the patient is not able to be discharged

home, the designation of a patient as Alternate Level of Care (ALC) is applied. ALC is typically associated with hospitals, where a patient's acute care or rehabilitation phase has ended, but they are not able to be discharged home or to a different care setting which offers other services and care or to their home. This might occur when a patient's family is unable to support their family member's care at home, home support is not yet in place, or when a patient is awaiting placement in a residential care facility.

In 2015/16, B.C. hospitals reported providing over 418,000 ALC days, most of which (89%) were provided to seniors. The issue of ALC is complex, but there are two primary concerns associated with ALC: first, if a patient no longer require acute care but is unable to be discharged from the bed, then a patient who does require the bed will experience delays in accessing the bed (as an example, experiencing a hospital stay in a corridor or other less than optimal space). Perhaps more importantly, acute hospitals are designed to provide acute care, and are not adept at providing residential-type care. The impact for the patient can be significant, including increasing frailty and being subject to hospital acquired infections.

In an effort to in part mitigate the number of ALC days in hospitals in B.C. the provincial government announced in 2013, that regional health authorities would receive $50 million, over three years, for targeted primary and community care initiatives. This funding was intended to help expand or roll out innovations such as the Home is Best (Home First) program across all five health authorities. The Home is Best philosophy was based on evidence that home is the best place for seniors to live and convalesce following hospitalization.

The initial "Home First" service was designed to provide intensive short-term support immediately following hospital discharge, at which point the services are gradually reduced until clients are able to be supported with regular home and community care services. "Home First" was introduced following successful pilots in both Fraser Health and Vancouver Coastal Health. Each pilot reported sizeable reductions in emergency department visits (69% and 25%, respectively) and acute care admissions (50% and 30%). The funding for the initiation of "Home First" program was time limited, and health authorities were expected to integrate principles and practices into their service models.

The "Home First" program targeted services to support seniors with complex care needs return to and remain living at home, avoiding future hospital admissions or transfers to residential care. This can include bathing, washing, dressing, grooming, taking medications and other personal care needs. The program's target audience were those seniors waiting for a residential care bed or a residential care eligibility assessment, in hospital.

Scenario
Using home support to expedite discharge from hospital

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A successful example of Home First was Island Health's initiative in the South Island health service delivery area. The project was built on the philosophy that even those who are assessed as needing placement may find they can function in the community if they receive the appropriate level of support. The data show that, over a two year period, 707 seniors who were in acute care awaiting placement were returned home. For three months, there were intense supports in place. This included support from occupational therapists to ensure the home was accessible (ramps, slip/trip hazards removed) and overnight or live in caregiving where necessary. The goal was to ensure that clients could remain at home after three months with four hours per day of home support or less. The results showed that, after three months, only 28% proceeded to residential care as planned; 31% remained at home with home support as per provincial guidelines (at or below four hours per day) and the remainder were no longer on the program.

While all health authorities may have "Home First" strategies, they differ in the guidelines for enhanced home support, and consequently comparison of services is challenging. For example, health authorities may offer enhanced service as short as 12 hours or 2 weeks of support whichever comes first (although more can be authorized if necessary) or as much service as required within a three month period. Data shows that, in practice, the average short term home support client, with service initiated within one week of discharge from hospital, received 54 days of service with an average of 1.03 hours per day.

Our review of the data revealed that the level of home support delivered to clients varied by health authority, with clients in Island Health receiving the most home support per day and those in Northern Health receiving the least. Clients in Inland Health received short term support from an average of 88 days after discharge (the highest), while those in Interior Health received it for an average of 42 days post-discharge (the lowest). A separate analysis showed that Island Health had the highest proportion of clients receiving four hours or more per day of short term service, and the lowest proportion of clients receiving one hour per day or less. This variation across the health authorities and the low intensity of service per day suggests there is room for not only for standardizing home support allocation but additionally for increasing home support.

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It is clear from both the evidence and the experiences of seniors and their families that more can and should be done to ensure all home support options and resources are being fully exhausted for seniors being discharged from hospital, both those who are awaiting residential care, and those who are intending to remain at home.

Alleviating burden on family caregivers. Needs to be updated with new data. Check duplication on page 7.

One of the consequences of seniors living as independently as possible for as long as possible is the increasing strain on unpaid caregivers, and family caregivers in particular. It is estimated that the value of unpaid caregiver labour in B.C. is approximated $3.5 billion. According to the Office of the Seniors Advocate's 2017 report *Coregivers in Distress: A Growing Problem*, 96% of B.C. seniors eligible for home support also receive support from an unpaid caregiver. This report found that 31% of caregivers were assessed as experiencing actual distress meaning they were angry, depressed or in conflict because of caring for their loved one and/or believe they would not be able to keep performing their care activities.

B.C. has one of the highest rates of caregiver distress in the country at 30%. The OSA analysis showed that while 54% of caregivers would benefit from respite services such as adult day programs, home support or respite beds only 7% had used an adult day program, only 11% had used a respite bed and only 53% had received home support. Evidence supports a strong correlation between caregiver distress and the number of hours of care being provided by the caregiver. Caregiver distress reduces when a robust home support service is in place. We compared B.C. to Alberta and found some notable differences:

- A higher percentage of caregivers reported distress (B.C. 29%; Alberta 14%)
- A lower percentage of clients received home support services in the last 7 days (B.C. 53%, Alberta 65%)
- The complexity of client needs was higher (B.C. 53%, Alberta 37%)

To summarize, clients in B.C. have higher needs and more caregiver distress, but received less home support than their counterparts in Alberta. While the home support program is intended to supplement unpaid caregiver support (family caregivers), it is also intended to reduce reliance on more costly healthcare resources (hospital and residential care). B.C. data indicates that robust home support services are necessary to support individuals in remaining in their own home, and that the services provided in the community need to be responsive to the needs of the population. Home support has significant capacity to support individuals in their own homes, and to perform an important role in reducing length of stay in hospital.

Recommendation: Health Authorities must ensure home support services are designed to smoothly and quickly transition individuals from hospital to home with sufficient resources for success, inclusive of flexible and innovative respite services and overnight care.

Meeting clients' needs by improving choice and flexibility

An important step in the OSA's review of B.C.'s home support program was to understand how clients and their family members view the program. Client satisfaction is an important component in understanding whether the home support being delivered is meeting clients' needs. In the fall of 2015, the OSA sent a standardized survey to all current B.C. home support clients and their family members. The OSA released the results of the survey, with almost 10,000 responses, in its report, *Listening to Your Voice: Home Support Survey Results*.

The responses showed that the majority of respondents (78%) felt the program was meeting their needs most or all of the time, however clients with higher complexity of needs were more likely to rate home support services as sometimes, rarely or never meeting their needs. Those who responded to the survey showed a higher level of physical and cognitive function than the home support population in general. Overall the survey highlighted the following areas for improvement:

> **Skill of workers** – less than half of clients (47%) report their workers have all of the necessary skills to provide good care
>
> **Number of workers and use of substitute workers** – 48% of respondent felt they had too many different regular home support workers or different substitute workers.
>
> **Additional services** – 28% of respondents would like help with housekeeping. Clients assessed as having great difficulty in performing ordinary housework are much more likely to respond that home support services did not meet their needs.

Expanding suite of services available through home support

In addition, two important themes in the comments made by survey respondents were identified – the inflexibility of the home support system in B.C., and the fact that it was not providing all of the services they need.

The OSA's home support survey clearly revealed that many clients want services that are not currently offered; most notably 33% expressed a desire for housekeeping services, a service that was removed from the suite of home supports services in the 1990s. Currently, if a senior is seeking assistance with Instrumental Activities of Daily Living such as shopping, housework or yard work, they have to find help themselves or are referred to the Better at Home program administered through the United Way of the Lower Mainland. For many seniors, this fragmentation of services is not ideal.

It is important to understand that the burden of IADLs falls to unpaid caregivers much of the time, often becoming part of the caregiver burden and stress. Perhaps the time has come to consider further innovative strategies (in addition to the United Way Better at Home program) to provide assistance with household chores. For example, if individuals receiving home support (who are generally low income) received a stipend from government in response to caregiver burden such that the home support client could purchase services to alleviate stress from their family member (for example some housekeeping services, yard work, snow shoveling etc.). This strategy could be designed such that Home Support Case Managers provided assessment of caregiver burden and "approved" a stipend based on a pre-determined income sliding scale.

Modification of the current home support system would allow for a more family-centred approach. In this model, similar to the home support approach in Ontario, the family becomes the "client." Recognizing the importance of family caregivers means giving them the flexibility to design home support service that optimizes their input, recognizing that non-clinical supports such as homemaking, meal preparation, supportive housing, transportation and respite are often essential to supporting an individual at home.

Recommendation: Ministry of Health and Health Authorities jointly design an innovative self-directed and family-centred approach to address the importance of addressing non-clinical supports such as housekeeping and meal preparation have in reducing caregiver burden.

Supporting self-directed care

In addition to encouraging more flexibility in the existing system, some seniors are telling us that they would like to direct their care themselves in conjunction with their families and caregivers. When reviewing literature and research from other jurisdictions, it is clear that the most effective home support systems are those that allow clients, their families and caring networks, the ability to tailor a full suite of services that best fits their needs.

As stated earlier, there is one self-directed model of care that exists in B.C. called the Choice in Supports for Independent Living program or CSIL. This is a self-directed model of care designed for a specific population and used by a small percentage of home support clients (3%). Similar models are utilized in home support systems around the world. In the CSIL program, health authorities provide the client or their designated representative with funding (based on their care needs) to employ their own workers directly. In effect, the client becomes their own employment agency for the purpose of managing their

support workers. This program is targeted to individuals with moderate to high care needs who have met all other criteria required for subsidized home support.

The overriding advantage to self-directed care is that the person requiring care has much more control over their day to day care and can devise a system of care that works for them, improving personalization and consistency of care. The current CSIL program has some complex requirements for the client or family caregiver to implement in order to access the program, and improving these processes could result in more people accessing the program. There may also be clients who would benefit from utilizing a combination of both health authority delivered service and self-directed service, again a hybrid delivery model that exists in many other jurisdictions world-wide.

Scenario
s.22

Recommendation: Ministry of Health and Health Authorities jointly design an innovative self-directed care option that reduces blends the best aspects of case management and CSIL. This innovative program would provide funding to caregivers to hire home support workers, have oversight and support from Case Managers, and result in a hybrid model of home support better meeting the needs of our aging and frail population.

Ensuring access by low income seniors

Depending on their income, home support clients in B.C. may be required to contribute to the cost of the home support services they receive via a client contribution. In many circumstances, the client contribution can present a significant cost barrier to clients. B.C. is one of the few provinces in Canada that requires clients to pay a per diem rate for service. A comparison between B.C.'s home support program and Ontario's home support program found that a significantly greater proportion of Ontario seniors access that province's home support program; while there are many differences between the programs, it is likely that Ontario's lack of a client contribution amount is one factor influencing this finding.

Approximately one third of home support clients are required to pay a client contribution rate for home support. The remaining two thirds do not pay a client contribution are in receipt of the Guaranteed Income Supplement (GIS). Recipients of GIS, and other federal income-tested benefits like the Allowance for spouses of GIS recipients, do not have a client contribution for home support.

The formula for determining the client contribution amount is based on the client's income. If a home support client is married or part of a common law relationship, the partner's income is included in the calculation. If both partners receive home support, only one client contribution is required, and it will be equal to the client contribution that would prevail were only one partner receiving home support.

The client contribution is calculated as a daily rate. The monthly client contribution is the daily rate times the number of days on which service was received. The formula is as follows:

Net income (line 236 of CRA Income Tax submission)
(-) Income tax paid
(-) Universal child care benefit amount
(-) RDSP payment amount
(-) Earned income up to $25,000 (lines 101, 104, 135, 137, 139, 141 and 143)
(-) Basic deduction amount ($10,284 for singles, $16,752 for couples)
(=) Remaining annual income
(÷) 720
(=) Daily rate

The assessed client contribution is independent of the number of hours, per day, of service; that is, a client will pay the same, per day, regardless of whether they receive one hour or eight hours of service in that day.

If the service delivered to a client is less than the assessed client contribution, they are billed only for the actual cost of service delivery. The following table outlines the cost per hour of home support service provided by the health authorities that would be used to determine the actual service delivery cost:

		NHA	IHA	FHA	VCH	VIHA
Cost per Hour of Long term Home Support	Owned and Operated	$50	$37.95	$35.16	$34.34-$37.00	$35
	Contracted			$33.65	$34.38-$36.38	$36.50

While the lowest income clients—those on GIS—are exempt from client contributions, moderate income clients may face prohibitively high client contributions.

Consider a single senior with an income of $25,000 per year—just above the threshold for receiving GIS...

> This client would be assessed a monthly client contribution of $550 for daily home support, leaving them with $1,400 per month of after-tax income. If this senior faces the rental market in Metro Vancouver, with an average rent of $1,080 per month for a one bedroom, they have very little left over for other living expenses, such as groceries, utilities, and transportation to medical appointments.

Now consider a single senior with an income of $35,000 per year...

> This client would be assessed a monthly client contribution of $880 for daily home support, leaving them with $1,740 per month of after-tax income—an extra $10,000 per year of gross income translates to only $340 per month of extra income after deducting the increased income taxes owed and higher client contribution.

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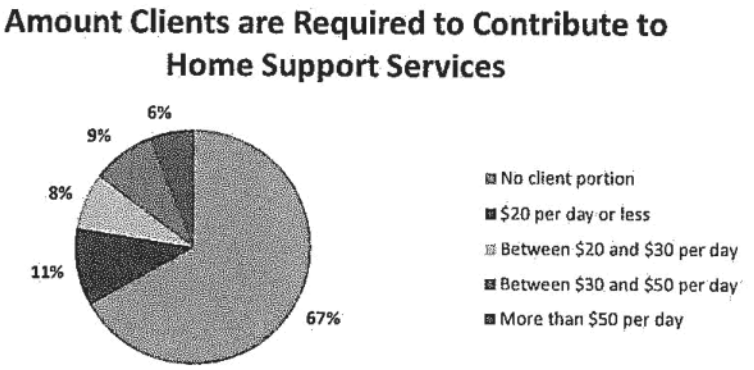
In the OSA's housing report, *Seniors' Housing in B.C.: Affordable, Appropriate, Available*, the routine living expenses of a senior in Victoria or Vancouver were estimated at $1,000 per month. When factoring in rent, it is clear that the client contribution for home support can be prohibitively expensive for seniors receiving daily or near-daily home support visits.

Whether the client contribution is potentially a barrier to receiving home support is greatly dependent on individual circumstances. Some seniors may be living mortgage-free, but 40% of senior households in B.C. with an income below $30,000 are renters. While not all parts of the province face the high market rents seen in Vancouver, cost of living is much more uniform. Lower rents outside of B.C.'s large metropolitan areas may be offset by higher utility costs, higher transportation costs (particularly in areas with underdeveloped transit systems), and higher grocery costs. Even seniors who are living without a mortgage may still find the cost of a home support client contribution to be too high, as their ability to save for home repairs could be eroded.

Although the majority of home support clients do not have a client contribution, the majority of clients with a client contribution must pay in excess of $20 per day. Nine percent of home support clients (29% of those with a client contribution) pay up to $20 per day; these clients would see the largest relative benefit of a revised basic deduction amount.



The basic deductions used in the calculation of the client contribution, has not changed since 1997. The basic deduction amount is intended to "protect" some of a client's income for basic living expenses such as rent, food, and utilities; by remaining unchanged for 19 years, the basic deduction has failed to keep pace with the actual cost of living, leaving clients with too high of a bill for home support.

Increasing the basic deduction amount from $10,284 to $14,500 for singles (with a corresponding increase for couples) would bring down the daily client contribution by $5.86, which, on an annual basis, translates to savings of $2,110 for a client receiving daily home support and $609 for a client receiving twice-weekly home support. This change would update the basic deduction amount to reflect the rate of inflation over the last 19 years.

For clients whose income is just over the threshold for receiving the Guaranteed Income Supplement (and, therefore, not obligated to contribute to the cost of home support), updating the basic deduction amount to reflect inflation since 1997 would reduce by one third the client contribution for home support services.

Recommendation: Ministry of Health adjust the rate setting calculation by adjusting the basic deduction amount from $10,284 to $14,500. Further the Ministry of Health commit to reviewing the basic deduction amount every two years to ensure that low income seniors are not losing ground economically in their ability to access home support services.

Allowing seniors access to equity in their homes to help fund their home support needs

Maintaining autonomy in direction our own affairs for as long as possible is an important tenet of independence. Ensuring clients have flexibility to meet the costs of the care they need to stay in their own homes is important. The Seniors Advocate proposes a program that allows homeowners to access equity in their home to pay for care needs.

While the median income for B.C. seniors is less than $27,000, the majority of seniors—80%—own their own home. A significant number of low-income seniors, particularly those living in regions with strong housing markets, may have substantial equity established in their homes. In the Seniors Advocate's first housing report, a recommendation to the provincial government was made to create a Homeowner Expense Deferral Account program, modelled after the Property Tax Deferment program currently in place. This program would allow low or moderate income seniors to use the equity in their home to offset the costs of housing by deferring some, or all, of the major ongoing and exceptional expenses associated with home ownership.

A similar home equity account program is proposed for seniors eligible for home support services, allowing for deferral of home support costs against home equity. Interest would accumulate on an annual basis, and the balance would be payable upon a client ceasing to receive any home support services, either because of death or initiation of private-pay services. All seniors eligible for home support, and with sufficient equity in their home (at least 25%), would be eligible.

This type of program would ensure that seniors who have wealth established in their homes but a limited, fixed income would be able to afford home support services while remaining in the home of their choosing. While one-quarter of all senior home owners have a household income of less than $30,000 per year, the majority of seniors with a household income of less than $30,000 per year are home owners. For a senior right at the $30,000 per year point, the annual deductible, incorporating the proposed $14,000 basic income amount, would be around $13,000. Deferring this amount against home equity would allow this senior to receive the home support services they require while keeping money aside for expenses such as home repairs or home modifications to allow for continued independence.

The home equity account would function like a line of credit against the home owner's equity. To balance financial fairness to both the government (lender) and home owner (borrower), the interest rate would be set at the prime rate. This would be far below what is available from commercial home equity loans or reverse mortgages, which are generally in excess of a 5% interest rate. Eligible expenses for the home equity account would include the annual home support deductible as well as any private services a client may wish to purchase in excess of what the health authority has assessed as necessary. Giving seniors the choice about where best to allocate their money when it comes to what they know they need to remain living independently is crucial in ensuring home support works and is able to grant independence.

Recommendation: Ministry of Health review and adopt a home owner health expense deferral program to allow those individuals 65 years and older to leverage equity in their homes to pay for health care costs.

Conclusion

The needs and desires of British Columbia's 850,000 seniors are as diverse as the communities in which they live; however, one goal that unites them is the fact that, overwhelmingly, they want to remain in their own homes as they age. The provision of publicly-subsidized home support is a key service in enabling seniors to live independently in their homes for as long as possible. Ensuring that all seniors have equitable access to the services no matter where they live in the province is imperative.

When we look at the evidence, it is important to highlight the efficient and effective work that is being done by health authorities and individual home support workers. However, when we look at the goals of home support in preventing admission to both residential and acute care, it is clear that the home support system is not being fully exhausted before moving to the more costly option of residential care. The efficiency and effectiveness of our health system would be significantly improved with adjustments to include care options that are flexibly administered, self-directed and supported through case management services.

At the same time, it is important to ensure that all seniors are able to access a fair and equitable home support system. While the majority of seniors on home support don't directly pay for the service, approximately one third of clients have a client contribution based on an outdated calculation. Updating the funding formula to reflect cost of living increases would ensure that limited income is not a barrier to accessing home support services, and would ensure an accessible and equitable approach for B.C.'s seniors.

The Seniors Advocate spends significant time reaching out to B.C.'s seniors and listening to their concerns. A recurring theme the Advocate has encountered is that seniors desire more choice and flexibility in deciding what services they need to allow them to remain in their own homes. Allowing clients to choose how to spend the money that would otherwise go to their publicly-provisioned care increases flexibility, convenience, and quality of life with the additional benefit of a lower cost per hour for the government. Self-directed care is increasingly becoming a key tool in many countries' home support programs.

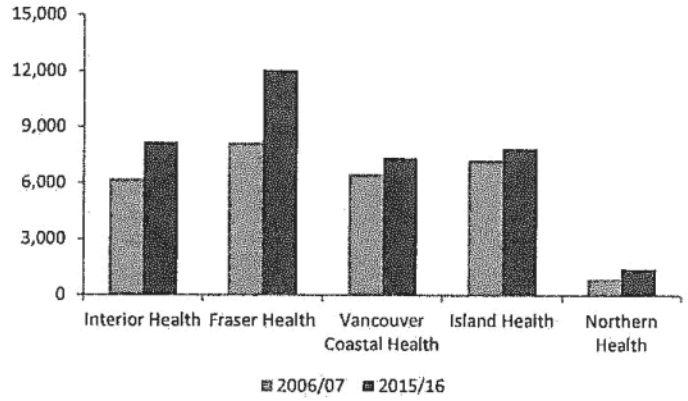
Similarly, home support clients desire access to a broader suite of services, particularly when it comes to housekeeping. While limited housekeeping services may be available to certain clients under the goal of hazard reduction services, most health authorities provide very limited if any housekeeping services. The Advocate recommends allowing all clients to access the ADL and IADL services in a more flexible and self-directed manner that meets the needs of clients and families who are providing care.

The recommendations outlined in this report speak to ensuring that more seniors are able to benefit from home support, and that clients of home support have fairer access to a broader suite of services

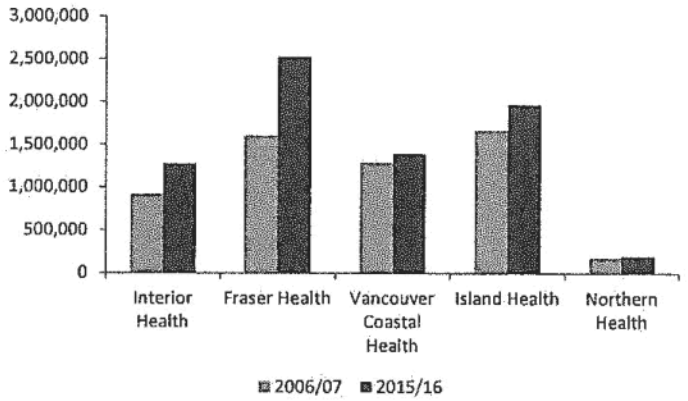
not only today but into the future. Enabling seniors to stay in their own homes as they age is not only important from a quality of life perspective, but also from a health system perspective. Home support is significantly more cost effective than residential care and extended hospitalizations. With British Columbia's seniors population projected to grow significantly in the coming two decades, it is vitally important that the home support system is ready to respond to the increase in clients and more effectively work in conjunction with the long term care and acute care systems in place in the province.

Appendix: Breakdown of Analysis by Health Authority

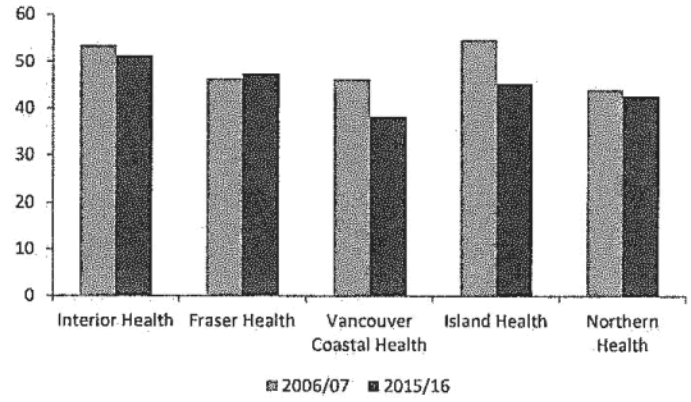
Graph: Client counts, by Health Authority, 65+



Graph: Hours, by Health Authority, 65+



Graph: Clients per 1,000 population, by Health Authority, 65+



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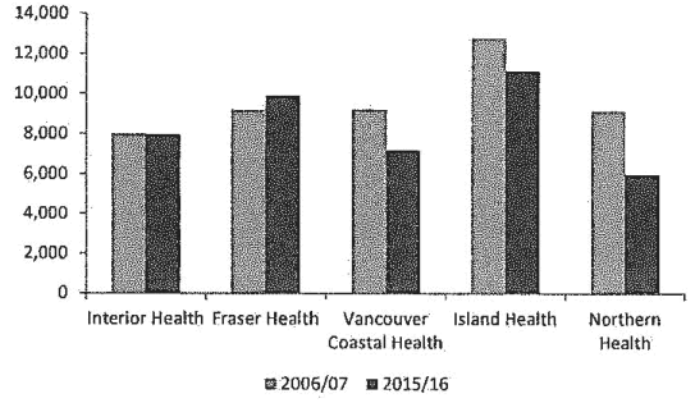
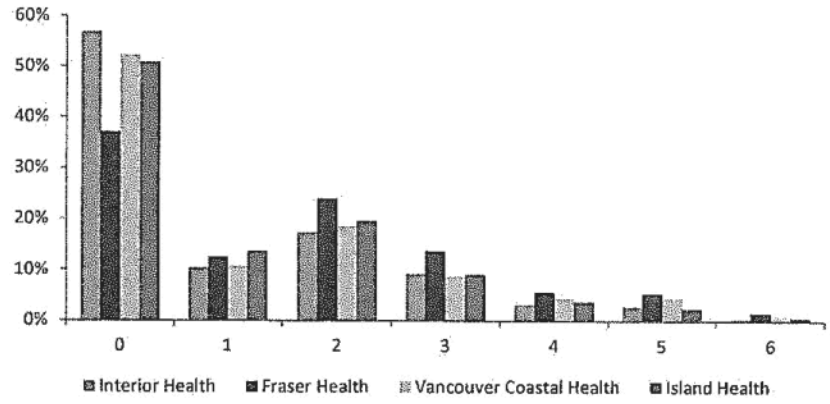
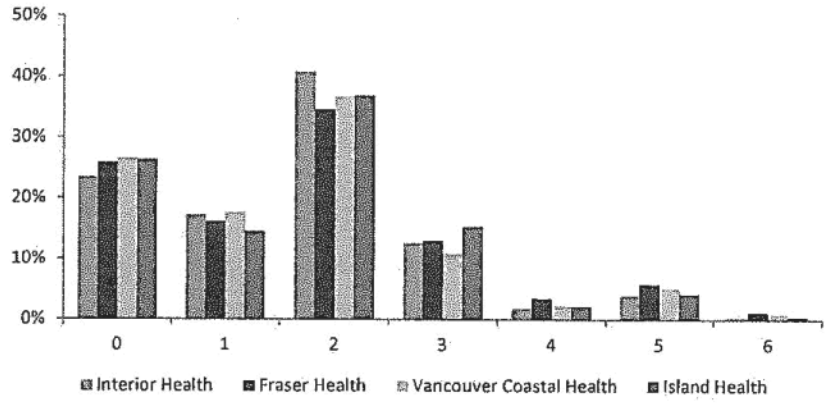


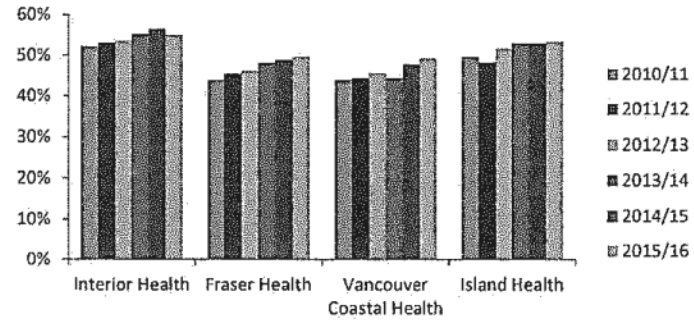
Graph: Distribution of ADL scores, by Health Authority



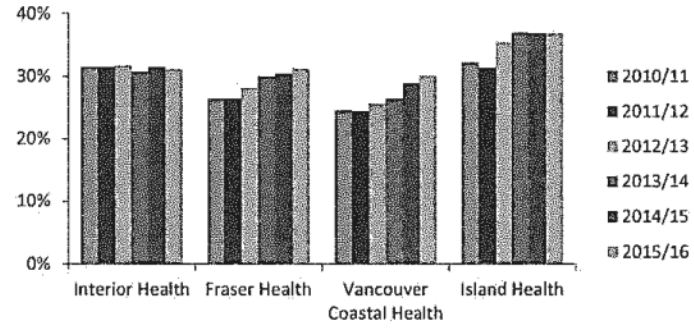
Graph: Distribution of CPS scores, by Health Authority



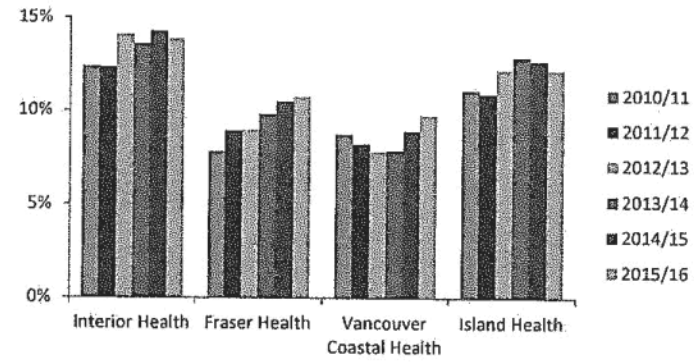
Graph: Distribution of MAPLe 4/5 Scores, by Health Authority



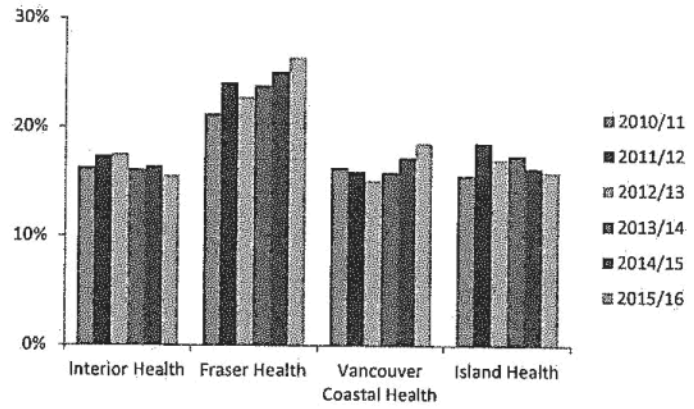
Graph: Distribution of dementia prevalence, by Health Authority



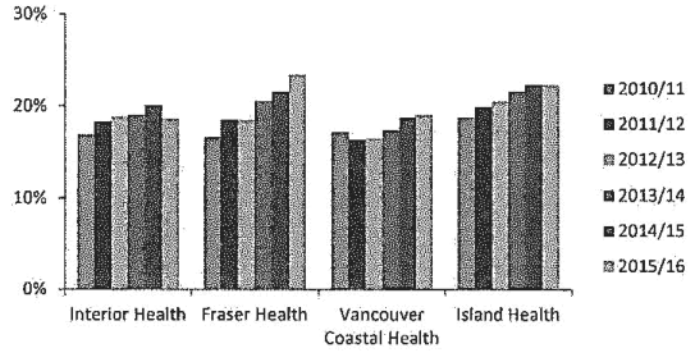
Graph: Distribution of aggressive behaviours, by Health Authority



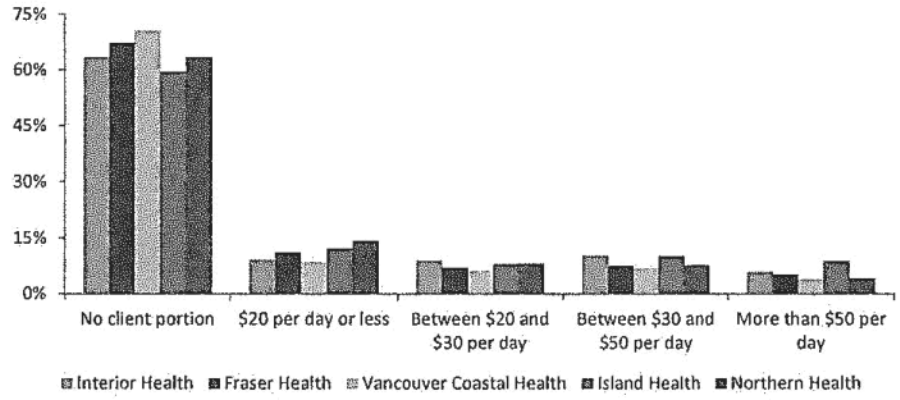
Graph: Distribution of ADL Score 3 or higher, by Health Authority



Graph: Distribution of CPS Score 3 or higher, by Health Authority



Graph: Amount clients are required to contribute to home support services, by Health Authority



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Withheld pursuant to/removed as

s.13

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Withheld pursuant to/removed as

s.22;s.13

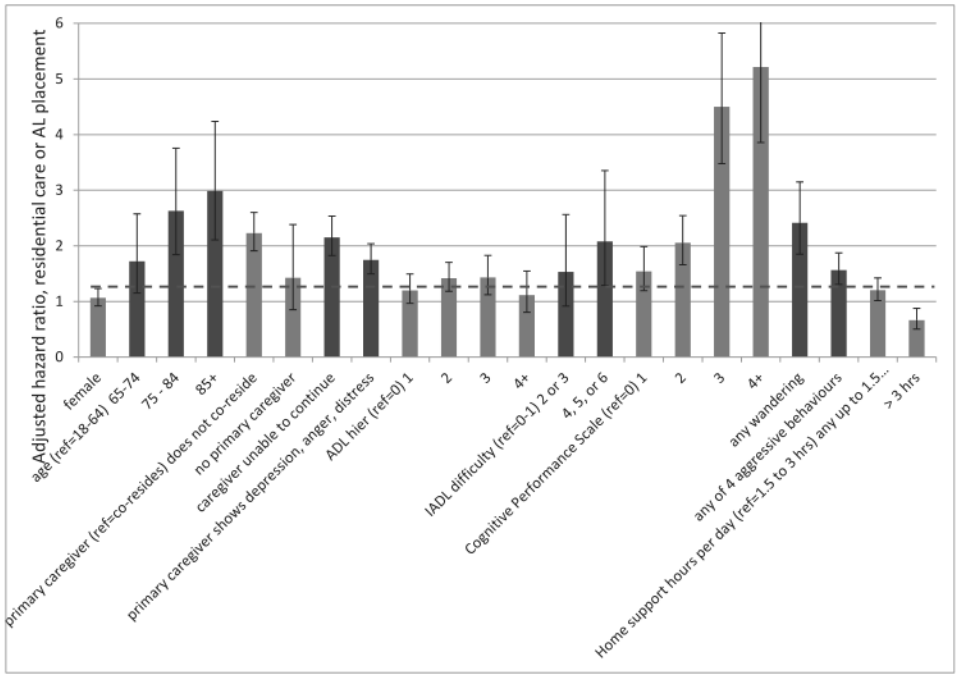
Page 131

Withheld pursuant to/removed as

s.13

	hazard ratio	LCL	UCL
female	1.065	0.920	1.233
age (ref=18-64) 65-74	1.722	1.151	2.574
75 - 84	2.629	1.841	3.756
85+	2.987	2.107	4.236
primary caregiver (ref=co-resides) does not co-reside	2.228	1.910	2.599
no primary caregiver	1.424	0.851	2.382
caregiver unable to continue	2.152	1.826	2.535
primary caregiver shows depression, anger, distress	1.746	1.495	2.038
ADL hier (ref=0) 1	1.201	0.966	1.493
2	1.419	1.183	1.702
3	1.431	1.121	1.828
4+	1.116	0.805	1.547
IADL difficulty (ref=0-1) 2 or 3	1.532	0.916	2.563
4, 5, or 6	2.079	1.289	3.352
Cognitive Performance Scale (ref=0) 1	1.540	1.194	1.986
2	2.054	1.659	2.543
3	4.500	3.477	5.824
4+	5.214	3.857	7.049
any wandering	2.413	1.850	3.148
any of 4 aggressive behaviours	1.564	1.306	1.873
Home support hours per day (ref=1.5 to 3 hrs) any up to 1.5 hours	1.202	1.016	1.422
> 3 hrs	0.664	0.503	0.876

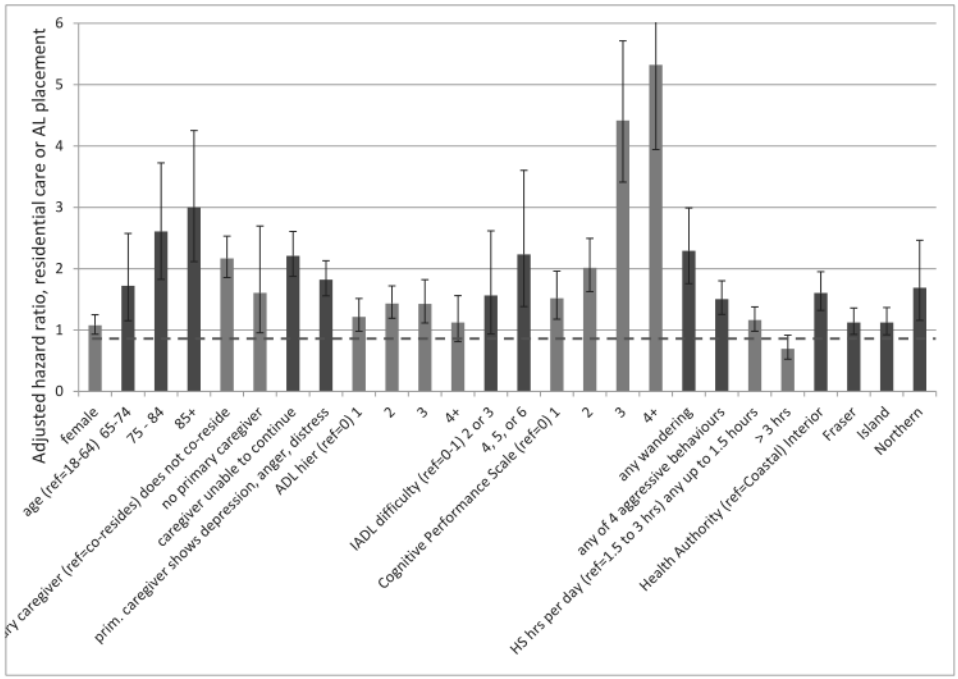
any copay tested, not significant



offset1	offset2
0.145	0.168
0.571	0.852
0.788	1.127
0.88	1.249
0.318	0.371
0.573	0.958
0.326	0.383
0.251	0.292
0.235	0.292
0.236	0.283
0.31	0.397
0.311	0.431
0.616	1.031
0.79	1.273
0.346	0.446
0.395	0.489
1.023	1.324
1.357	1.835
0.563	0.735
0.258	0.309
0.186	0.22
0.161	0.212

	hazard ratio	LCL	UCL
female	1.079	0.932	1.249
age (ref=18-64) 65-74	1.722	1.152	2.575
75 - 84	2.608	1.826	3.725
85+	2.999	2.115	4.252
primary caregiver (ref=co-resides) does not co-reside	2.168	1.856	2.531
no primary caregiver	1.604	0.955	2.696
caregiver unable to continue	2.210	1.874	2.606
prim. caregiver shows depression, anger, distress	1.821	1.557	2.130
ADL hier (ref=0) 1	1.217	0.979	1.514
2	1.432	1.192	1.720
3	1.425	1.115	1.821
4+	1.124	0.810	1.561
IADL difficulty (ref=0-1) 2 or 3	1.564	0.935	2.617
4, 5, or 6	2.233	1.383	3.603
Cognitive Performance Scale (ref=0) 1	1.518	1.177	1.959
2	2.015	1.627	2.494
3	4.415	3.411	5.714
4+	5.325	3.942	7.194
any wandering	2.292	1.756	2.991
any of 4 aggressive behaviours	1.504	1.255	1.803
HS hrs per day (ref=1.5 to 3 hrs) any up to 1.5 hours	1.163	0.981	1.377
> 3 hrs	0.693	0.525	0.916
Health Authority (ref=Coastal) Interior	1.605	1.320	1.951
Fraser	1.124	0.929	1.359
Island	1.123	0.923	1.367
Northern	1.689	1.158	2.464

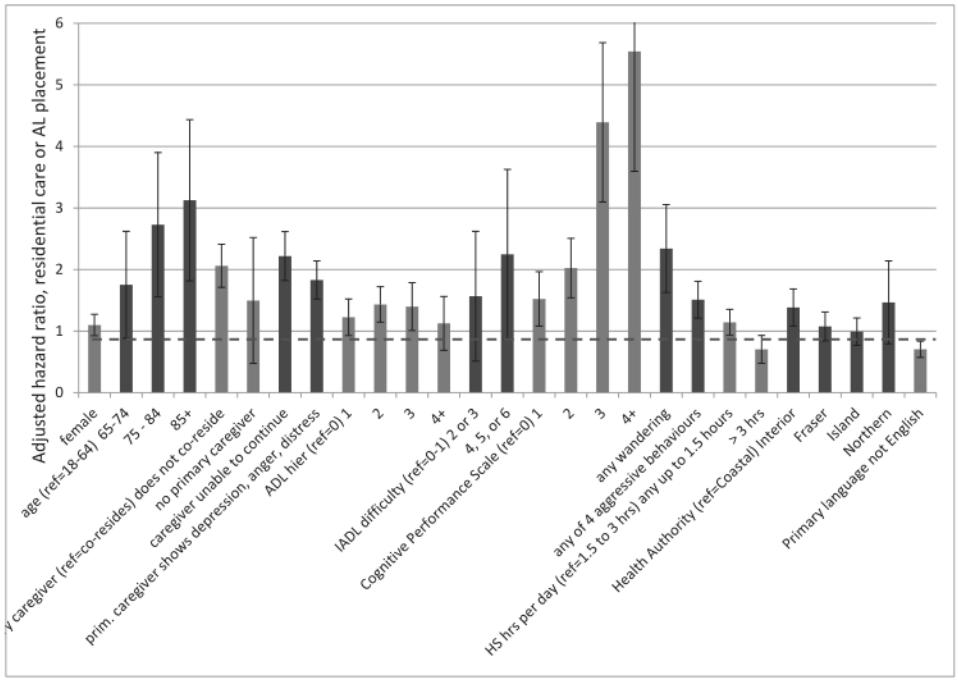
any copay tested, not significant



offset1	offset2
0.15	0.17
0.57	0.85
0.78	1.12
0.88	1.25
0.31	0.36
0.65	1.09
0.34	0.40
0.26	0.31
0.24	0.30
0.24	0.29
0.31	0.40
0.31	0.44
0.63	1.05
0.85	1.37
0.34	0.44
0.39	0.48
1.00	1.30
1.38	1.87
0.54	0.70
0.25	0.30
0.18	0.21
0.17	0.22
0.29	0.35
0.20	0.24
0.20	0.24
0.53	0.78

	hazard ratio	LCL	UCL
female	1.099	0.949	1.273
age (ref=18-64) 65-74	1.752	1.172	2.621
75 - 84	2.729	1.909	3.901
85+	3.126	2.203	4.435
primary caregiver (ref=co-resides) does not co-reside	2.060	1.762	2.410
no primary caregiver	1.497	0.889	2.519
caregiver unable to continue	2.219	1.882	2.616
prim. caregiver shows depression, anger, distress	1.830	1.565	2.139
ADL hier (ref=0) 1	1.225	0.985	1.522
2	1.433	1.193	1.721
3	1.397	1.093	1.786
4+	1.125	0.810	1.562
IADL difficulty (ref=0-1) 2 or 3	1.567	0.936	2.621
4, 5, or 6	2.247	1.393	3.627
Cognitive Performance Scale (ref=0) 1	1.523	1.181	1.965
2	2.024	1.635	2.507
3	4.392	3.392	5.686
4+	5.541	4.101	7.486
any wandering	2.341	1.794	3.054
any of 4 aggressive behaviours	1.510	1.260	1.809
HS hrs per day (ref=1.5 to 3 hrs) any up to 1.5 hours	1.142	0.964	1.353
> 3 hrs	0.703	0.532	0.930
Health Authority (ref=Coastal) Interior	1.384	1.137	1.685
Fraser	1.076	0.884	1.310
Island	0.991	0.809	1.213
Northern	1.466	1.005	2.140
Primary language not English	0.704	0.593	0.836

any copay tested, not significant



offset1	offset2
0.15	0.17
0.58	0.87
0.82	1.17
0.92	1.31
0.30	0.35
0.61	1.02
0.34	0.40
0.27	0.31
0.24	0.30
0.24	0.29
0.30	0.39
0.32	0.44
0.63	1.05
0.85	1.38
0.34	0.44
0.39	0.48
1.00	1.29
1.44	1.95
0.55	0.71
0.25	0.30
0.18	0.21
0.17	0.23
0.25	0.30
0.19	0.23
0.18	0.22
0.46	0.67
0.11	0.13