Home and Community Care Redesign

2002-03 to 2004-05

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Introduction:

Based on the New Era goals of the Government of British Columbia, major strategic shifts are underway within health care. To achieve the goals of high quality, patient centered care in an affordable and sustainable public health care system, the Home and Community Care system must lead the way in strategic redesign initiatives. The Home and Community Care system of the future, must:

- Provide responsive and appropriate services to support individuals and their caregivers in remaining in the community
- Provide appropriate and high quality services in a residential setting for individuals who need this specialized environment
- Provide responsive and appropriate care to individuals who do not require the acute care setting, but do require a stay in a therapeutic environment prior to returning home
- Provide responsive and appropriate support to the caregiver
- Mobilize community based volunteers and agencies to provide the network of support necessary to individuals living in communities

Home and Community services provide a range of health and support services that are designed to supplement the efforts of individuals to care for themselves with the assistance of family and friends. The goals and plans outlined in this document have been developed for consistency with:

- The Ministry of Health Services and Planning redesign principles and policies,
- The recommendations of the Community for Life Report (Review of Continuing Care Services in British Columbia,
- The Quality Framework of responsiveness, system competency, client and community focus, and worklife

Access to Home and Community services will be **responsive** to client and caregiver needs and ensure appropriate options are available when needed. Improved assessment tools will ensure consistency in determining client goals and needs, and ensure appropriate care plans are implemented. Service delivery options may be different from what has been provided in the past, but these options will be evidence based and built upon best practices and shared learning.

System competency will be reflected in the Interior Health ability to meet emerging service needs through new service delivery options (ie. Assisted Living), and demonstrated in staff developing service plans based on **both client and community** capacity.

The ability of the system and staff to deliver services that are responsive and appropriate will create **a work environment** that values creativity and requires communication and learning.

Interior Health's goals for Home and Community Care redesign are:

1. **To ensure home and community based services provide clients with the option of remaining as independent as possible in their own homes**.

Consultation within the region and across the province with clients and caregivers has provided direction to service planners to increase the range of services available, including targeted strategies to support caregivers. This is consistent with an international trend away from a dependence upon residential care as the only option when care needs increase. Strategies for reaching this goal include: appropriately expanding services to 24/7, increasing respite services, providing expanded rehabilitation services, providing geriatric assessment and treatment services and expanding Adult Day Program services.

Outcomes of this goal will be: a decrease in the admission of clients with lower assessed care needs into residential care; a corresponding increase in the proportion of clients receiving services in the community; and the emergence of efficient/ effective models of care. An outcome to be avoided is an increase in caregiver burden for the caregivers of community living clients.

2. **To focus our residential services to clients with high and complex care needs.**

The increased range of community and home based services will create a change in the criteria for admission to residential care. A shift is already being experienced in the presenting care needs of clients that would benefit from 24 hour professional care but for whom an acute care setting is inappropriate or for whom home or community based services become inadequate. The types of services provided in the residential care setting will include palliation, respite, transitional/reactivation, and convalescent care in addition to traditional residential care with specialized care for dementia clients. Strategies for achieving this shift in care will include: upgrading or replacing physical plants that are inappropriate for high care needs; reallocation of resources to high needs and specialized units (complex medical care or complex dementia care): and, consistently applying best practice models within residential care.

The outcome of these strategies will be: the implementation of a needs based priority residential access list (based upon provincial policy), an increase in the care levels at which clients are admitted to residential care; a decrease in the proportion of clients receiving residential care; an increase in the number of beds designated as complex/ specialized care; and, an increase in the number of specialized units to meet sub acute health needs.

3. **To continue to alleviate system pressure.**

Timely access to appropriate services is a key indicator of delivering effective services. Home and Community Care services must continue to meet a range of needs by providing expanded service choices and options. A lack of capacity in any part of the service system will result in inappropriate use of other services and waitlists. Strategies include provision of information and referral services (HealthLink), expansion of acute substitution services (i.e., Home IV programs), development of convalescent services, and continued improvement in discharge and care coordination across the service continuum.

Outcomes expected will be a decrease in ALC length of stay, the development of client and service provider `friendly' referral and access systems, and improved coordination.

4. In partnership with Housing Agencies, increase the number of units and the range of housing environments into which personal and professional care can be provided.

A key premise of Home and Community Care redesign is the role of emerging best practice housing models in which the preferred environment for maintaining clients' functional independence is in their own home. Supporting people to function in their own environments and supported by their social networks builds on the individuals functional capacity and maintains independence. Assisted Living and Dementia Cottages are two housing models that are being piloted in BC and have been successfully implemented in other jurisdictions. Strategies for increasing the capacity of affordable housing environments into which personal and scheduled professional care can be provided are: converting existing subsidized housing; developing partnerships with housing providers both non profit and private; piloting and developing assisted living models; and developing housing options for target populations.

Outcomes expected are an increase in the number of assisted living units, a decrease in placement admissions to residential care, and a decrease in ALC .

5. Implementing Population Health Promotion initiatives to support healthy aging and to prevent deterioration of chronic conditions.

Taking a population health promotion approach to health issues is a critical component of any service plan. Priority initiatives in this plan are: diabetes education; injury and falls prevention; and, immunization programs.

Outcomes will be: a decrease in the incidence of falls in seniors; a decrease in unplanned admissions to acute care; a decrease in secondary and tertiary complications of diabetes; and, a decrease in unplanned admission caused by influenza.

6. Development of the infrastructure necessary to support renewal.

Effective implementation of the Home and Community Care redesign is dependent on the concurrent development and strengthening of the infrastructure to support the programs and services. Infrastructure development includes:

- information systems and technology to support sharing of clinical information and communication;
- the implementation of the InterRai suite of tools to support assessment and care planning by service providers;
- development and implementation of IH policies to support service delivery (i.e., priority access list management and risk tools)
- the provision of appropriate physical plant and leased space;
- implementation of programs to support practice change, including pilot projects to facilitate modeling and shared learning experiences;
- a human resource plan to ensure recruitment and retention of staff; and,
- a communication plan regarding service choices, healthy aging, and access to services.

The following planning principles are being used within Interior Health to achieve Home and Community Care redesign:

Residential Bed Planning Principles

Currently Interior Health has 90 residential care beds/ thousand population over the age of 75. A bed planning target of 75 residential beds/thousand population over the age of 75 for urban areas and 82.5 residential bed/ thousand population over the age of 75 for rural areas will be used to determine facility closure, upgrading, and redevelopment priorities. Overall planning for residential care will include: the closure of facilities unable to meet future needs due to physical plant constraints, the upgrading of both staffing levels and physical plants to provide care to higher needs clients, and the replacement of beds with new facilities designed to meet service needs.

Supportive Living and Assisted Living Planning Principles

Currently Interior Health is piloting affordable assisted living units in the Okanagan. For purposes of planning capacity, the strategies for the next three years are based upon achieving six assisted living units/ 1000 population over the age of 65.

Home Care Planning Principles

Service standards for providing personal care and caregiver support within Home Care are currently being implemented across Interior Health. Reinvestment of resources will be into programs that support clients requiring health monitoring, service coordination and personal assistance to remain in the community as long as possible. Other priorities will be for specialized clinical home and community based services to prevent acute care admission and to facilitate timely return to home.

Preparation of This Plan

The Home & Community Care Redesign plan has been completed based upon the Ministry of Health Services performance and service standards, the principles of Community for Life Report, the planning already done in consultation with communities through the Continuing Care Renewal planning process, and in consultation with the Service Provider Managers and Leadership Teams of the Health Service Areas within Interior Health. Individual development plans have been prepared for and in consultation with each Health Service Delivery Area, which are summarized in this document's tables and appendices. A regional meeting of Service Managers was held in Kelowna on February 14th & 15th to discuss and address the utilization targets and strategies with approximately 40 people attending from all Health Service Delivery Areas. A presentation of Home and Community Care Redesign was also completed at the Regional Management meeting, March 11, 2002 in Kelowna. The drafts of this report have also been distributed to various management levels throughout this process. Feedback received at various presentations and discussions have been incorporated into the report or appendix to this document for further discussion.

Service Redesign

Residential Care

Introduction

Currently there are no standards for the `right' number of residential beds. The average age of individuals residing in residential care facilities is over the age of 80 years. Planning for beds is currently based upon the size of the population over the age of 75 years. In future, planning may be based on the over 80 population. Across Canada, the average is 101 beds per 1,000 population over the age of 75 (2000), Saskatchewan at 121 beds per 1,000 population over the age of 75 is one of the highest in Canada and BC is estimated to be 104 beds per 1,000 population over the age of 75 (Source: Saskatchewan Commission on Medicare, Ministry of Health 1999 bed numbers and People 25). It is generally accepted that within Canada, we admit people into the residential care environment too early, primarily because of a lack of alternative settings into which appropriate support and personal care can be provided. Consultation with clients and caregivers has clearly indicated that admission to residential care is not their preferred choice - often it is there only choice.

European countries have a much lower rate of institutionalization than Canada, and Alberta is considered the leader in Canada in providing non-residential service options based on the European experience. Factors that need to be considered in setting targets for beds include:

- the array of community services both publicly funded, non profit, and volunteer based that is available to the population;
- availability and flexibility of affordable housing options into which care services can be made available;
- the availability of both residential and acute `substitutionary care' (i.e., palliative, geriatric assessment, transition, reactivation and convalescent);
- the use of effective case management models of care to support people living in the community;
- the application of emerging information, based on experience and research, regarding the type of services that support clients and caregivers to live independently in the community; and
- our willingness to be challenged in our current assumptions about service delivery models.

For planning purposes, Interior Health has set a target of 75 beds/ 1000 population over the age of 75 for urban health service areas (Okanagan and Thompson) and 82.5 beds/ 1000 population over the age of 75 for rural (Cariboo Chilcotin, Kootenay Boundary, and East Kootenay) health service areas. With the aging of the population over the next 5 years, this ratio beds to thousand population will decrease, however the following trends will also need to be considered and monitored:

- Admission to residential care will occur later in life (offsetting need for beds)

- Many clients who would have accessed residential care in the past will avoid residential care in the future because of alternative service delivery (offsetting need for beds)
- The length of stay of an individual newly admitted to residential care is measured in months rather than years. This means that overall capacity of existing beds is improved (offsetting the need for beds).
- The use of residential bed capacity for non placement programs that substitute for acute care (i.e., convalescent, palliative) and meet the episodic needs of community living clients (i.e., reactivation, geriatric assessment) (potentially increasing the need for beds)

Reasonable proximity to residential care will remain important for maintaining social networks for individuals requiring this environment. However as the beds/1000 population decrease and the importance of maintaining a reasonable number of beds per site (for operating efficiencies), proximity will decrease for individuals living outside population centers.

Recommendations for Site Closures and Redevelopment

Due to the disruption and stress for residents living in facilities identified for closures, and their families, information regarding the future of specific sites is extremely sensitive. Prior to publicly announcing the future of these sites, thorough plans will be developed to ensure:

- Alternative capacity is being developed within the community,
- That individual residents and their family members are spoken to in person and that staff have had an opportunity to meet with them to discuss their care options, and
- That staff impacted are advised in a caring and respectful manner.

Clients living in residential care facilities will be moved on a priority basis into alternative settings according to their needs and preferences and with minimum disruption.

Discussions have been held with the Health Service Delivery Area managers responsible for residential care. Recommendations for site closures are based upon the following;

- Sites are unable to meet the care needs of clients with high and complex care needs. (NOTE: These recommendations have been assessed against the preliminary results of the HSG report provided in March)
- Closure of complete sites is preferred to provide resources for reinvestment into Assisted Living and community based options;
- Alignment with plans to increase community capacity
- Recommendations of the acute care role review to ensure adequacy of total beds at a site needed to maintain efficiencies;
- Alignment with the planning parameter of beds per thousand population over 75
- Planning already underway by the Health Service Areas management team;

Residential Bed Plan Assumptions:

- Needs based priority residential access list will be implemented consistently across Interior Health. This will be supported through provincial and IH policy, implementation of improved assessment tools, and consistent application of a risk assessment tool
- Identified bed closures will generate, on average $115 per bed/ day in savings (including the loss of revenue of an average resident contribution of $30/bed/day)
- Funding reallocations will occur to address staffing adjustments for the remaining sites that will be responsible for meeting higher and specialized care needs
- Funding (i.e., through disposition of assets) will be available to complete capital projects at the remaining sites to adapt the physical plant to providing higher levels of care.
- Funding reallocations will occur to facilitate bed redevelopment to ensure bed capacity is not compromised.

Table 1: Residential Care Services by Health Service Area

Health Service Delivery Area	EK HSA	WKB HSA	OK HSA	TCC HSA	Interior Health
Actual # Beds (March, 2002)	524	739	2,682	763	4,708
Current Beds/1000 pop'n 75+	108	121	81	86	90
Target # Beds @ 75 beds/1,000 (with additional 10% rural factor if applicable)	399	503	2,475	674	4051
Number of beds to reduce	125	236	202	89	652
Bed reductions # and closures	139	212	203	97	651
Add New Residential Beds	59	115	375	188	737
Less beds converted to new	58	139	482	225	904
Revised Bed Plan #	386	503	2,372	629	3890
Revised beds/1000 pop'n 75+	79.9	82.5	71.8	71.3	73.7

Project Upgrades and Redevelopment Priorities

Priorities for projects are determined using the following criteria:

- Alignment with the strategic directions of Interior Health and the Ministries of Health including Home and Community Care Redesign.
- Alignment to the residential bed planning model and current and projected target bed goals for each Health Service area and communities as appropriate.

- Alignment of the functional capacity of facilities to accommodate the higher levels of care in communities.
- Safety, capacity, suitability, effectiveness, efficiency and innovation of projects and facilities.
- Timeliness of projects to proceed, those already started receive priority provided other criteria are appropriate.
- Priorities should consider the opportunity for long-term development and improvements to residential care facilities.

Functional Assessment of Residential Care Facilities

A functional assessment of residential care facilities is in process with the preliminary report received March 8, 2002. The Health Services Group has, as a provincial initiative, assessed all facilities in the province to a common standard. The assessment process includes a physical and functional assessment. The report has assisted Interior Health Authority in assessing facilities into three categories;

1. Facilities that are physically in good condition and meet the functional requirements of anticipated care levels of residents in facilities at approximately a 50 % IC3 and 50% EC level. These facilities are appropriate for capital maintenance and minor upgrades.
2. Facilities that have the capital capacity for upgrades to be moved into category 1, that is the value of capital improvements required does not exceed the capital value of the asset.
3. Facilities that are beyond their useful life and require physical or functional improvements that exceed the value of the asset.

The residential bed plan to date has considered the recommendations of this preliminary report and assessments of facilities as completed to date. The final report will be reviewed and further recommendations may be considered.

Assisted Living

Introduction

Assisted Living is a new model of care that can be both a substitute for residential care and an effective (both from cost and client outcome) community based service model. A recent Health Services Utilization and Research Commission study suggest that social housing for seniors may be of greater benefit than home care in maintaining independence. Experience with assisted living in Edmonton has demonstrated that individuals living in supportive and assisted housing avoid accessing residential care in the last few months or years of life.

Within B.C., 3500 subsidized housing units for seniors assisted living units will be made available through BC Housing Management Commission over the next three years. BC Housing funding will provide housing subsidies, and the Health Authorities will be responsible for funding the care component from within existing dollars. Affordable assisted living will be created both within existing seniors housing and through new builds in partnership with both non profit agencies and private providers.

The Interior Health Home and Community Care Redesign plan includes the capacity for 6 assisted living units/ 1000 population over 65. A standard for the availability of affordable Assisted Living has not been developed yet in Canada or in BC.

Proximity to supportive and assisted housing will be improved for the population served by Interior Health as clients with health needs will be encouraged to try the full range of community based options prior to residential care being considered.

Recommendation for Allocation of Assisted Living Units

- Based on population target of 6 units/ 1000 population over 65
- Availability of existing seniors housing project under BC Housing programs
- Accessing BC Housing methodology for determining housing need
- Opportunities to incorporate assisted living into residential site redevelopment
- Availability of community capacity to provide affordable housing and supportive living non profit societies
- Interest of private providers in providing affordable supportive living projects into a community

Table 2: Assisted Living Units by Health Service Delivery Area

Health Service Delivery Area	EK HSDA	WKB HSDA	Ok HSDA	TCC HSDA	Interior Health
Actual Units (March, 2002)					
Current Units/1000 pop'n 65+					
Target Units @ 6 /1,000 pop'n 65+	74	86	418	137	715

Home Care

Introduction

Access to Home and Community based care will be critical, as an increasing proportion of clients will be supported in the community. Health Service Areas will need to examine the operational delivery of Home Care services to ensure:

- Best practices in case management are implemented
- Staff roles and responsibilities resulting from changes in service delivery models are reviewed and adjusted
- Opportunities for group services are maximized (i.e., through cluster scheduling, adult day programs)
- Care maps and clinical pathways for post acute are developed and implemented
- Standards are established for distances traveled to provide in home care

- Nursing clinics are established
- Staff scheduling approaches permit responsiveness to fluctuating workload and retaining staff (a human resources issue given collective agreement language)

Across Interior Health, the standard for home support services levels will be based on meeting personal care needs and supporting the informal caregiver (i.e., respite options and education).

Table 3: Home Support Services By Health Service Delivery Area

Health Service Delivery Area	EK HSDA	WKB HSDA	Ok HSDA	TCC HSDA	Interior Health
Actual Hours 00/01[1]	161,791	211,675	586,795	216,812	1,177,074
Current Hrs/1000 pop'n 65+	14730	16057	9962	9243	10968
T					
N					
Year 2005 Hours @ /1,000					
Year 2007 beds @ /1,000					

Target hours will be determined following a review of service standards implemented

Performance Targets

In February 2002, the Ministry of Health Services issued Performance Agreements for April 2002 through March 2003 for all Health Authorities. The performance measures listed below are the Ministry of Health Services expectations of Home and Community Care redesign initiatives over the next three years.

Expected Performance

- Full implementation of the new assessment tool for home care (MDS-HC) over the next three years.

- Full implementation of the new assessment tool for residential care (MDS V2.0) over the next five years.

    a) Increase the percentage of home and community care clients with high care needs living in their own home, specifically:

    Target 02/03 2 % increase
    Target 03/04 5 % increase
    Target 04/05 5 % increase

Performance Expectation 1

[1] Source: Continuing Care Data Warehouse: MOH

Implement the Residential Admission Policy limiting admittance to those clients with complex care needs (IC3 and EC). Measured by an increase in each of the next three years in the ratio of IC3 and EC clients to IC2 and PC clients

Performance Expectation 2

Implement the Palliative Benefits Program. Measured by an increase in each of the next three years in the percentage of clients dying at home and in hospice, compared to in hospital, and a decrease in the average length of stay in hospital for palliative care clients

Performance Expectation 3

Implement alternative services, such as enhanced home based services or transitional care, to achieve in each of the next three years:

- decreases in inappropriate emergency visits by HCC clients,
- decreases in admissions to acute care hospitals of HCC clients, and
- increases in early discharges of HCC clients from hospitals.

Performance Expectation 4

Implement alternative services, such as integrated primary health care programs for the frail elderly, to achieve decreases over the next three years in the inappropriate admissions to residential facilities

Performance Measure

Percentage of home and community care clients with high care needs living in their own home (in Agreement)

Target 02/03: 2% increase in the number living at home
Target 03/04: 5% increase in the number living at home
Target 04/05: 5% increase in the number living at home

Alternative level of care days as a percentage of total inpatient days

Target 02/03: 5% decrease
Target 03/04 5% decrease
Target 04/05: 5% decrease

In addition to the Ministry of Health Service performance measures, Interior Health is in the process of developing indicators that would show progress towards meeting the goals of Home and Community Care Redesign. These measures may include:

- Alternate Levels of Care/1000 population 65+ years (cases and days)
- Rates of Unplanned Acute Care admissions for selected conditions (hip fracture, influenza, and pneumonia)
- Utilization rates of home care nursing and community rehabilitation programs
- Home Support Hour trends (by care levels, by 1000 population 65+ years)

Appendix 1: Inventory of Residential Care Facilities

Health Service Delivery Area	EK HSA	WKB HSA	OK HSA	TCC HSA	Interior Health
Number of facilities	15	17	43	12	87
Number of private owners	1	2	14	1	18
Facilities with reductions	1	2	3	1	7
Facilities for closure	6	6	10	4	26
New or replacement facilities	1	2	4 or 5	2	9 or 10

Appendix 2: East Kootenay Health Service Area

LHA Name	Current Beds	Bed Target	Bed Reduction	Bed Redevelopment Priority	Revised Bed Plan
Fernie and area (including Sparwood and Elkford)	58	50		50 -58	50
Cranbrook and area	167	119	60		107
Creston and Area	173	107	50		123
Kimberly and Area	69	59	18		51
Windermere and Area	20	38	0	9	29
Golden	37	25	11		26
Total	524	399	139	1	386

Comments:

- Plan reduces bed numbers slightly below target bed numbers
- Windermere and area should be priority for assisted living development in recognition of actual beds to target
- Achievement of dollar targets to be confirmed once actual operating grants are confirmed
- Allocation of assisted living still to be determined, however known opportunities exist in Sparwood, Cranbrook, Kimberly and Creston.

Appendix 3: West Kootenay Boundary Service Area

LHA Name	Current Beds	Bed Target	Bed Reductions	Bed Redevelopment	Revised Bed Plan
Arrow Lakes	66	31	32		34
Grand Forks and Kettle Valley /Boundary	96	88	29		67
Castlegar	105	74	0		105
Nelson and Area	196	154	65	85 -79	137
Trail (includes Rossland)	276	156	127	30 -60	160
Total	739	503	212		503

Comments:

- Plan meets target bed numbers
- Achievement of dollar targets to be confirmed once actual operating grants are confirmed
- Allocation of assisted living still to be determined, however known opportunities exist in Trail and Castlegar

Appendix 4: Okanagan Health Service Area

LHA Name	Current Beds	Bed Target	Bed Reductions	Bed Redevelopment	Revised Bed Plan
Central Okanagan (Kelowna, Westbank, Lake Country, Peachland)	1077	1019	58		1019
Penticton (in conjunction with Summerland)	396	386	48	100 -82	366
Summerland (in conjunction with Penticton)	164	115	0	75 -114	125
Princeton (in conjunction with Keremeos)	36	26	0		36
Keremeos (in conjunction with Princeton)	25	40	0		25
Revelstoke	49	29	21		28
Salmon Arm	202	209		75 -101	181
South Okanagan (Oliver, Osoyoos)	196	191	5		190
Vernon (in conjunction with Armstrong and Enderby)	415	370	55	125 -154	331
Armstrong/ Spallumchen (in conjunction with Vernon and Enderby)	70	50		-30	40
Enderby (in conjunction with Vernon and Armstrong)	47	41	16		31
Total	2682	2475	203	-107	2372

Comments:

- Achievement of dollar targets to be confirmed once actual operating grants are confirmed
- Allocation of assisted living still to be determined, however known opportunities exist in Penticton and Revelstoke. Currently 20 units operating in the Central Okanagan and an additional 35 coming on-stream in Sept 2002.
- The communities of Princeton and Keremeos are considered combined in terms of overall beds to population
- The communities of Summerland and Penticton are considered combined in terms of beds to combinations.
- Redevelopment of beds in Penticton has been awarded through a tender process

Appendix 5: Thompson/Caribou/Chilcotin Health Service Delivery Area

LHA Name	Current Beds	Bed Target	Bed Reductions	Bed Redevelopment	Revised Bed Plan (after closures)
Kamloops	492	434	64	102 -153	377
North Thompson	0	14	0	21	21
Lillooet	22	16	0		22
South Cariboo	24	32	0		24
Merritt	55	43	0		55
100 Mile House	65	63	0		65
Cariboo/ Chilcotin	105	73	33	65 -72	65
Total	763	674	107	-37	629

Comments:

- Plan exceeds target bed number
- Achievement of dollar targets to be confirmed once actual operating grants are confirmed
- Allocation of assisted living still to be determined.