HOME SUPPORT

We Can Do Better

OFFICE OF THE
SENIORS ADVOCATE
BRITISH COLUMBIA

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Throughout the past five years, I have heard from tens of thousands of seniors about the issues that matter to them, and indeed the wants, hopes, dreams and aspirations of those who are 65 or older are as diverse as the people themselves. However, if there is one issue where seniors hold a near-unanimous opinion, it is in their desire to live independently, in their own home, for as long as possible.

No matter what our age, living independently requires the ability to find safe, affordable housing and the capability to complete the tasks necessary to care for ourselves and our surroundings. As we age, some of us will experience some challenges with everyday tasks we once could do ourselves and we will look to family and friends to help us out. Many of us will also turn to a professional type of help, often known as home support, to assist us.

The provincial home support program is a lifeline for many seniors in B.C. who would undoubtedly need to live in a long-term care facility if it were not for the assistance they receive with the personal care and medication management the program provides. However, when my office reviewed the current program to look at its overall effectiveness and whether it is meeting the needs of B.C.'s seniors, we found that it is falling short on many fronts.

Who is it serving, how well is it serving them, who is it not serving, why is it not serving them, and what are the overall consequences if the program is failing are the test questions we asked in relation to the B.C. home support program. To get the answers, we looked at both qualitative and quantitative data. What we found was a program that, while meeting the needs of some seniors, was falling seriously short of the mark in meeting the needs of most seniors and, as a consequence, was creating overburdened family caregivers, prematurely placing seniors in long-term care, increasing lengths of stay in hospital, and unnecessarily costing taxpayers tens of millions of dollars each year that could be saved with an effective home support program.

AMONG THE FINDINGS:

- Complaints to the Patient Care Quality Office (PCQO) for home support/home care have increased by 62% in the last five years.
- Public home support is unaffordable to most seniors. For example, through the regulated daily rate co-payment, a senior with an income of $28,000 is required to pay $8,800 a year for daily home support.
- Over the past five years, the seniors population has grown 22% but the number of home support clients has only increased by 15%.
- Overall, 72% of seniors aged 85 or older living in the community have high complexity (40%) or medium complexity (33%) chronic conditions, yet only 16% are receiving publicly-subsidized home support service.
- The majority of home support clients (51%) are at high or very high risk of placement in a long-term care facility. Despite this, 86% receive less than two hours of home support, on average, per day.
- Almost one-third of family caregivers are in distress; this has increased 3.4% in the last five years. On average, 82% of clients of distressed caregivers receive less than two hours of service per day.
- 61% of those admitted to long term care received no home support in the 90 days prior to their admission.
- Approximately 4,200 long-term care beds are occupied by seniors who could live in the community with home support and/or assisted living.

- The cost to taxpayers to subsidize a long-term care bed is estimated at $57,600 per year. The cost of two hours of daily home support is $27,740 per year, a savings of $29,860 per year.

- The average senior could save an estimated $10,000 per year by living in long-term care versus living at home with home support, but taxpayers would pay an average of $28,000 more.

- Community Health Workers (CHWs) who provide home support service are paid less than care aides in other sectors and have the highest rate of casual positions (50%).

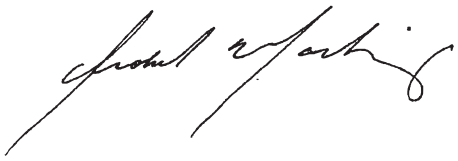
- More than 75% of the CHW workforce is employed in a part-time or casual position.

In addition to the numbers, this report gives voice to the experience of many seniors as expressed to the Office of the Seniors Advocate (OSA). Through their phone calls, emails, letters, and conversations, clients and family members speak of a service that is inflexible, insufficient, unreliable and too expensive. Notwithstanding these many challenges, some clients and family members—particularly those who responded to the OSA's 2016 survey of home support clients—spoke of satisfaction with the service and placed confidence in the skills of the community health workers (CHWs) who deliver the service. This tells us that when clients have light care needs and require only limited amounts of home support, the program can be effective.

Through removing financial barriers, expanding the scope of service, increasing flexibility for the care team, empowering clients and family with needed information, recognizing the care needs of family caregivers, and designing a training and compensation strategy to support an expanding workforce, B.C. can become a leader in supporting seniors in the community. While this will be a challenge on many fronts, I believe it is a challenge we can meet.

I would like to thank the many people and organizations who provided input to this report. The Ministry of Health, as the data steward, provided much of the base for our quantitative analysis. The five health authorities and their contracted home support agencies—Bayshore, Saint Elizabeth, ParaMed, Greater Vancouver Community Services, Beacon Community Services, and We Care—were generous with their time, opinions and data. The Health Employers Association of British Columbia was able to assist us in understanding some of the unique human resource challenges that exist in home support. Finally, a very large thank you goes to the many seniors and their families who, through calls, letters, emails, and conversations, provided insight into the impact of home support on the day-to-day lives of seniors. Together, I know we are all committed to improving the quality of life for B.C.'s seniors.

Sincerely,



Isobel Mackenzie
Seniors Advocate
Province of British Columbia

INTRODUCTION

The majority of B.C. seniors want to live in their own homes for as long as possible. The good news is, most seniors will achieve this goal. Currently in B.C., 94% of people aged 65 or older live independently. At age 85 or older, almost three-quarters (72%) of B.C. seniors still live in their own home, with the remainder either living in a retirement residence/assisted living (10%) or a licensed long-term care facility/nursing home (17%)[1].

While most seniors continue to live in their own homes, sometimes assistance is required to complete everyday tasks that once could be done independently. An estimated 29% of community-dwelling seniors are living with chronic conditions of medium complexity and a further 20% have chronic conditions with high complexity. The percentage of seniors with high complexity chronic conditions rises to 40% when we look at community-dwelling seniors aged 85 or older[2]. These are seniors who likely need some assistance with tasks such as preparing meals, getting up and dressed in the morning, bathing and managing medications. In health care, these activities are referred to as the **activities of daily living** (ADLs). Other activities such as banking, shopping, and housekeeping are referred to as the **instrumental activities of daily living** (IADLs). To understand the distinction, think in terms of *if it needs to be done daily or it involves personal hygiene, it is likely an ADL and if it needs to be done intermittently, and/or does not involve personal body care, it is likely an IADL*.

To live independently without the assistance of others, a senior must be able to perform both their ADLs and IADLs. If they are not able to perform and manage these activities, they will need some assistance to live independently. For many seniors, this assistance comes from their spouse or adult children. The assistance provided by family and friends is often referred to as family caregiving, informal care or unpaid caregiving. Regardless of the term used to describe the assistance, the amount of care family and friends provide is fundamental to assisting frail seniors to remain living independently. In addition to—or sometimes in lieu of—friends and family, seniors can also receive assistance with their ADLs through B.C.'s provincial home support program.

CONTEXT

Each year in B.C., more than 40,000 people receive a total of 8.8 million hours[3] of home support[4] delivered by almost 10,000 community health workers (CHWs). Evidence demonstrates that, for some seniors, the current provincial home support program is effective. However, if seniors are experiencing moderate to significant challenges managing their ADLs, and/or cannot manage IADLs, and/or are not in receipt of the Guaranteed Income Supplement (GIS), they will likely find there is limited affordable (publicly funded) services available. The bulk of the burden then falls to family and friends to provide support and, failing that, the likelihood of placement in a care facility increases.

A robust and comprehensive home support program offering true "wrap around" services would allow for better use of health care dollars while providing improved support to seniors with the goal of preventing placement in long-term care and reducing hospitalizations.

Gaps in service exist because the current provincial home support program in British Columbia does not include services for the provision of IADLs, has a narrow definition of ADLs, and charges a client contribution that is waived for less than a third of seniors[5], leaving the remaining seniors population paying up to 40% of their disposable income for daily home support.

As noted, despite these limitations, some seniors are successfully supported by the current program; however, a review of the data and feedback from seniors reveals that the full potential of home support services to assist seniors to remain in their own homes is not being realized in British Columbia. The result of this underperformance is an increased burden on families and caregivers, premature placement in long-term care facilities, and a reduction in the overall quality of life that British Columbians expect for seniors.

BACKGROUND

During the past half century, the home support program has seen significant change. The program has shifted from one centralized around "homemaker" services with a heavy emphasis on social supports and IADLs, to the current program today which focuses almost exclusively on personal care (ADLs) and delegated nursing tasks. These changes mirror—to some extent—the shifting demographics and evolving expectations of seniors to live independently in their own homes for as long as is possible. While some of the changes in home support have been positive, an examination of current data and the reports of individual experiences make clear that there are still significant opportunities to improve the service.

These potential improvements include:

- increased accessibility;
- a widening of the scope of services;
- more flexibility in care plans;
- enhanced reliability and continuity;
- reduced costs for clients; and
- increased attention to IADL service needs.

Providing a robust and comprehensive home support program that offers true "wrap around" services aimed at preventing or deferring placement in long-term care and reducing hospitalizations will achieve the concomitant objectives of efficient use of health care dollars and support for seniors who wish to remain in their own homes as long as possible.

The value of a comprehensive home support program is not a new discussion. As far back as the late 1990s, and into the early part of the new millennium, respected B.C. academics and researchers—such as Dr. Neena Chappell, Dr. Michael Prince and Marcus Hollander—were publishing widely on the issue of home care and home support. The common thread running through their research was the financial efficiency of home support as a strategy to defer or prevent admission to long-term care and emphasized the need to ensure early support

through publicly funded programs such as housekeeping and meal preparation to achieve maximum results. Unfortunately, services have moved away from the social care model of early intervention to focus more on personal care tasks, and the full potential cost savings from long-term care substitution that home support can offer has not been achieved.

THE CURRENT SYSTEM

In British Columbia, provincially-subsidized assistance for seniors is offered through the Home and Community Care (HCC) program. Services include:

- home support
- home care nursing (HCN)
- physical and occupational therapy (PT/OT)
- nutrition/dietitian
- social work
- adult day program (ADP)
- assisted living (AL)
- long-term care placement (LTC)
- in-home or in-facility respite

The number of lives touched by these services is significant. For example, in fiscal year 2017/18[6].

- 93,651 people received professional home care services (HCN, PT/OT, nutrition, and/or social work);
- 5,895 accessed ADP;
- 6,093 resided in a subsidized assisted living facility; and
- 40,293 lived in a publicly-funded LTC facility.

In addition, **over 43,000 people received a total of 8,767,512 hours of home support**[7]. The services provided by home support include:

- Personal care (dressing, grooming)
- Bathing
- Managing incontinence and assistance with toileting
- Meal preparation (heat/serve only)
- Assistance with eating including tube feeding

- Lifting and transferring including use of mechanical lifts
- Laundry
- Respite care
- Medication management / administration
- Oxygen equipment maintenance
- Compression stockings
- Catheter care
- Bowel care
- Other delegated tasks under the Personal Assistance Guidelines

Costing half a billion dollars per year, home support is the most significant HCC expenditure after long-term care. Focused on seniors who are experiencing difficulty with living independently the characteristics of B.C.'s home support clients include[8]:

- An average age of 81 (46% aged 85 or older)
- 30% married
- 66% female
- 46% co-reside with their primary caregiver.
- 51% at high to very high risk for long-term care placement (MAPLe 4 or 5)
- 30% have a diagnosis of Alzheimer's or other dementia
- 26% have diabetes
- 15% have congestive heart failure
- 21% show signs of depression
- 43% take nine or more medications (37% report difficulty managing medications)
- 31% have a caregiver in distress

Home support can be provided as a short-term intervention or on a long-term basis for seniors who require regular, ongoing support. Long-term home support is authorized for seniors by the health authority using a comprehensive and standardized functional, clinical, and environmental assessment that is conducted in a senior's home. Short-term home support, in comparison, is usually initiated to facilitate discharge from a hospital, and is expected to be for a finite duration.

There is no standardized assessment for short-term home support, and each health authority has slightly different guidelines for who will qualify and what services will be authorized under short-term home support. Generally, short-term service is not expected to be in place longer than three weeks before further assessment is conducted to determine if long-term home support is necessary. Short-term home support does not require a financial contribution to be paid by the client. In any given year, approximately 8% of the home support hours are short-term.

The authorization for long-term home support is completed by a HCC case manager. During a home visit, the case manager uses the interRAI Resident Assessment Instrument – Home Care (RAI-HC) assessment to determine the senior's level of cognitive and physical functioning, mood and behavior, psycho-social needs, health status, environmental suitability, and family/ community support. This comprehensive assessment is completed in collaboration with the senior and, where appropriate, their family or caregiver. This same assessment is used in most Canadian provinces.

Using the RAI-HC assessment, a care plan is developed that outlines the specific tasks that the community health worker is to undertake. The nursing supervisor develops the care plan in consultation with the client and, if appropriate, the family. Care plans are to be updated annually or more frequently if needed. Clients are to be provided with a copy of the care plan. There is no standardized template for a care plan for the province; they vary between and within health authorities.

In addition to the RAI-HC assessment, seniors undergo a financial assessment to determine the amount, if any, they will contribute to the cost of their home support service. The financial contribution is waived for seniors in receipt of any of the following forms of financial assistance:

- Guaranteed Income Supplement (GIS); includes spousal/survivor's allowance
- Income assistance and disability assistance (under 65 only)
- War Veteran's Allowance; includes spousal/survivor's allowance

Approximately 28% of B.C. seniors receive GIS[9] and therefore would qualify for an exemption. Less than 1% of B.C. seniors receive the War Veteran's Allowance[10] and no seniors qualify for income assistance and disability assistance.

For all other seniors, the daily rate is calculated based on a senior's most recent Notice of Assessment from the Canada Revenue Agency (CRA). Seniors with employment income have their client contribution capped at $300 per month regardless of their calculated daily rate. Approximately 17% of seniors aged 85 or older report employment income[11]. In all cases, the financial assessment considers both the senior's and their spouse's combined income, including when assessing whether an exemption to the daily rate applies. Almost two-thirds (64%) of those receiving long-term home support do not pay a daily rate because they are in receipt of one of the above-listed benefits, while another 16% are capped at the $300 per month rate. The remaining 20% pay for their home support based on the calculated daily rate[12].

EXAMINING THE EVIDENCE: HOW ARE WE DOING?

The home support program is structured to meet two main objectives. The first is to support seniors to live in their own homes for as long as possible, delaying and/or deferring the need to move to a long-term care facility. The second objective is to provide post-discharge supports to those seniors who have been hospitalized, allowing them to leave the hospital as soon as it is safe to do so.

The measure of whether or not the provincial home support program is meeting its stated objectives is multifaceted. In this report, we looked at a combination of qualitative evidence including feedback from seniors and their family members as well as quantitative evidence through utilization data. Using this two-pronged approach gives a balanced assessment that looks at the system as a whole yet allows the voice of individual experience to be heard.

WHAT THE PEOPLE TELL US

Over the past five years, the OSA has received tens of thousands of phone calls, emails and letters from seniors and their family members. As well, the Seniors Advocate has engaged with thousands of seniors around the province through personal outreach. In all cases, a fairly consistent message of the need for changes in home support is communicated.

The themes that emerge in seniors' struggles with home support are:

- Too restrictive in services offered
- Inflexible in meeting the needs of the client and their family
- Insufficient hours of service
- Too expensive
- Too many different workers
- Unreliable
- Bureaucracy is frustrating

Some of the stories we have heard include:

An 84-year-old woman with mild dementia lives alone in a house with accessibility challenges. *She is scheduled for knee replacement surgery. Her daughter is advised that surgery is "elective", and policy does not authorize home support post-discharge for "elective surgery", so the daughter is expected to make arrangements in advance. The daughter is unable to achieve this, and her mother remains in hospital several days longer than would have been necessary had she been able to receive health authority authorized and coordinated home support.*

A woman in her late 80s is discharged from a rural hospital into the care of her 91-year-old husband. *The family is advised that home support could provide: 30 minutes in the morning; 30 minutes in the evening; one hour per week for a bath and three hours per week of respite. In addition, the local ADP would pick her up at 8:00 am and return at 3:00 pm one day of the week. Unfortunately, the only service actually received was 20 minutes in the morning and 20 minutes in the afternoon (10 minutes allotted for driving time for each visit). No evening service, bath service, or respite shift was ever provided, and admission to ADP never happened due to a wait list. The care was too much for the 91-year-old husband, so his wife was readmitted to hospital while she awaited admission to a long-term care facility where she now resides.*

An 89-year-old woman, who lives independently with her husband, has been hospitalized for a month and suffers from severe macular degeneration, peripheral neuropathy, mild cognitive impairment, and has deconditioned to the point where she cannot currently be left alone. *Upon discharge, she will need assistance in the morning to get up, washed, and dressed, and in the evening to get undressed and assisted into bed. The husband can manage medications and some assistance to the toilet, but the wife cannot be left alone, and the husband needs to attend to his own medical appointments. Family are told the policy for home support upon discharge only allows for*

14 hours or 14 days of home support, whichever comes first, with no authorization for respite until assessment for long-term home supports is completed, and that assessment will not occur before 14 days has passed. The actual assessment for long term home support does not occur for 8 weeks post discharge and while short term home supports continued during the 8 weeks, no respite was provided.

A family are told that home support will not prepare meals. *The family must have the meal fully prepared and the CHW can heat it up in the microwave or, if it is a cold meal, they can remove it from the fridge and take the wrapper off. Cleaning up the kitchen is not considered part of the care plan for meal preparation.*

A couple in their early 90s live independently. *The husband is challenged with congestive heart failure, mobility issues, and some cognitive impairment, although he manages his own personal care. The wife has no cognitive impairment but has chronic obstructive pulmonary disease (COPD) and significant mobility issues related to complications from Parkinson's disease. The wife receives daily home support and once per week laundry. The couple are advised by the home support supervisor that only the wife's laundry can be done by the CHW as the husband is not a client, despite the fact the wife does not create a full load of laundry. The CHW also is only permitted to heat the meal for the wife and not the husband, as he is not the client. The husband will not qualify for his own service as policy does not permit service only for meal preparation or laundry; the client must require personal care as well.*

An 86-year-old man with Parkinson's disease has recently developed symptoms of dementia. *His wife, also in her 80s, has a heart condition and mild dementia. When the wife was admitted to hospital, her daughter spoke to a hospital social worker about the need for home supports given her dad's developing dementia. No home support was approved, and the wife was discharged. Over the next six months,*

there was an increasing inability of the husband to manage his wife's medication; additionally, the wife suffered a fall and was re-hospitalized. Two days later the husband was hospitalized with a pneumothorax. Both spouses fit the criteria for "failure to thrive" and were in hospital for a month. Their daughter was notified 48 hours in advance that her parents were to be discharged. Health authority-approved home support could not be provided as the couple lived in a condominium building that did not have a lockbox for access, which was required by the health authority. Additionally, the daughter was told the medications would be contracted to a local pharmacy delivery company and would cost $1,800 per month for the medications to be delivered daily. The daughter was overwhelmed and, in the end, both parents were placed in a long-term care facility.

Over the past four years, complaints to the Patient Care Quality Office (PCQO) for home care and home support have increased by 62%.

In these and many other stories, people also spoke about challenges with service delivery: missed visits; lack of communication; the number of different workers; and the need for more training of staff (especially around dementia). These are all issues that need to be addressed.

While each story we heard is unique, there is an overall theme of a system-driven approach that is focused on individual tasks and inflexible policies rather than looking at the whole picture and fundamentally understanding the totality of what is required to live independently. Policies around meal preparation perhaps best illustrate this. If a person is unable to microwave a dinner or take a wrapper off a sandwich, how are they able to ensure the food is in the fridge and ready to serve and how do the dishes get washed up and put away? The purpose of meal preparation is to ensure seniors are able to eat properly and live independently. This involves steps beyond simply heating or unwrapping food, yet we have focused on a narrow definition of meal preparation

and have made no provision for how we will ensure the food is in the house or how the house will get cleaned.

The increasing frustration with home support as described in anecdotal feedback received by the OSA is reflected in the complaints received by health authorities. Over the past four years, complaints to the Patient Care Quality Office (PCQO) for home care and home support have increased by 62%[13].

However, there are also those who have benefited from the home support program and who are grateful for the service they receive. Some of the letters and calls with complaints also reference the skill, care, and compassion of the staff involved in home support. There remains, however, a thread of frustration running through most experiences.

Recognizing that, in general, those who are dissatisfied are more likely to speak out than those who are satisfied, the OSA undertook a comprehensive survey of all home support clients and issued the report *Listening to Your Voice: Home Support Survey Results* (September 2016). The survey was sent to 17,477 clients who received service during a 30-day period in the spring of 2015. More than 5,000 clients and 4,000 family members responded. The survey data offer a slightly more encouraging picture of home support than is reflected in the letters, emails, and phone calls we received. Responses included:

- 62% rated the quality of their home support service as excellent or above average with 33% rating it as average or below average;
- 78% reported home support was meeting their needs most of the time or always;
- 80% felt their home support worker had enough time to complete tasks;
- 92% found their workers respectful and caring;
- 90% could communicate effectively with their worker; and
- 47% thought the workers had all of the skills required, while 40% thought they had some or most of the skills.

On the question of the number of different workers, which is often referenced as frustrating to many seniors, the response was more positive than negative; 63% felt they had about the right number of different workers and 56% held the same opinion of their substitute workers.

The survey indicated that, for many clients, the program is working. However, while the majority found the service above average or excellent, nearly 4 out of 10 clients rated the service as average or below average, and it is not meeting the needs of almost a quarter of the clients; furthermore, less than half of clients thought workers had all of the skills required to provide good care. This would suggest a program that has opportunities for improvement.

We also need to examine the limitations of the survey. While the survey had responses from a large number of seniors receiving home support, it was not from a representative sample of seniors receiving home support. Survey responses were linked to RAI-HC assessments and administrative service records. Analysis of the response patterns indicated that survey respondents were less frail, had less complex needs, and received less frequent service than the average home support client. Seniors receiving less frequent service and who are less frail are likely to experience their service differently than those who require more complex and more frequent service; indeed, with increased care needs and more frequent service we found lower levels of satisfaction.

More significantly, the survey did not account for those seniors who might benefit from home support but are not receiving it. Determining who might benefit from home support but are not receiving it is complicated. Good data exists for those who receive home support, but

there is no good standard measurement for those who might benefit from home support but are not receiving it. There are, however, some indicators that could be used to approximate how well the home support program is meeting the needs of a growing population of seniors and these include:

- Utilization data relative to population;
- Intensity of service; and
- Care needs of residents in long-term care.

WHAT THE NUMBERS TELL US

Over the last five years, the number of home support clients aged 65 or older has increased 14.7% and the hours delivered to these clients has increased 11.9%[14]. During this time period, however, the population in this age group also grew by 22.4%[15]. The test of keeping pace with demand needs to measure the growth in the target population relative to the service levels.

Examining utilization data compared to population growth over the past five years shows that home support service overall, whether measured by the number of recipients (figure 1) or hours delivered (figure 2), has not been keeping pace with B.C.'s growing seniors population. In addition, those who are receiving service are receiving fewer hours of service today than they received five years ago (figure 3). The reduction in service is most noticeable for those aged 85 years of age or older. This is concerning, as this age group is more likely to need both a broader range of services and higher levels of service as they experience more chronic health conditions. The data tell us that 39.9% of seniors aged 85 or older who live in the community have highly complex chronic conditions and a further 32.5% have chronic conditions of medium complexity. However, only 16% are receiving HCC home support services.

If the home support services were efficiently and effectively used, evidence would indicate both an increase in service intensity for those aged 85 or older, as well as, at the very least, a stable proportion of the seniors population aged 85 or older in receipt of service and remaining in their own homes. What we find is the opposite.

HOME SUPPORT RECIPIENTS PER 1,000 POPULATION[16]

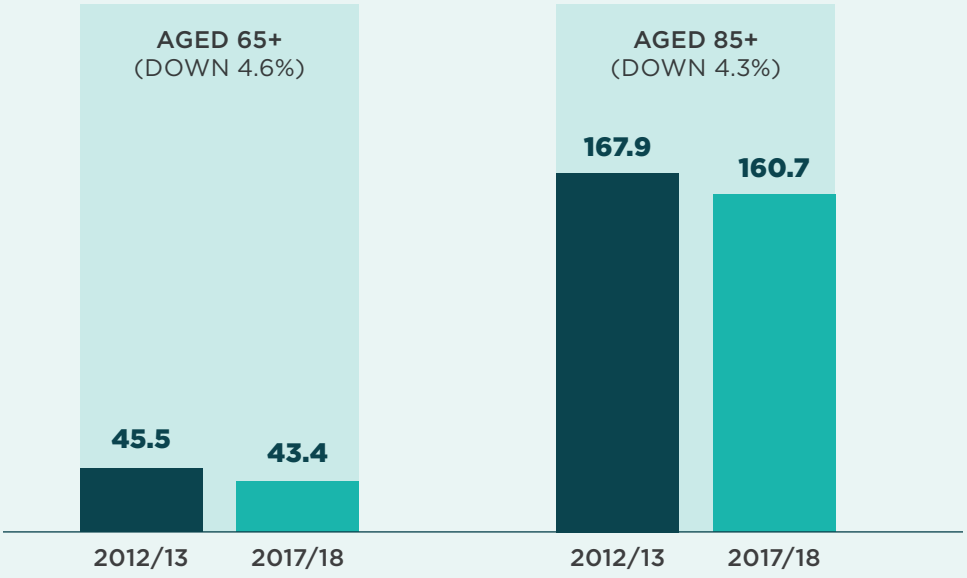


FIGURE 1

HOME SUPPORT HOURS DELIVERED PER 1,000 POPULATION[17]

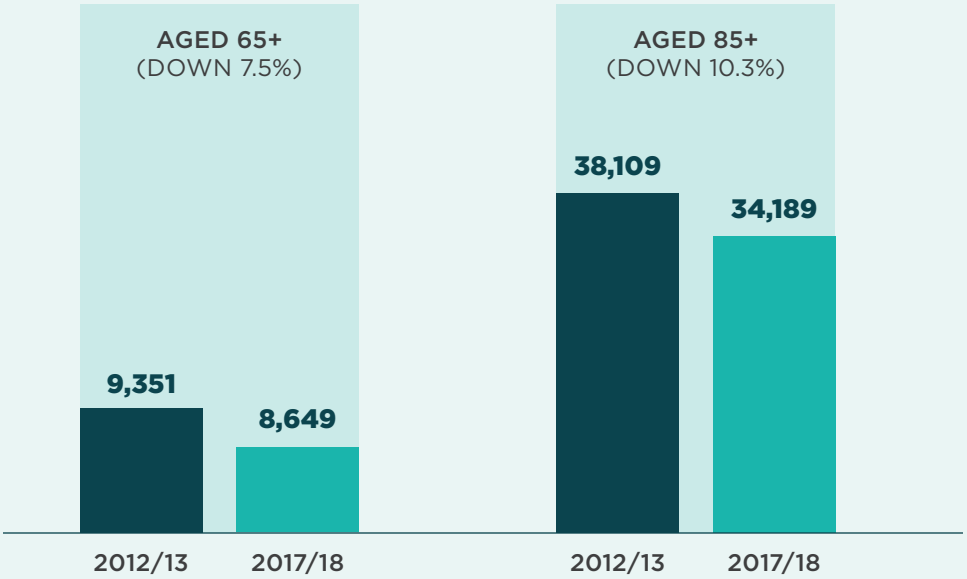


FIGURE 2

HOME SUPPORT HOURS DELIVERED PER RECIPIENT[18]

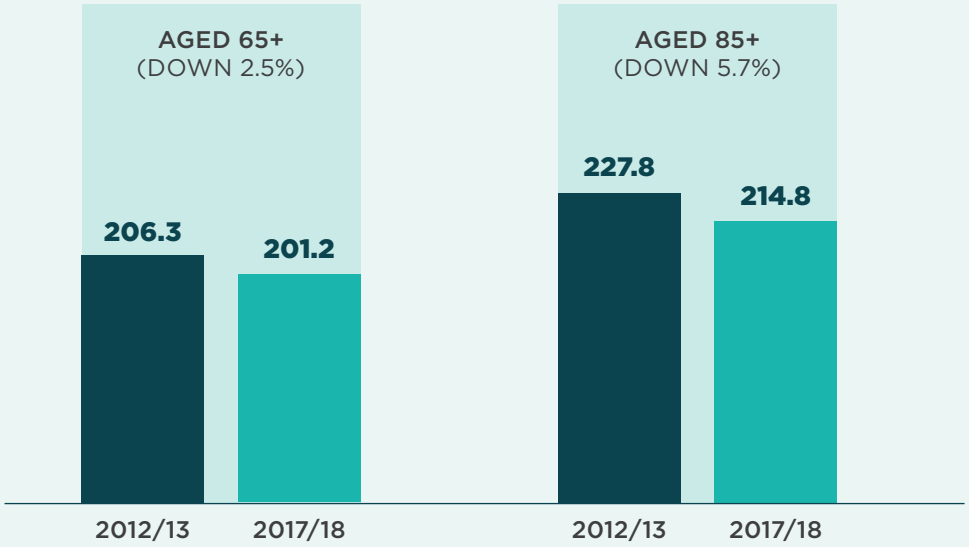


FIGURE 3

CHRONIC HEALTH CONDITIONS BY AGE[19]

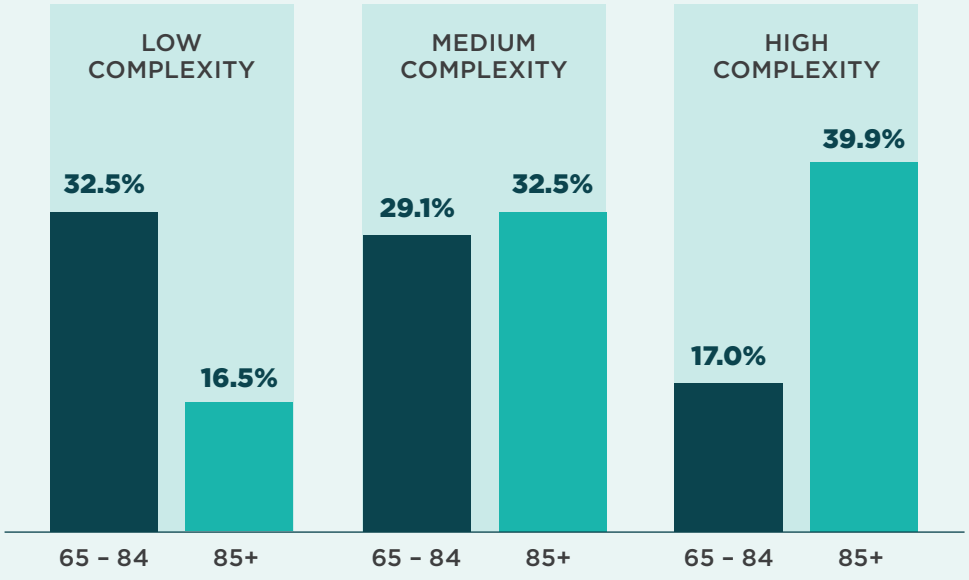


FIGURE 4

A review of the complexity and acuity of home support recipients as measured by data collected through RAI-HC assessments was conducted for the same time period to determine if decreased hours per client was a result of decreased complexity within the home support population. What we found is the frailty and complexity of the clients, as measured across five different indicators (figure 5), has been increasing while the intensity of service, as measured by hours per client, has been decreasing (figure 3), which is counterintuitive and not what we would expect to find.

A further analysis of the distribution of the home support hours illuminates the potential gap between the needs of the client and their family member and the service provided. We have looked at the distribution of hours over two measures: *eligible days* and *days of service*.

CLINICAL CHARACTERISTICS OF HOME SUPPORT RECIPIENTS[20]

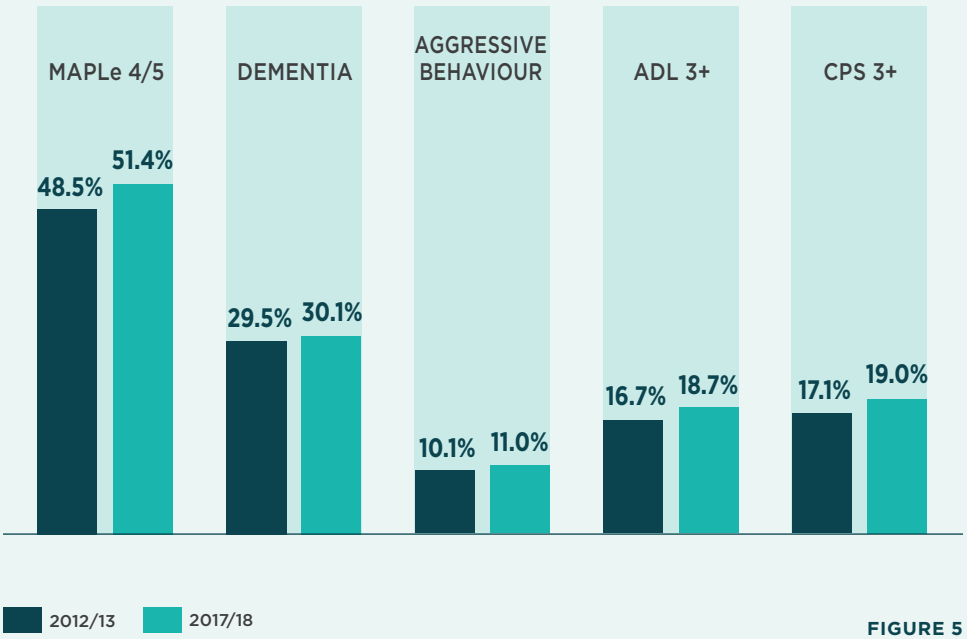


FIGURE 5

Eligible days tells us how many hours of service, on average, would be received per day based on the assumption the client receives daily service. The *days of service* tells us how many hours are received, on a day that service was actually delivered, recognizing that most home support clients do not receive daily service. Calculating the proportion of clients in receipt of daily service requires a "discount factor" to allow for clients who may be hospitalized or have cancelled service due to appointments. We used a discount factor of 20%. This means that our calculation assumes daily service for clients receiving service on 24 or more days per month. Based on this assumption, the data tell us that only 41% of home support clients receive daily service.

When looking at the total *eligible* service days, data demonstrate that most clients received, on average, less than an hour of service per day (figure 6).

- 63% received less than 1 hour
- 23% received between 1 to 1.5 hours
- 8% received between 2 to 2.5 hours
- 3% received between 3 to 3.5 hours
- 3% received 4 or more hours per day

HOURS PER DAY FOR HOME SUPPORT RECIPIENTS; ELIGIBLE DAYS[21]

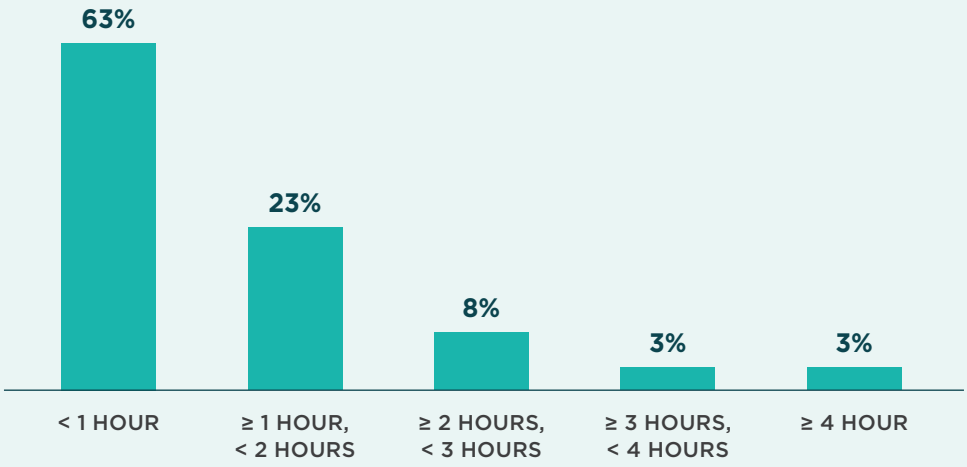


FIGURE 6

Only 41% of home support clients receive daily service.

When looking at service days (figure 7), for all clients, data show:

- 27% received less than 1 hour
- 47% received 1 to 1.5 hours
- 14% received 2 to 2.5 hours
- 6% received 3 to 3.5 hours
- 6% received 4 or more hours per day

HOURS PER DAY FOR HOME SUPPORT RECIPIENTS; SERVICE DAYS[22]

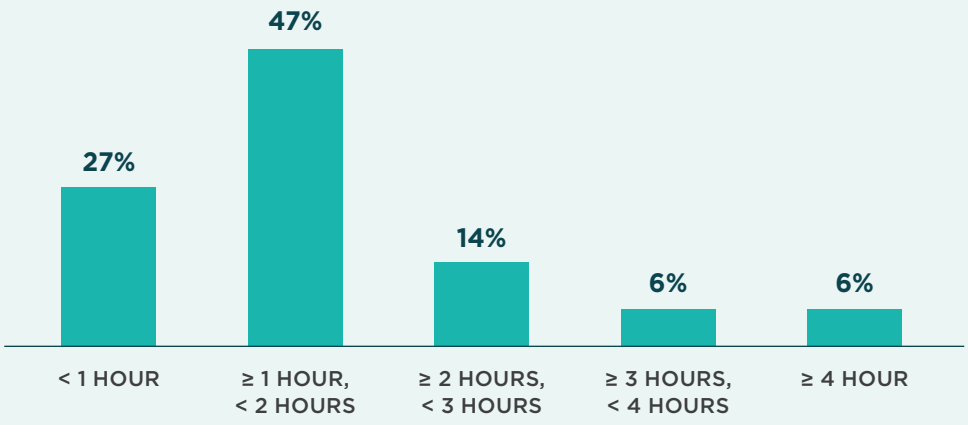


FIGURE 7

In addition to the overall distribution of hours, we also examined the distribution of hours related to clinical complexity, as measured by the MAPLe score. The Method for Assigning Priority Levels (MAPLe) is an algorithm calculated from various RAI-HC elements that is used by health care professionals to prioritize clients' needs and to appropriately allocate home care resources including placement in long-term care. MAPLe identifies five levels of function and risk.

Descriptions[23] of functioning along the five-point MAPLe scale are as follows:

- **MAPLe 1 (low risk)** – Clients are generally independent without physical disabilities and with only minor cognitive loss. There are no problems with behavior, the home environment, medication or skin ulcers. Some limited home care support may be needed because of early losses of function in limited areas.

- **MAPLe 2 (mild risk)** – Clients need only a light level of care due to some problems with instrumental activities of daily living (e.g., housework, transportation) or loss of physical stamina.

- **MAPLe 3 (moderate risk)** – Clients are beginning to show impairments in individual functioning that may be a threat to their independence, such as problems in the home environment, difficulty managing medications, or physical disability combined with mild cognitive impairment.

- **MAPLe 4 (high risk)** – Clients are experiencing more complex problems, including challenging behavior or physical disability combined with cognitive impairment. These [clients] have elevated risks of [long-term care] placement and caregiver distress.

- **MAPLe 5 (very high risk)** – Clients have impairments in multiple areas of function that have a pronounced impact on their ability to remain independent in the community. These include factors such as physical disability, cognitive impairment, falls, challenging behavior and wandering. Rates of [long-term care] placements and caregiver distress are highest in this group.

Even among seniors with highly complex care needs—the ones with the highest likelihood for admission to long-term care, based on their MAPLe score—there is limited home support provided (figure 8). A client assessed at MAPLe 4 is only receiving an average of 1.1 hours for their eligible days and 1.8 hours on their service days. Clients assessed at very high risk for placement (MAPLe 5) are only receiving an average of 1.2 hours based on eligible service days and 2.1 hours per day on days of service. The difference between the hours on service days and eligible days also reinforces that most high need clients are not receiving daily service.

These utilization patterns are demonstrating that the current home support program is not providing the level of support we would anticipate from a program that holds the objective of supporting independent living for seniors as they progress through the aging continuum. This is especially true when we look at the hours of service for clients at MAPLe 4 and 5, which is the tipping point for a move to long-term care. It appears that almost half of MAPLe 5 clients are not receiving daily service and on the days service is received, it is averaging only 2.1 hours of service. Given their high care needs and low level of home support, these seniors must be receiving significant help from others, likely family caregivers, in order to live independently.

HOURS PER DAY BY MAPLe SCORE[24]

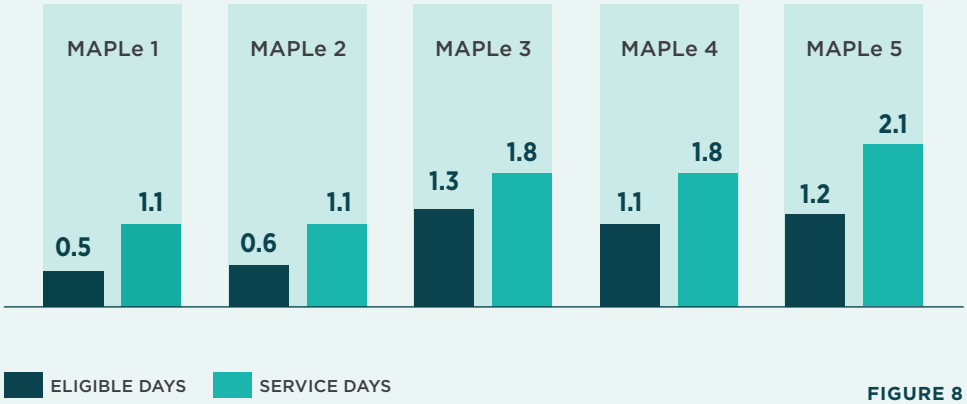


FIGURE 8

FAMILY CAREGIVERS: OVERBURDENED AND UNDER-RESOURCED

The gaps in the current home support program are increasingly filled by family members. In part, this results from the home support philosophy that the program is designed to supplement, and not substitute for, family support. The ability of family members to contribute is considered in the assessment process and development of the care plan. RAI-HC assessment data tell us that 96% of seniors receiving home support have an unpaid caregiver (likely a family member) who is key to their ability to remain at home, and 46% of these caregivers co-reside with the senior. However, RAI-HC assessment data also tell us that almost one-third of these caregivers are in distress from caring for their loved one[25].

The Office of the Seniors Advocate has reported on the issues facing family caregivers and their rising level of distress in two reports: *Caregivers in Distress: More Respite Needed* (September 2015) and a follow-up titled *Caregivers in Distress: A Growing Problem* (August 2017). These reports highlighted a significant level of distress among those who are providing care for home support recipients. In the last five years, the rate of distress among caregivers to home support recipients has increased by 3.4%[26]. On a national level, among all clients who were assessed with the RAI-HC in 2017/18, British Columbia had the second-highest rate of caregiver distress in Canada[27].

Relief to caregivers comes in many forms. One of these is through the provision of home support hours to assist in the actual tasks related to caregiving, while another is through respite blocks that provide time for the caregiver to be absent from their caregiving duties for a few hours (typically four). On both these measures, the data show that more needs to be done to provide sufficient support to address caregiver distress.

A review of the data indicated that distress correlated most highly with the level of a senior's cognitive impairment. Currently, home support service is primarily focused on ADL assistance. A senior with cognitive impairment may only require some cueing to be able to perform basic

31% of family caregivers are in distress.

ADL tasks but they cannot be left alone due to concerns for safety and wandering. Under current guidelines, this would result in no service or very limited service as many assessments require assistance with personal care as the threshold for receiving service of any kind.

Among seniors with a distressed caregiver, 31% were assessed as very high risk for placement; this is compared to 10% assessed at very high risk for placement among those seniors without a distressed caregiver. When we examine the hours for distressed caregivers, we find that we are falling short in our support for distressed caregivers disproportionately to other caregivers.

As the charts on the next page demonstrate, distressed caregivers are caring for loved ones who are three times more likely to be assessed as MAPLe 5 (figure 9), yet only 4% of distressed caregivers are in situations where they are receiving an average of four hours or more per day (figure 10). The hours for clients with distressed caregivers demonstrates the significant lack of support through the home support program. For respite to be meaningful, it likely requires a break for the caregiver of a few hours. There needs to be time to get out of the house and attend to errands, appointments, physical exercise, and social activities. Three to four hours would be a reasonable expectation for respite and we can see from the hours per service day this is not being provided in a meaningful way for caregivers overall and especially for caregivers in distress. What is most disquieting is to find the rate of caregiver distress doubles to 62% when looking at those seniors who are admitted to long-term care.

DISTRIBUTION OF MAPLe SCORES, BY CAREGIVER DISTRESS[28]

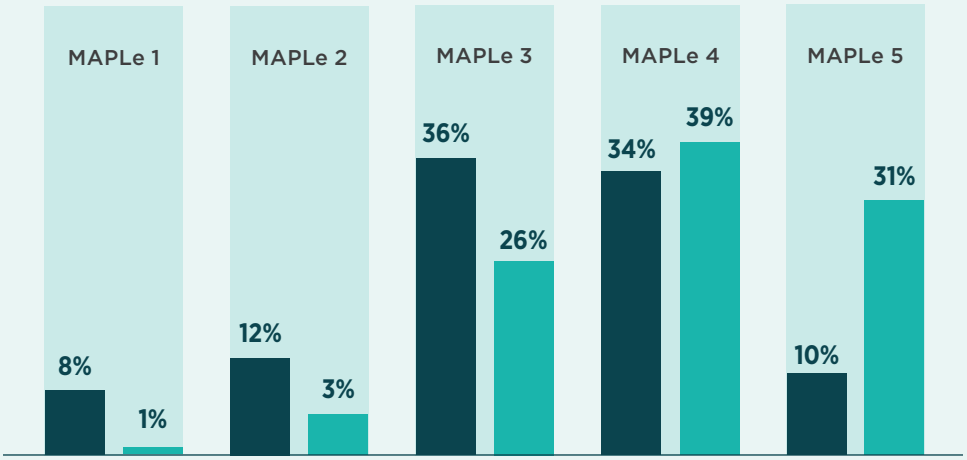


FIGURE 9

DISTRIBUTION OF ELIGIBLE HOURS, BY CAREGIVER DISTRESS[29]

DISTRIBUTION OF SERVICE HOURS, BY CAREGIVER DISTRESS[29]

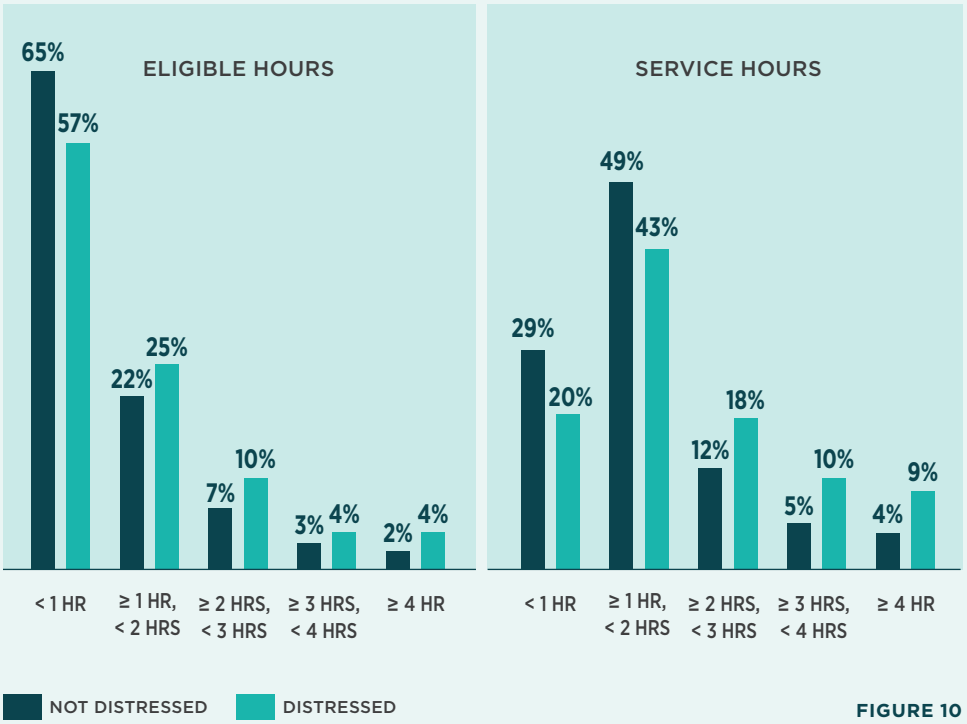


FIGURE 10

APPROPRIATE LEVELS OF CARE

Another measure of whether the home support program is meeting the goal of keeping seniors at home and, by extension, deferring admissions to licensed long-term care facilities, is the degree of physical and cognitive functioning of residents within the long-term care population. If a home support program is robust and flexible and is succeeding at supporting seniors to remain in their home for as long as possible, the data would demonstrate almost no residents in long-term care with little to no physical and/or cognitive impairment, as we would expect this population to be supported in the community.

This premise was previously examined by the Office of the Seniors Advocate in reviewing potentially inappropriate placements to long-term care in two separate reports titled *Placement, Drugs and Therapy: We Can Do Better* (2015) and *Placement, Drugs and Therapy: Making Progress* (2016). The reports created profiles of clients who could, based on their care needs, be living in the community or an assisted living facility; these profiles were matched against the population living in long-term care to identify potentially inappropriate placements. The three profiles are:

- **Light care needs** – residents with high physical and cognitive functioning, and no aggressive behaviors
- **Dementia care needs** – residents with moderate cognitive impairment, but high physical functioning and no aggressive behaviours
- **Higher physical care needs** – residents with moderate physical impairment but no cognitive impairments

Essentially, these are residents with fewer deficits in cognitive functioning and who have the ability to complete ADL tasks independently or, at most, with some cueing from a care worker. The latest data from the 2016 report showed that up to 15% of residents met this threshold.

A simpler approach to examining whether seniors are being placed prematurely in long-term care is to review the ADL hierarchy and cognitive performance scale (CPS) scores, which are seven-point

scales calculated based on the level of impairment a resident has with, respectively, their physical and cognitive function. If a resident scores as ADL 2 or less and has a score of CPS 2 or less, there is a strong likelihood their needs could be supported either in their own home or in assisted living. In analyzing the 2017/18 data, 17% of residents had care needs that potentially did not require the intensive services of a long-term care facility[30].

Given that two different approaches produced similar results reinforces the validity of the findings.

In trying to determine why light care need residents were living in long-term care, the OSA examined the utilization of home support hours prior to a resident's admission to a care facility. The data demonstrate that the potential of home support does not come close to being exhausted for the majority of seniors admitted to long-term care. We found that 61% of seniors admitted to long-term care in 2017/18 received no home support service in a 90-day window prior to their admission (figure 11), and of those who received it, service levels rarely approached the economic tipping point of four hours per day.

HOME SUPPORT ACCESSED BY LONG-TERM CARE RESIDENTS 90 DAYS PRIOR TO ADMISSION[31]

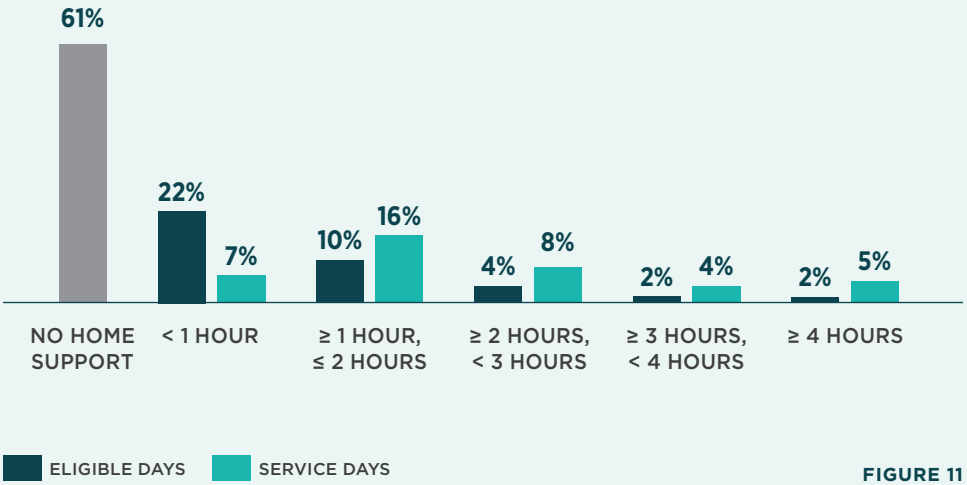


FIGURE 11

61% of seniors admitted to long-term care received no home support in the 90 days prior to admission.

When we examine the RAI-HC assessment that determined admission to long-term care, we find that 49% of those admitted to long-term care were ADL 2 or less and we find that 34% were CPS 2 or less, yet 83% showed an overall decline in function. Perhaps most surprising was that 79% were having trouble managing medications. Medication management is an authorized home support service. At 62%, we also see a level of caregiver distress twice as high among caregivers to seniors who are admitted to long-term care versus among caregivers to seniors who remain at home[32].

Notwithstanding what the data are telling us about the system overall, we can find some specific examples where health authorities adopted a targeted response and achieved positive results. Most notable were a series of pilot projects initiated under the Home is Best/Home First initiative, created six years ago.

In 2013, the Ministry of Health directed $50 million over three years to health authorities for targeted community care initiatives, resulting in the "Home is Best/Home First" projects. The first wave of projects were designed to provide intensive short-term support immediately following hospital discharge. Research suggested that seniors recovered more quickly in their own homes compared to experiencing an extended stay in hospital. This, combined with the ever-present congestion in acute hospitals, made a compelling case for discharge from hospital as soon as it was safe to do so. The result was the development of a "front-end loaded" home support service to meet the needs of frail seniors being discharged from hospital, which was piloted under the project name of Home is Best.

Pilots were run in both Fraser and Vancouver Coastal health authorities. Each pilot reported sizeable reductions in emergency department visits (69% and 25%, respectively) and acute care admissions (50% and 30%, respectively)[33]. The funding for the initiation of the program was timelimited and health authorities were expected to integrate principles and practices into their service models.

In addition to those seniors who could return home more quickly after an acute care episode, there are also those seniors who are in the hospital waiting for placement in a long-term care facility; these patients are designated as alternative level of care or ALC. During 2017/18[34], 4.6% of acute care admissions incurred ALC days, and among all acute care days, 12.5% were ALC days, and thus used by patients who, by definition of their ALC status, had care needs that did not require the resources of an acute care facility. The average patient designated as ALC had an ALC length of stay of 19.4 days. For hospital admissions by seniors aged 80 or older, 22.4% of all acute care days were ALC days.

Overall, approximately 45% of admissions to long-term care came directly from hospital[35]. Waiting in hospital for admission to long-term care is detrimental to the senior's health status as physical deterioration caused by the immobility of being confined to a hospital bed leads to a gradual loss of strength and physical ability to perform ADLs. This can result in more intensive support needed once admitted to long-term care. Deterioration of mental status, often presenting in a delirium, is also associated with hospitalization. In addition, there is the cost to the system as a bed in the hospital can cost $800 to $1,200 per day.

The second wave of the Home is Best/Home First initiative looked at the ALC population in acute care hospitals. While introduced in slightly differing models in each health authority, the basic premise was to provide enhanced home supports to a senior waiting in hospital for a long-term care bed to facilitate a discharge from hospital and allow them to wait at home; this project was called Home First. Island Health expanded the mandate and designed a project to potentially support the senior at home indefinitely, eliminating the need to transfer to LTC.

The Island Health pilot offered home support services that were intense at the beginning and could include live-in and overnight service. The ultimate goal was to find the balance where enough service was provided to support the senior to stay at home for the long term, but at service levels that were financially sustainable for the health authority. The results demonstrate this can be an effective approach.

In Island Health, the pilot project saw less than one-third of the clients enrolled in the Home First program ultimately placed in long-term care. Figure 12, below, illustrates the paths followed by 707 seniors over three years in Island Health during the pilot project.

PATHS FOLLOWED BY SENIORS OVER THREE YEARS IN ISLAND HEALTH DURING THE PILOT PROJECT[36]

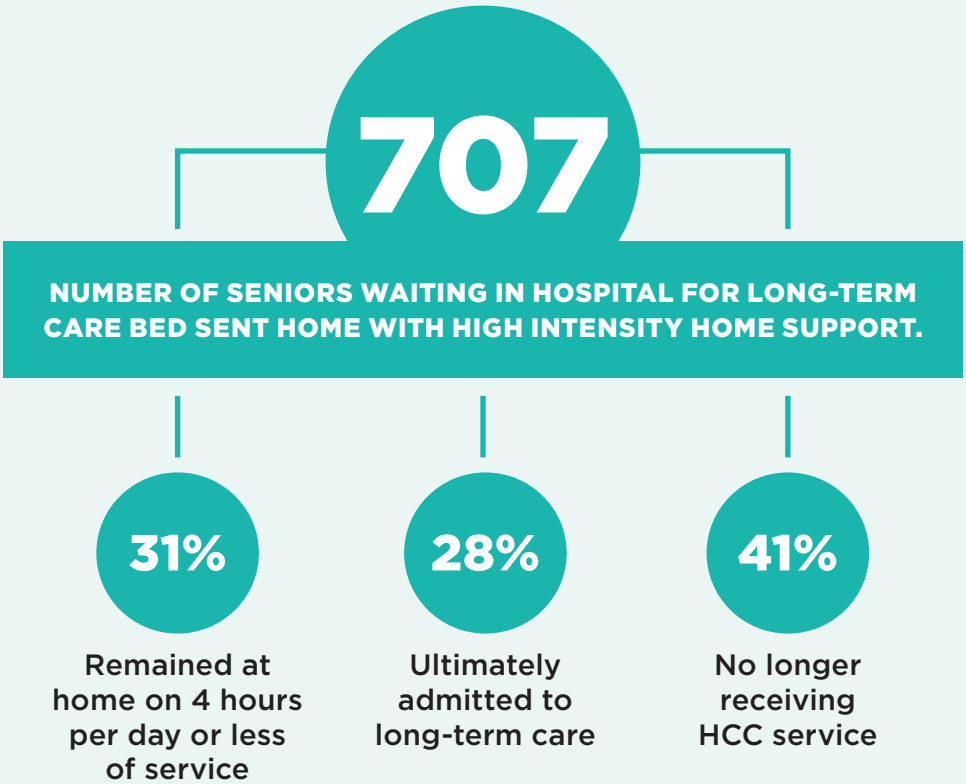


FIGURE 12

The average monthly long-term care resident's subsidy is $4,641. The cost of two hours of daily home support is $2,312.

Each of these 707 seniors in Island Health's pilot Home First program were assessed as requiring admission to a long-term care facility and, therefore, were not expected to be successful at returning home with supports. Yet, with flexible, focused, and effective home supports that were initially intense but tapered to a sustainable level of four hours per day or less, 31% of these individuals were able to remain at home. Ultimately, only 28% were admitted to a care facility, and the remainder (41%) were not in long-term care or receiving home support when the pilot ended.

The premise of the program was the recognition that many seniors will recover some or much of their function over time, and once in their own home, can have their ability to manage ADL and IADLs more accurately assessed. Like the pilots that focused on fast discharge from hospital, the success of the program came from the innovative, flexible approach to "front-end loading" home support services. The results showed that it is possible to change the trajectory of admission to a care facility to one of possibly deferring placement in long-term care, and potentially remaining at home indefinitely.

While the pilot projects were undertaken by different health authorities and for sometimes different goals, there was a shared overall methodology of intense home supports to support the quickest possible safe discharge. The results demonstrated this approach can work and be cost effective. Unfortunately, these were only pilot projects that faded along with the targeted funding.

What we are left with today is data that show 61% of admissions to long-term care received no home support 90 days prior to admission and hospital discharge home support (short-term) data that show an average of only 1.1 hours per day upon discharge. We also find

explicit policies that look to restrict home support hours post-discharge rather than the front-end loading approach of the successful pilot projects.

Most health authorities have policies that restrict the hours and type of services that will be offered under short-term service. No two health authorities have exactly the same set of policies, but common examples of some policies include:

- Home support hours are restricted to 14 hours or 14 days, whichever comes first;
- No access to meal preparation unless personal care is also required;
- No access to respite care;
- No provision of housekeeping; and
- Patient/client must be able to manage at home for up to two days post-discharge to allow for the home support services to be set up.

The lack of clearly written policies that support the practice of approving home support at discharge from hospital is frustrating to families as well as front line staff. It also creates potentially significant discrepancies between health authorities. We can find examples of authorizations for live-in and overnight service in southern Vancouver Island, while other health authorities offer no such service. Health authorities have conflicting policies about who will authorize the discharge hours, with some requiring the senior first go home and then be assessed, resulting in no service until the assessment is complete, the care plan developed, and CHWs can be scheduled. This means the senior cannot reasonably expect to receive service on their first day post-discharge.

Seniors who have experienced the need for home support for the first time post-discharge speak to frustration with a system that places the burden on families to manage the care supports needed for their loved ones. The experience for seniors who are already receiving home support when they are hospitalized can be different as it is easier to increase service hours for an existing client than initiate service for a new client. Analysis of administrative data over time shows that approximately 41% of short-term home support recipients will convert to long-term service within one year and that, overall, half of long-term home support recipients initially started out on short-term service[38].

Regardless of whether a home support client is new to the system as a result of hospitalization or is an existing client who has been hospitalized, both the data and the stories speak of a system that is not appreciating the cost-effectiveness of home support as a substitute for acute care and/or long-term care.

THE ECONOMICS OF HOME SUPPORT

Living at home is the desired choice for most seniors. It is also the most economical option in many circumstances. Traditionally, the rule of thumb for cost effectiveness of home support was four hours per day or 120 hours per month, as this was deemed the tipping point where long-term care became more cost effective. As the utilization data show, 97% of clients receive an average of much less than four hours per day. Despite seeking an explicit written policy on the maximum number of home support hours that can be authorized, the OSA could not find any. The lack of specific information creates a vacuum in which seniors and their family members are without the knowledge of what is possible and, as such, may make decisions about placing a loved one in long-term care when a different decision might have been made had all the alternatives been known. This notion is reinforced by data showing cases where seniors are placed in long-term care when their care needs could be addressed in the community. In addition to the human cost, this is placing an additional economic burden on the health care system.

The average monthly long-term care resident subsidy is $4,641 and the median subsidy is $4,825.

In long-term care, residents are assessed a monthly contribution equal to 80% of their after-tax income, up to a maximum payment of $3,377.10. This results in the potential public subsidy of $2,100 to $6,100 per resident, per month depending on the client contribution and the facility cost (facility costs range from $5,500 to $7,300 per resident, per month). **The average monthly long-term care resident subsidy is $4,641 and the median subsidy is $4,825**[39].

The cost to deliver an hour of home support varies based on geography. While labour costs are consistent across the province, mileage charges and travel time can affect the overall cost. In the Lower Mainland and southern Vancouver Island, where the bulk of the population lives, the cost per hour is estimated at $38. Based on an assumption of daily service and no client contribution (as is true for most recipients), this translates into the following estimated monthly costs:

MONTHLY HOME SUPPORT COSTS	
One hour per day	$1,156
Two hours per day	$2,312
Three hours per day	$3,468
Four hours per day	$4,623

MONTHLY LONG-TERM CARE COSTS

Average subsidy in long-term care: $4,641

Median subsidy: $4,825

The economic argument of up to four hours per day of home support being less expensive than long-term care still holds true for the vast majority of current home support clients. For potential home support clients, the economics of four hours will depend on their income versus the funding of the facility where they are placed. For both current and potential home support clients, the economics of three hours per day holds in almost all circumstances.

A client who requires three to four hours per day of home support may also be a good candidate for self-directed care, which is a model of home support in which funding is provided directly to the client who, in turn, hires his or her own health care workers (or, more likely, has a designated representative to hire workers). Currently, in B.C., the only version of self-directed care implemented is called Choices in Supports for Independent Living, or CSIL. While CSIL is a program with a very narrow scope (health conditions which are stable and not degenerative, which generally excludes dementia) and a small client base (approximately 1,000 clients), the benefits of a generalized version of self-directed care are well established in other jurisdictions, such as the United Kingdom, where around one-third of publicly-subsidized home support clients utilize some form of self-directed care.

In B.C., the CSIL program funds the client at a rate of $31.47 per hour for each hour authorized; thus, the monthly cost for three to four hours of daily home support is $3,829 for four hours and $2,872 for three hours. Aside from the cost savings over traditional home support, self-directed care enables clients and/or their family to direct health care workers to deliver exactly the care that is considered to be most beneficial to the client. An analysis of the initial pilot project to roll out self-directed care in the United Kingdom found that care quality outcomes were unchanged relative to government-directed care, but significant cost savings were realized[40]. In B.C., an analysis of caregiver distress among CSIL clients found that caregivers to clients with highly complex needs had approximately 50% lower distress rates than caregivers to clients supported by health authority -directed home support[41].

The current CSIL program is, as mentioned, cumbersome and constrained by policies that make it unsuitable for many age-related impairments. It was a program originally designed to support a population of young, physically disabled people with high care needs to remain at home (rather than a facility) and, if possible, facilitate their participation in the workforce. There are many elements that do not work well for a frail elderly population, but there are also some general aspects of the program that do. There are stories about how difficult the process to access CSIL can be and how certain services are not authorized under CSIL but are allowed under home support. However, there are also stories about how it was a "life saver" and allowed the family to keep their loved one at home. For those who are on the CSIL program, there is a fairly high level of satisfaction, but many who would like to access self-directed care have encountered frustrations when dealing with B.C.'s only incarnation of such a program.

PUBLIC HOME SUPPORT: A FINANCIAL BURDEN FOR MOST SENIORS

British Columbia is one of the few provinces to charge a fee for home support, and among those provinces that do have a fee, B.C. has the highest rate. In order to receive long-term home support services, a financial assessment is completed, and the senior is informed of their assessed client contribution in the form of a daily rate. This daily rate is assessed using the senior's most recent CRA Notice of Assessment. The daily rate is applied to each day that service is received and is billed on a monthly basis.

The financial contribution is waived for seniors in receipt of any of the following forms of financial assistance:

- Guaranteed Income Supplement (GIS); includes spousal/survivor's allowance
- Income assistance and disability assistance (under 65 only)
- War Veteran's Allowance; includes spousal/survivor's allowance

Seniors who are receiving short-term home support are also not required to pay the client contribution. However, if these seniors require long-term home support, the assessed daily rate would begin to apply when they converted to long-term home support.

The daily rate formula is set out in the Continuing Care Fees Regulation under the *Continuing Care Act*. The formula begins with a client's net income, subtracts any income tax paid, further subtracts a pre-set deduction amount, and divides this remainder by 720. The number of 720 is chosen based on a 360-day year multiplied by two. Effectively, what this means is that a client is charged half of their net income, minus income tax and a preset deduction. This results in a client paying 25-40% of their income for home support if they receive daily service. In the case of a couple, income from both spouses is considered.

The current formula can result in extremely high daily rates, particularly in the case of couples where even moderate incomes can result in daily

A senior with an annual income of $28,000 will pay $8,800 per year (or 33% of income) for daily home support

rates that actually exceed the cost to the health authority of providing the service. As such, each health authority establishes an hourly "billing rate" for their home support services and clients pay the lesser of the daily rate or hourly billing rate for hours of service received. The billing rate varies between and within health authorities. The majority of home support is delivered in the Lower Mainland where the current billing rate is $38 an hour; as such, we will use this figure to illustrate how the billing rate works when calculating a client's fee for home support.

If a senior's daily rate is $30 and they receive one hour of service per day or more, they would pay only $30, despite the cost of the service being $38 per hour. If a senior's daily rate, however, was $70 and they received one hour of service, they would pay only $38. If they received 2 or more hours of service, they would pay the full daily rate of $70, as the actual cost ($76) exceeded the daily rate.

The daily rate is cost prohibitive for most seniors. In the box below, we have illustrated the cost of daily home support for different income levels, both seniors and couples.

DAILY RATE EXAMPLES

Single with income of $26,000
Daily rate: $20
Annual cost for daily home support: $7,300
(30% of after-tax income)

Single with income of $50,000
Daily rate: $45
Annual cost for daily home support (2+ hours/day): $16,425
(39% of after-tax income)
Annual cost for daily home support (1 hour/day): $13,870
(32% of after-tax income)

Couple with combined income of $65,000
Daily rate: $60
Annual cost for daily home support (2+ hours/day): $21,900
(37% of after-tax income)
Annual cost for daily home support (1 hour/day): $13,870
(23% of after-tax income)

These seniors are all living independently, meaning they must pay for housing, food, transportation, utilities, medication, and supplies in addition to the payment for home support services. The financial burden is significant and might explain in part the disproportionately lower use of home support by seniors who are required to pay the full client rate. In addition to the complete exemption from a financial contribution to home support for seniors on GIS, there is additional rate relief for clients with employment income. If a home support client or their spouse has employment income as defined by the Canada Revenue Agency (CRA), the maximum amount they will be required to pay, regardless of their client rate, is $300 per month. For example, if the daily rate is assessed at $50 and a client receives daily service of one hour, they will be charged $50 per day for the first six days of service, at which point the $300 cap will have been reached;there will be no charge for service on the remaining days of the month.

Without the cap, the client would have paid $1,500 per month for their daily service. Approximately 16% of long-term home support recipients have their home support payments capped by the employment income clause.

Currently, 64% of clients receiving long-term home support have no client daily rate, meaning that they are in receipt of GIS or one of the other federal/provincial benefits that entitles a person to free home support. However, only 28% of seniors in British Columbia are in receipt of GIS, and less than one percent are in receipt of one of the other qualifying benefits. Based on home support uptake rates, this phenomenon demonstrates that a person is over five times more likely to receive home support services if they are not required to pay for it.

The application of the daily rate also presents a compelling economic argument for seniors to move to long-term care versus remain at home and receive daily home support. The chart below shows a comparison of costs for a senior to live at home with daily home support and pay the daily rate versus accept placement in a long-term care facility.

As we can see from the analysis on the next page, at three different income levels, the economics of long-term care are compelling to a potential consumer of HCC services. With an income of $27,800, a senior will spend an estimated $10,000 more, per year, to live at

SINGLE SENIOR	$27,800		$56,000		$80,000	
	AT HOME	LONG-TERM CARE	AT HOME	LONG-TERM CARE	AT HOME	LONG-TERM CARE
GROSS INCOME	$27,800	$27,800	$56,000	$56,000	$80,000	$80,000
EXPENSES						
HOUSING[1]	$15,000	$21,200	$15,000	$40,525	$15,000	$40,525
Food[2]	$2,920	$0	$2,920	$0	$2,920	$0
Health Care						
Fair Pharmacare[3]	$700		$2,275		$3,350	
Over-the-counter medication	$1,000		$1,000		$1,000	
Supplies (incontinence)	$600		$600		$600	
Dental/Vision/PT/ Hearing Aids	$2,000	$2,000	$2,000	$2,000	$2,000	$2,000
Personal Alarm System	$480		$480		$480	
Home Support[4]	$8,800	$0	$20,911	$0	$29,987	$0
Clothing/Personal Care	$1,200	$1,200	$1,200	$1,200	$1,200	$1,200
Telecommunications[5]	$1,760	$360	$1,760	$360	$1,760	$360
TOTAL EXPENSES	$34,540	$24,760	$48,146	$44,085	$58,297	$44,085
ANNUAL COST SAVINGS OF LONG-TERM CARE VS. HOME		$9,780		$4,061		$14,212

A senior with an income of $28,000 per year will save an estimated $9,780 per year living in long-term care versus living at home with two hours of daily home support, but the taxpayers will pay $36,875 more.

home than in a long-term care facility. A high-income senior with an income of $80,000 per year will spend just over $14,000 more over a year to live at home than in a care facility. The health care system, in contrast, will spend much more to care for them in a facility.

There are three main issues with the client contribution (co-payment):

- It renders home support unaffordable to many seniors, and as a result, seniors who would benefit from this service are not accessing it. In the end, this may cause greater financial burden on the system with higher use of other health care services such as physicians, the hospital, and long-term care facilities.
- It creates a financial incentive for seniors to move into a long-term care facility instead of remaining at home and receiving home support services. While this may be more economical for the senior, since the client contribution can be as much as 40% of after-tax income, it is costlier for government.
- It creates inequity based on the source of income rather than actual income. In the case of GIS, a single senior can have as much as $25,457 in income and still be receiving GIS. However, if their income is as much as $1 higher, they revert to a daily rate of roughly $20 for home support and will go from paying nothing to paying $7,200 per year for daily service. In the case of employment income, there is an inequity between those who either have employment income themselves or have a spouse earning income and those who do not.

THE HUMAN RESOURCE CHALLENGE

Home support is a challenging industry on many fronts, but most particularly in the recruiting and retaining of staff. The staff who deliver home support are formally referred to as Community Health Workers (CHWs). Regardless of the employer, almost all CHWs who deliver home support are members of a union that is part of the Community Subsector Collective Agreement. All CHWs have the same level of training, and are registered with the British Columbia Care Aide & Community Health Worker Registry.

Data from the Health Employers Association of BC (HEABC) indicate that just over 50% of CHWs are employed in a casual status. Even for those who are not casual and do receive benefits, few are able to achieve full-time work through a regular five-day-a-week, eight-hour shift. To a large measure, this issue has been created by the current design of the home support program. Restricted service authorizations for home support have resulted in a predominantly one hour per day service with heavy emphasis on morning service. The chart on the next page shows a typical distribution of service start times for a one-day period in southern Vancouver Island.

The data shows 248 CHWs are needed at 8:00 a.m. However, that number drops to:

- 222 for 9:00 a.m.
- 206 for 10:00 a.m.
- 159 and 149 for 11:00 a.m. and 12:00 p.m., respectively

By 1:00 p.m. the number moves up again, but at 203 CHWs, it is still 45 fewer workers than were needed at 8:00 a.m. Given that 90% or more of these start times represent either a 30 minute or one hour visit, it is clear that achieving full-time work with a standard, eight-hour day is extremely challenging.

This data helps to explain the apparent contradiction between employers who say they need more workers, and staff who complain of not receiving enough work. Employers in home support need more staff, but only for select hours, and CHWs are looking for regular, full-time employment.

NUMBER OF CHWS NEEDED AT EACH SHIFT START[42]

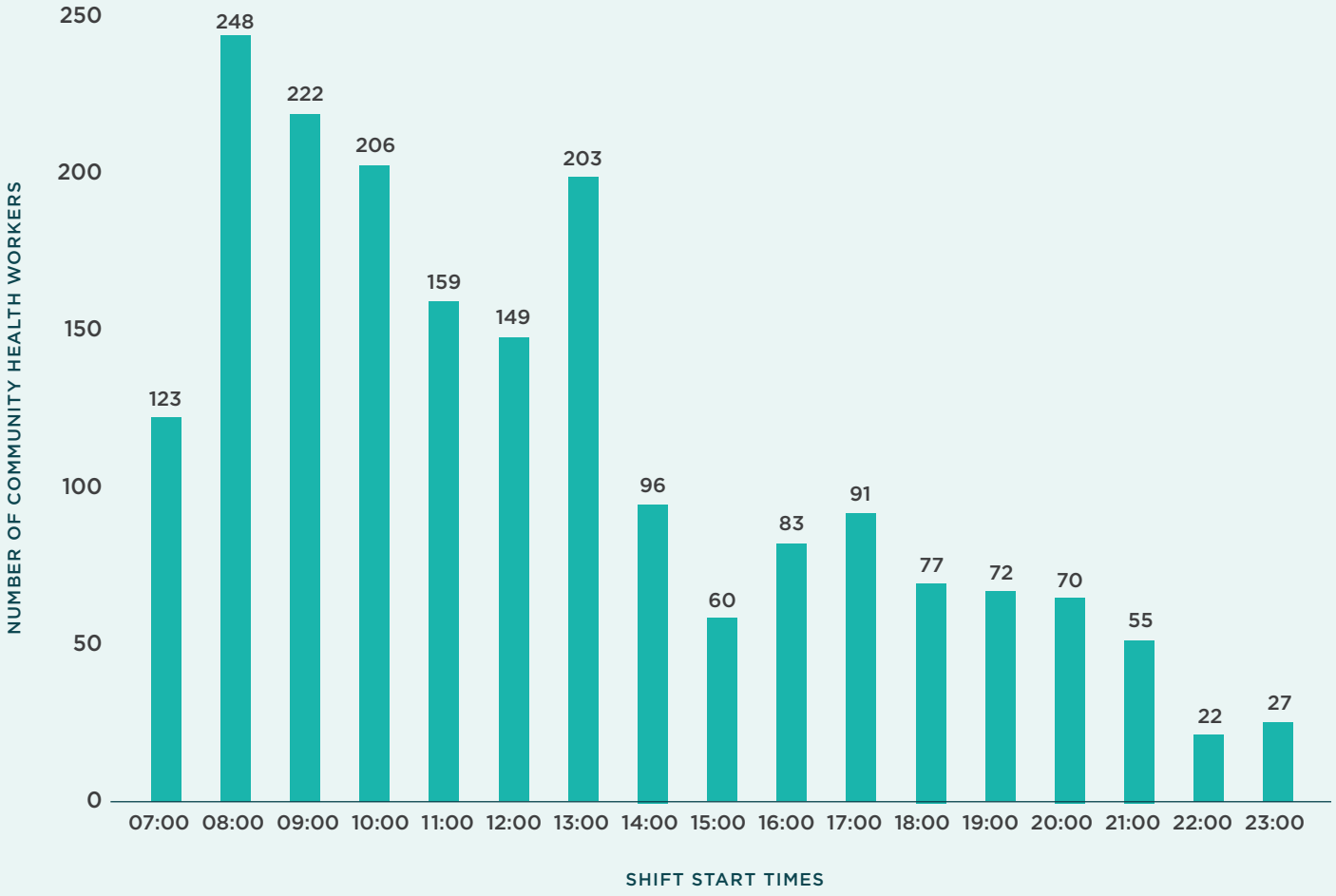


FIGURE 13

Expanding the scope of services provided in the home support program to include IADL assistance, and to enhance the existing ADL supports offered, will provide some increased ability for full-time work as there will be tasks and activities that can be done outside the 8:00 to 11:00 a.m. peak. More importantly, expanding the scope of services will also meet the goal of supporting seniors to remain living in their own homes for as long as possible. The current data suggests that adding services that can be delivered outside of the morning peak —for example, housekeeping, respite, drives, walking programs, meal preparation—could utilize capacity within the existing workforce.

However, despite current excess capacity in the afternoon and evenings, there is still an existing shortage of workers for the peak morning hours. When this is combined with the increased demand that will flow from an overall expansion of the home support program, it is clear the workforce needs to be increased now.

Recruitment and retention of home support is one the greatest challenges, if not *the* greatest challenge, within HCC staffing. In addition to lower rates of pay relative to other care aide positions, home support has the highest rate of casual workers and the lowest percentage of fulltime positions compared to any other health care occupation. When factoring in the requirement that staff own and operate their own vehicle and the uncertainty of schedules that change daily, it is clear we need to address aspects of the job that are unattractive to many potential recruits if we are to be successful in making home support a career choice.

75% of the CHW workforce is part-time or casual. This needs to change if we are to attract the workforce needed to meet demand.

As efforts to expand the workforce are examined, health authorities may wish to explore training models that take an apprenticeship-like approach. Offering potential CHWs a sponsored training program where they can receive a stipend while they train as an integrated part of the HCC team may prove a powerful inducement for new recruits and provide the health authorities with better trained and committed workers. In addition, employers may need to examine the compensation for CHWs in light of both the current labour market and the relative attractiveness of other similar health care jobs such as those in long-term care and acute care.

WHAT NEEDS TO CHANGE

The vast majority of seniors want to remain living in their own home and home support is a key service that is necessary for many to achieve this goal. Home support has demonstrated that it can be a cost-effective alternative to licensed long-term care. However, the evidence demonstrates that home support is falling short in many instances: it is unaffordable for most; fails to fully meet the needs of those receiving it; and is not being utilized by a number of seniors who could benefit from it. Notwithstanding this, there is an existing infrastructure upon which we can build that can increase the capacity of our current program and, by extension better support seniors.

The issues we need to address include:

1. AFFORDABILITY

Most will agree that the current client contribution requirement is placing public home support beyond the financial reach of many B.C. seniors. When a senior with an income of $27,800 is required to spend $8,800 a year for a daily visit of home support, it is time to examine the effectiveness of the funding model. The data present a strong argument for the need to make home support service affordable for all B.C. seniors and not just those on GIS or in receipt of employment income. Given that seniors are five times more likely to use home support if they are not required to pay for it and given that 61% of seniors admitted to long-term care received no home support in the 90 days prior to admission, the argument to remove the economic impediment for seniors to use home support is compelling.

RECOMMENDATION:

The Ministry of Health remove the financial barrier created through the current regulated daily rate co-payment. The OSA recommends an approach of refreshing the allowable deductions to address inflation, retaining the current GIS exemption, and either extending the earned income rate cap to all remaining recipients of service, or examining a more progressive assessment similar to Fair Pharmacare.

2. INFLEXIBLE SERVICE

There is significant research to support the need for a comprehensive home support program that looks at all the activities seniors require assistance with in order to achieve independence.

CHWs are a trained and willing workforce eager to offer more service; however, they simply must be given the flexibility to provide just-in-time service that responds to the changing needs of their clients. The care plan is an important tool to guide the CHW, but CHWs are capable of understanding changing situations. If a client is not able to get out of bed one day due to a bout of the flu, the CHW would be most helpful in perhaps ordering food for the client or doing extra loads of laundry, but if that is not in the care plan, the CHW is not empowered to demonstrate initiative. The home support program should move toward flexible care plans that ensure the important aspects of care are delivered but also allow for a more responsive, holistic approach on the part of the CHW. By placing some autonomy in the hands of the people providing care to respond just-in-time to emerging service needs (assuming that there is no risk of injury for the worker and time allows), issues such as "I can heat up the dinner for you but not for your husband" will be addressed.

RECOMMENDATION:

The health authorities collaborate to design a standardized care plan for use throughout the province. The care plans must be sufficiently expansive and flexible to allow the CHW to meet the changing needs of the client and to support the client's family in caring for their loved one. Cleaning, full meal preparation, assisting with telephone orders, laundry, additional bathing, watering plants, and taking out garbage are all types of activities that CHWs should be empowered to do for the client or their caregiver on an as-needed basis.

3. NARROW SCOPE

We must look at the totality of needs—both ADL and IADL—and achieve a culture shift away from "this is what we will do" to one of "what can we do to help." It is not enough to simply get someone up and dressed in the morning. Medical appointments need to be scheduled, groceries ordered, bills paid, homes cleaned, toilets scrubbed, and social needs met. While many families willingly take this on for their loved ones, there are some seniors for whom there is no assistance in these areas. Assistance with ADLs is of limited to no use if a senior cannot adequately manage their IADLs. Providing more holistic support can be met to some extent by providing more flexibility for the CHW in the work they can do in the home; however, we must achieve better overall coordination of support services. This may require re-examining the role of the case manager, which has, over time, shifted to become a function of referring clients to services rather than direct coordination. Working as a team, CHWs and case managers have the necessary insights into the totality of a client's needs, but require the resources and supporting policies to ensure these needs are met.

RECOMMENDATION:

The Ministry of Health, in collaboration with representatives for case managers from all health authorities, examine the role of case management and determine if current resources are adequate to meet the demonstrated need for greater management and co-ordination of services within the existing, and a potentially expanded, home support client population.

4. OVERBURDENED FAMILY CAREGIVERS

Family caregivers are supporting 96% of the home support clients in this province and are keeping many seniors out of long-term care facilities and hospitals. These caregivers are in desperate need of help, with almost one-third in actual distress. The evidence is clear that more home support and, specifically, more respite is critically required. If overwhelmed family members are no longer able to cope, the health care system will be consumed by caring for the over 30,000 seniors that will be living in care homes or the hospital once the benevolence of their loved ones can no longer be depended upon. The data showing the level of caregiver distress at 62% for clients admitted to long-term care and the lack of service we provided to them prior to admission should serve as a catalyst for needed change.

RECOMMENDATION:

Support for family caregivers must be embedded as a goal of care within the care plan. Family caregivers need to be supported with a minimum of eight hours of respite per week if required. Where caregivers are in distress, a full review needs to be undertaken to ensure that the caregiver is receiving all possible supports through home support, adult day programs, and facility respite.

5. INCONSISTENT AND INCOMPLETE INFORMATION

We need to better empower seniors and their family members with the knowledge of what is available and what services they are entitled to receive. Currently, each health authority produces its own version of what home support will deliver and to whom. Policies are usually communicated verbally, and seniors and family members will often receive conflicting answers to their questions or learn that other families have been told something different. Seniors and their families need clear and consistent information on the provincial supports that are available to them. They also need a timely complaint process to follow if they are not provided the supports they are entitled to receive. The stories and the data speak to the imperative for seniors

and family members to have issues resolved quickly; this means in hours or days, not weeks or months. This will require a system for redress that is much more nimble and responsive than currently exists within health authorities.

RECOMMENDATION:
The Ministry of Health produce a standardized document for clients and their family members that clearly outlines the home support services they can expect to receive and the assessment process that will be used to determine eligibility. Information on how to access a time-sensitive complaint process if they are not receiving the services they are entitled to receive should also form part of the document.

6. CLIENT DIRECT FUNDING

For clients with high care needs and/or those who live in more rural and remote areas, we must find a more flexible form of client direct funding than CSIL. Some families, especially those who live in rural areas, may be able to keep their loved one at home if they were given the financial assistance and flexibility of client direct funding.

If faced with the move to a long-term care facility, considerations for allocation of client direct funding should balance the financial cost to the family of keeping a loved one at home against the financial burden to the health care system in placing them in a long-term care facility. If a family is willing and able to coordinate the hiring and supervision of care staff in order to keep a loved one deemed eligible for long-term at home instead, client direct funding up to the equivalent subsidy that client would receive in long-term care should be considered.

RECOMMENDATION:
The Ministry of Health develop a program for client direct funding that is flexible and accessible. The emphasis should be on high needs clients and clients living in rural and remote areas

7. WORKING CONDITIONS FOR COMMUNITY HEALTH WORKERS

The ability to realize the full potential of home support requires a skilled and sufficient workforce. The structural nature of home support creates challenges in recruiting CHWs. The high percentage of casual and part-time jobs, the requirement to have a vehicle, and the lack of predictability in scheduling are all issues that need to be addressed in a recruitment and retention strategy.

RECOMMENDATION:
The health authorities work collectively through HEABC to examine the incentives that are necessary to successfully recruit and retain CHWs. These incentives could include paid training, increased compensation, and stable part-time as well as full-time positions.

THE FUTURE

These changes are within our grasp, and the need is compelling when viewed through both a compassionate and economic lens. Seniors want to live independently for as long as possible and family members want to support their loved ones to live at home. Our health care system, which does offer many supports to seniors, still has many opportunities to improve, particularly in the delivery of home support. Through better support of seniors living at home, we can improve quality of life for seniors and their families while also improving our overall health care system through ensuring that people receive the right service, at the right time, in the right place.

ENDNOTES AND REFERENCES

[1] Source: Statistics Canada, *2016 Census*

[2] Source: B.C. Ministry of Health, *Health System Matrix*, 2017/18

[3] Source: B.C. Ministry of Health health authority data submissions

[4] Unless explicitly stated, all home support statistics in this report include both short- and long-term service, but exclude Choices in Supports for Independent Living (CSIL) service.

[5] Source: Employment and Social Development Canada, *Old Age Security (OAS) - Number of Persons Receiving OAS Benefits, by Province and by Type*

[6] Source: Office of the Seniors Advocate, *Monitoring Seniors Services 2018*

[7] Source: B.C. Ministry of Health health authority data submissions

[8] Source: *Home Care Reporting System* and *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[9] Source: Employment and Social Development Canada, *Old Age Security (OAS) - Number of Persons Receiving OAS Benefits, by Province and by Type*

[10] Source: Veterans Affairs Canada, *War Veterans Allowance statistics*

[11] Source: B.C. Ministry of Finance

[12] Source: B.C. Ministry of Health, *Health Authority Rates Setting*

[13] Source: Office of the Seniors Advocate, *Monitoring Seniors Services 2018*

[14] Source: B.C. Ministry of Health, *Home and Community Care Client Counts and Service Volumes*

[15] Source: B.C. Stats, *Population Estimates*

[16] Source: B.C. Ministry of Health, *Home and Community Care Age Standardized Rates*

[17] Source: B.C. Ministry of Health, *Home and Community Care Age Standardized Rates*

[18] Source: B.C. Ministry of Health, *Home and Community Care Client Counts and Service Volumes*

[19] Source: B.C. Ministry of Health, *Health System Matrix*, 2017/18

[20] Source: *Home Care Reporting System* and *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[21] Source: *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[22] Source: *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[23] Source: Health Council of Canada, *Seniors In Need, Caregivers In Distress: What Are The Home Care Priorities For Seniors In Canada?*

[24] Source: *Home Care Reporting System and Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[25] Source: *Home Care Reporting System* and *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[26] Source: *Home Care Reporting System* and *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[27] Source: Canadian Institute for Health Information, eReports

[28] Source: *Home Care Reporting System* and *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[29] Source: *Home Care Reporting System* and *Home and Community Care Minimum Reporting Requirements*, 2017/18 long-term home support recipients

[30] Source: *Continuing Care Reporting System*

[31] Source: *Home and Community Care Minimum Reporting Requirements*

[32] Source: *Home Care Reporting System* and *Home and Community Care Minimum Reporting Requirements*

[33] Source: Fraser Health Authority and Vancouver Coastal Health Authority

[34] Source: Canadian Institute for Health Information, *Your Health System: Insights*

[35] Source: *Home and Community Care Minimum Reporting Requirements and Discharge Abstract Database*

[36] Source: Island Health Authority

[37] Source: *Home and Community Care Minimum Reporting Requirements*, 2017/18 short-term home support recipients

[38] Source: *Home and Community Care Minimum Reporting Requirements*

[39] Source: *Home and Community Care Minimum Reporting Requirements*

[40] Source: Personal Social Services Research Unit, *Evaluation of the personal health budget pilot programme*

[41] Source: Office of the Seniors Advocate, *Caregivers in Distress: a Growing Problem*

[42] Source: Beacon Community Services, *Community hours by start time*

NOTES FROM TABLE ON PAGE 48

[1] *Housing is assumed to be approximately $15,000 per year based on either an average rent of $1025 or an averagecost of home ownership including taxes, strata fees, insurance, repairs and maintenance.*

[2] *Food costs of $8 per day is based on the average cost per day of food in long term care facilities (Quick Facts Directory)*

[3] *Pharmacare costs are based on the Annual Family Maximum (Fair Pharmacare Calculator)*

[4] *The cost of home support is calculated based on the BC Continuing Care Fees Regulation*

[5] *Telecommunications charges are based on $30 per month for telphone for both home and long-term care and $130 per month for TV/Internet for those at home*

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