HEALTH ASSOCIATION NOVA SCOTIA

Rising to the Challenge: Responding to Increasing Demands in Home Care

A report prepared by Health Association Nova Scotia for the
Home Care Network in collaboration with the Department of Health and Wellness
and the District Health Authorities

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Meeting Increasing Demands for Home Care

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EXECUTIVE SUMMARY

Enhancing the delivery of home care services and helping people to live well in their homes and communities for as long as possible, is a strategic priority for the Nova Scotia Department of Health and Wellness (DHW) and one that is shared by home support agencies as well. Nova Scotia, like other Canadian provinces and the western world in general, is challenged with effectively responding to the care needs of an aging population. In fact, Nova Scotia has the oldest population per capita in Canada and the proportion of Nova Scotians aged 65 or older is expected to increase from approximately 17.7% to 25% by 2026. This is creating an impetus for a shift from acute to home and community based care. Expanding access to home care services, as well as the range of support services available, is increasingly being considered as a solution for reducing the wait lists for long term care and home care, reducing the number of clients waiting in hospital for long term care placement, and ultimately, ensuring that Nova Scotians receive the right care, at the right place, at the right time.

Home support agencies also support this strategic focus but have concerns about the limits of their capacity to provide services, now and into the future, and wish to proactively identify ways to improve the system to ensure the sector is well positioned to manage the rising demands for care going forward. Despite provincial government increases in the home care budget, wait lists for home care services persist, particularly in District 9, and greater pressures are being placed on both district staff and home support agencies province-wide to respond more quickly.

Purpose and Scope

The provincial Home Care Network, comprised of operators of home support agencies in the province, identified this issue as a strategic priority in the fall of 2013 and developed a working group to "determine how the sector can best prepare to effectively respond to increased demand for services in a way that is collaborative, client and family centred, accessible, affordable and sustainable." A Working Group with representation from the Home Care Network, District Health Authority (DHA) Vice Presidents of Community Services, and the Continuing Care Branch of the DHW, and the support of Health Association Nova Scotia, was formed to identify current and future challenges and bring forward recommendations to increase the capacity of the home care sector.

The Working Group met to identify issues and barriers and develop potential solutions. A review of relevant literature was conducted to inform the group's work and to support the development of evidence-based recommendations.

Providing a broader array of services and supports to enable people to remain home and improving access to existing home care services will be critically important to enable home care to meet the current and projected future increases in demand for care. The recommendations offered are designed to address these two key points and are summarized below. Some

recommendations will require further work to determine their feasibility and implementation processes, while others can begin immediately.

The Working Group believes adopting this approach will better position the sector to respond to current and anticipated future demands for care at home and indeed, enable Nova Scotians to remain at home where they want to be.

Nova Scotia is seen as a leader in Home Care across Canada and the recommendations provided are intended as a call to action to ensure Nova Scotia remains in this position.

Recommendations

1. **Build Human Resource Capacity in the Sector to Meet Client Care Needs**

2. **Expand Array of Services, Increase Flexibility to Access Services, and Examine Current Funding Approach**

3. **Better Utilize Evidence for System Planning, Improved Wait List Measurement and Management**

4. **Improve Communication, and Use of Technology to Support Better Sector-wide System Planning and Service Delivery**

5. **Improve Case/Care Management**

6. **Develop and Implement a Change Management Strategy**

7. **Develop a Caregiver Strategy**

SUMMARY OF RECOMMENDATIONS

Recommendation 1: Build Human Resource Capacity in the Sector to Meet Client Care Needs

It is recommended that the Department of Health and Wellness in collaboration with the Home Care Sector develop a human resource strategy to increase home support agency capacity to meet current and future needs by increasing staff levels.

1.1   Improve Data on the Supply of CCAs

In order to develop a human resource strategy for the home care sector, it is critical to know the current supply of Continuing Care Assistants (CCAs) in the health care system and the home care sector in particular. It is recommended that the Department of Health and Wellness improve data on the supply of CCAs by considering one of the following options:

- Make registration of CCAs in the current CCA Registry mandatory. It should be noted here that DHW is currently working on a policy to support mandating the CCA Registry.
- DHW work with currently funded Home Support Agencies to implement a human resource survey/database on a province-wide basis to capture the number of CCAs employed in the sector and other critical information, consistent with the work already underway.

1.2   Explore an Alternate Level of Worker

In order to meet the current and projected demands for care in the sector, and acknowledging the existing shortage of CCAs in the sector, it is recommended that a working group, comprised of the Department of Health and Wellness, Home Support Agencies, and others as appropriate, be formed to explore the development of an alternate level of worker to provide additional human resources to meet care needs – an alternate level of staffing for an extended menu of services.

Introduction of an additional level of worker should build on, and be incorporated within, the existing CCA curriculum.

Personal care and respite would remain outside the scope of this alternate worker (and retained by the CCA). The role of the alternate level worker could include, but not be limited to, the following activities: meal preparation, housekeeping, and other services currently not within the scope of the home care program such as banking, shopping, laundry, driving/accompanying clients to appointments or assisting clients to access public transportation, yard maintenance, minor home repairs, and other tasks deemed

necessary to enable a person to remain at home. Support for IADLs is consistent with the DHW IADL funding initiative as well, as a pool of people capable of providing such services may not be readily available.

1.3   Develop a CCA Recruitment Strategy

In order to meet current and projected shortages in the number of CCAs working in the home care sector, it is critical to attract new recruits to the field. It is recommended that the Departments of Health and Wellness and Labour and Advanced Education, in concert with Home Support Agencies/employers, the Continuing Care Assistant Program Advisory Committee, educational institutions offering the program, and other relevant stakeholders, develop a recruitment strategy to ensure a sufficient supply of CCAs to meet rising demands in this sector.

A mix of tools to recruit new entrants – financial incentives/bursaries, reduction/ subsidization of education costs, reduction of barriers to entry and the time frame CCAs have to complete their education, increased use of the Recognizing Prior Learning (RPL) process, and the like – could be explored, based on prior learnings to date. This work should seek to identify the barriers to entry and successful completion and potential solutions to attract staff to work in this field. Measures should expedite entry of new staff into the field, given the urgency of the current situation.

1.4   Promote Staff Retention and Workforce Stability

It is recommended that home support agencies and the Department of Health and Wellness work toward creating a work environment which promotes staff retention and workforce stability, including measures which support income stability for staff, along with flexibility as reflected an appropriate mix of staffing (full, part time and casual).

Agencies need to be agile and nimble enough to be able to quickly and cost effectively adjust staff hours to meet fluctuating demands while staff need to have a reliable and predictable source of income. It is acknowledged that every hour of service is not a billable hour; some measure of inefficiency (i.e. staff paid for cancelled hours) will be necessary given the nature of the service. (In acute and long term care, staff are paid whether a bed is occupied or not). It will be necessary to balance the need for optimal cost-efficiency and workforce stability.

> ## Recommendation 2: Expand Array of Services, Increase Flexibility to Access Services, and Examine Current Funding Approach
> Given our aging population and a growing body of evidence indicating that people can remain home longer with the right supports, it is recommended that both a broader array of services be offered and that more flexible funding mechanisms to improve access to these services be implemented. As well the existing funding model for Home Support Agencies should be examined to ensure it is based on actual costs of care, and information about how budget adjustments for client volume changes are currently calculated should be provided to agencies to ensure clarity of understanding.

2.1   Expand Array of Services and Increase Flexibility to Access Services

A broader array of services could be offered through the home care program and coordinated through the Care Coordinators. Some additional services could be offered by existing home support agencies, either directly or by subcontract to a third party, or independently of the existing agencies. This could include support for IADLs such as managing money, shopping/assistance with errands, transporting or accompanying clients to appointments, assisting clients to access public transportation, grounds maintenance, minor home repairs, snow shovelling, and the like.

It could also include provision of and/or more flexible use of funding to access a broader array of housing options, such as assisted living, improved access to personal alert systems and community-based programs, convalescent care, and more options for self-managed and supportive care. The guiding principle is that funding and systems should be enabling and supportive of client choice. People should not be made to fit programs; rather, programs should be designed to with enough flexibility to meet people's needs in an integrated way. These solutions are often more cost-effective than existing options.

It is recommended that the Department of Health and Wellness work with their DHA counterparts, home support agencies, and other community-based agencies, to design and implement such an approach. It is also recommended that, as different and more flexible models of care are contemplated, agencies and organizations serving persons with disabilities, along with the Department of Community Services, be engaged in this work. It is further recommended that consideration be given to involving seniors, recipients of care and their families/caregivers in this discussion to ensure a client perspective is a central focus.

2.2 Re-examine Existing Funding Model for Home Support Agencies

It is recommended that the Department of Health and Wellness, in collaboration with the Home Care Network, re-examine the funding model by which home support agencies are funded to deliver services in the province to ensure the system is sustainable, and reflects the actual cost of providing care.

2.3 Increase Understanding of Process for Obtaining Funding Increases

There is concern that not all agencies understand the basis upon which increased funding for volume increases is made. It is recommended that the Department of Health and Wellness offer an education session on Home Support agency budget preparation and business planning which would include review of the process for adding additional administrative staff as client volumes increase/decrease.

Recommendation 3: Better Utilize Evidence for System Planning, Improved Wait List Measurement and Management

It is recommended that additional efforts be made to define data needs and gather evidence to inform planning and decision-making. Further, evaluation should be embedded within this strategy to ensure we know what works and what does not in meeting increasing demands for care at home.

Efforts should also be made to improve wait list measurement and management as follows:

- **Improve Measurement/Develop Common Definitions of the Wait List**
  It is recommended that the Department of Health and Wellness clarify the definition of the wait list, its starting point, and other wait list metrics, and the process by which the data will be gathered, reported, shared, and utilized.[1]

- **Develop Response Time Standards**
  It is recommended that the Department of Health and Wellness and District Health Authorities, in collaboration with the Home Care Network, collectively develop response time standards to govern the response times of each party at various intervals in the process to clarify expectations and facilitate a smooth functioning system.

- **Improve Management of the Wait List**
  In order to ensure people have access to care as soon as possible, it is recommended that District Health Authorities more frequently monitor and update the wait list. Improved communication between Care Coordinators and home care agencies will support more active management of the wait list.

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[1] Note some of these initiatives have begun since project inception.

Recommendation 4: Improve Communication and Use of Technology to Support Better Sector-Wide System Planning and Service Delivery

It is recommended that the Department of Health and Wellness, DHAs, and home support agencies develop the mechanisms, tools and technology to more actively engage in joint system planning, problem identification, and resolution to enhance service delivery.

4.1 Establish Opportunities for Ongoing Sector-wide Planning and Dialogue

The effective design and delivery of home care services requires the engagement of all three of the primary players within the home care sector: home support agencies, the Department of Health and Wellness, and District Health Authorities. To ensure effective, integrated system-wide policy, planning and service delivery, allow the opportunity for issue identification and resolution, and promote ongoing collaboration and dialogue, it is recommended that the co-chairs of the Home Care Network have regular and ongoing discussions with their colleagues at the Department of Health and Wellness and District Health Authorities. Specifically, the following would be important strategic linkages:[2]

- Co-chairs, Home Care Network and the DHW Executive Director of Continuing Care

- Co-chairs, Home Care Network and Chair, DHA Directors of Continuing Care Group

- Local/DHA Home Support Agency directors dialogue with local/DHA Directors of Continuing Care

Opportunities for periodic dialogue with the following would also be useful:

- Co-chairs, Home Care Network and the DHA VPs Community designates as lead for Continuing Care (as required)

4.2 Make Better Use of Technology

It is recommended that the Department of Health and Wellness, working with home support agencies, undertake the following initiatives to make better use of technology to improve access to information to support quality improvement and enhance decision-making:

- Enhance/enable electronic exchange of client-related information between DHA Care Coordinators and home support agencies.

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[2] Note that some of these initiatives have begun since the initiation of this project.

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- Continue to support use of software and mobile telephone technology to achieve efficiencies in care delivery and enhance occupational health and safety for home care staff.

- Explore innovative uses of technology to support greater capacity of individuals, together with their health care providers, to monitor and manage their health at home.

4.3   Better Inform Clients of Services Available

It is recommended that DHA Care Coordinators and Home Support agencies provide clients with information about services that may be helpful to them, at the earliest possible opportunity. This may be in the form of print materials and/or a discussion of needs and program eligibility requirements, and support to access services. Development of a checklist of programs and services is recommended as a helpful tool for care providers to use as a reference to ensure they inform clients about what may be available to them.

Recommendation 5:   Improve Case/Care Management
To ensure role optimization of staff, expedite changes to client care plans, and improve case management, it is recommended to:

5.1   Enable Care Coordinators to Do More Intense Management of Complex Cases

District Health Authorities revamp the case management system by providing more intensive case management to those cases with a multiple providers and/or greater complexity, applying a higher level of clinical skills to those cases which need it most.

5.2   Allow Home Support Agencies to Change Service Hours

The Department of Health and Wellness amend home care policy and processes to empower home support agencies to make changes to service hours authorized/care plans, within certain parametres (e.g. within 10% of hours authorized?), with notice to Care Coordinators, in recognition that home support agency staff are in the best position to know when clients' needs change. Allowing the home care delivery system to respond more quickly will meet client care needs more expeditiously, free up service hours for potential use by other clients, and enable Care Coordinators to devote more time to management of more complex cases.

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5.3 Allow Home Support Agencies to Change Care Plans/Authorize Additional Services Beyond the Current Scope of Home Care Services

The Department of Health and Wellness allow home support agencies to change care plans/authorize additional services beyond the current scope of home care services to meet client needs, beginning with personal alert systems and bed loan programs. This could be built upon as services and processes expand.

5.4 Build Relationships and Enhance Communication

That DHAs and home support agencies actively seek out opportunities at the local level to build interagency relationships, directly communicate about cases, share concerns, identify and resolve issues, and clarify expectations so that care provided is optimal and systemic issues are addressed. Case management is supported by good collaborative relationships among the agencies involved in the delivery of that care.

5.5 Orientation of New Staff

That home support agencies and District Health Authority Continuing Care Coordinators explore opportunities for joint orientation of new staff enabling each to better understand the other's role and challenges. Visits to home support agencies should be embedded in orientation for new Care Coordinators. Similarly, orientation of new home support agency management and supervisory staff should involve cross fertilization and visits to the Care Coordinators' work sites.

Recommendation 6:   Develop and Implement a Change Management Strategy

It is recommended that a change management strategy be developed to both inform stakeholders of nature of the change(s) to support a shift to a "home first" philosophy to enable people to remain at home and to develop successful implementation strategies. Stakeholders include but are not limited to first and foremost the clients, their support system (friends, family), leaders in the health care sectors, physicians, managers and health care providers.

Recommendation 7: Develop a Caregiver Strategy

Given the critical role played by friend/family caregivers, it is recommended that DHW in concert with Caregivers Nova Scotia, the Home Care Network, and other interested parties as appropriate, develop a strategy to support caregivers to provide care to loved ones at home which addresses the physical (provision of respite, personal care), financial (income replacement, coverage of costs of caring for another person at home), and emotional (respite, support programs) aspects of caregiving. Enhance income support to caregivers, for example, through an income replacement program, perhaps modelled on the caregiver benefit, which is simpler to access and more comprehensive than the federal benefit available only to those who pay into employment insurance and which has limits and restrictive eligibility rules. Equipping caregivers with the capacity to provide support will be a key linchpin in the success of any strategy to support the provision of care at home.

BACKGROUND

The demand for home care services is increasing. As of 2011, the Canadian Home Care Association reported that approximately 1.4 million individuals across the country received home care. That number translates into approximately 1 in 6 Canadians or 1 in 10 Nova Scotians. The provision of homecare services increased 55% over a 3 year period from 2008 to 2011.[3]

In addition, demographic trends and other factors are contributing to an increase in the demand for both long term care and home care and this is expected to continue. The growing demand for long term care means there is an increase in the volume of individuals currently on the long term care waitlist and likewise, occupying alternate levels of care (ALC) beds in hospitals. Further, in some areas of the province, people who need home care services are not receiving them. For example, as of the week of November 2-8, 2013, approximately 250 people representing about 8600 hours of service were waiting for care.[4] Thus, expanding access to home care services is critical to help respond to these system pressures in order to ensure Nova Scotians receive the right care, at the right time, and in the right place.

Consequently, there is a strategic shift on the part of the Nova Scotia Department of Health and Wellness (DHW) to increase investment in home care, as evidenced by the $32.6 million increase in the 2014/15 budget for home care services,[5] including the development of an additional 1500 home care "spaces".[6] In recognition of the current and forecasted increasing pressures on home care, the sector wishes to be proactive in its efforts to build capacity to respond.

Purpose and Scope

The provincial Home Care Network identified the need to respond to rising demands for home care as a strategic priority in its fall 2013 strategic planning session. To act on this priority, a project charter was developed and a Working Group formed to: *determine how the sector can*

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[3] Canadian Home Care Association (2013). *Portraits of Home Care in Canada: Executive Summary*.
http://www.cdnhomecare.ca/media.php?mid=3394

[4] Department of Health and Wellness. Continuing Care Spring Forum. Halifax, 2013.

[5] Province of Nova Scotia (2014). Budget Highlights for Fiscal Year 2014-15. *News Release*.
http://novascotia.ca/news/release/?id=20140403002

[6] Province of Nova Scotia (2013). Seniors Will Live Better with New Continuing Care Plan. *News Release*.
http://novascotia.ca/news/release/?id=20130904007

best prepare to effectively respond to the increased demand for services in a way that is collaborative, client and family centered, accessible, affordable and sustainable.

The Working Group included representation from the Home Care Network, the District Health Authority (DHA) VPs of Community, and the Continuing Care Branch of Department of Health and Wellness and was supported by Health Association Nova Scotia (see Appendix "B" for a complete list of the working group members). The Working Group agreed upon the following principles to guide the work:

- *Our Working Group has a firm belief in person-centred care and the importance of a collaborative, system-wide approach in arriving at the best solutions to meet client needs.*

- *Our Working Group believes services must be designed and delivered in a way which is client and family centred.*

- *Our Working Group will make decisions based on evidence.*

- *Our Working Group considers innovation a key to successfully responding to client needs.*

- *Our Working Group believes in sustainable, affordable and accessible solutions.*

The scope of the work was limited to home care services provided by Home Support Workers/ Continuing Care Assistants and excluded ancillary services such as Nursing, Occupational Therapist (OT) or Physiotherapist (PT) services.

To gather information surrounding the current challenges of the home care sector, the Working Group met regularly over a four month period. During that time, key stakeholder engagement sessions were conducted involving those engaged in the design and delivery of home care services – DHW policy makers, DHA staff reflective of their responsibility for assessment and authorization of home care services to clients, and home support agencies who directly deliver services. Sessions were facilitated by Health Association staff. Additionally, a targeted review of relevant literature was conducted to support the development of evidence-based recommendations.

Current State

The ability of the sector to adequately meet future demands warrants an understanding of the current state of home care. This includes examining the forces driving increased demand for home care, identifying current program offerings, measuring current unmet needs and anticipated future demand, and assessing the capacity of the sector to meet that demand.

Driving Factors

Demographics and Illness Burden

Current demographics and future projections combined with other system drivers are contributing to an increase in demand for home care services – an aging population, rates of chronic disease, disability, dementia, and the number of increasing deaths.

Nova Scotia has some of the highest rates of chronic disease[7], higher rates of disability[8], as well as an aging population. In fact, Nova Scotia has the oldest population per capita in Canada and the proportion of Nova Scotians aged 65 or older is expected to increase from approximately 17.7% to 25% by 2026[9]. As of 2011, there were over 23,400 clients receiving home care services in Nova Scotia[10], and of significance, it has been estimated that 82% of home care clients are seniors.[11]

The prevalence of dementia is also increasing. Alzheimer's disease and related dementias affect about 1.6 per cent of our population. It is estimated that more than 17,000 Nova Scotians are currently living with some form of the disease. As our population ages, we expect to have double the number of seniors in Nova Scotia by the year 2038, many of whom will be living with some form of dementia[12]. Indeed, by 2031, it is projected that 28,771 Nova Scotians (2.5% of Nova Scotia's population will have developed Alzheimer's or a related disease.[13] The number of deaths is also on the rise requiring an increase in palliative care, much of which will need to be delivered at home given the demographic trends, the desire of Nova Scotians to remain at home to die, and limitations to the availability of hospice palliative care in other settings.[14]

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[7] http://novascotia.ca/dhw/primaryhealthcare/chronic-disease-management.asp

[8] Statistics Canada. *Participation and Activity Limitation Survey 2006: Tables.* Ottawa: Statistics Canada, 2007 (Cat. No. 89-628-XIE - No. 003)

[9] Seniors Secretariat. (2005). Seniors Statistical Profile. pg. 3. https://novascotia.ca/seniors/pub/StatProfile05.pdf

[10] Continuing Care Branch, Department of Health and Wellness (2013). What We Hear…What We Know ….What We're Doing…What Can You Do? [PPT Slides] Presented at Spring 2013 Forum

[11] CIHI (2011). Health Care in Canada, 2011: A Focus on Seniors and Aging. Provincial and Territorial Summaries of Findings.https://secure.cihi.ca/free_products/HCIC2011_Summary_of_P_T_findings_en.pdf
[12] Department of Health and Wellness. URL: https://novascotia.ca/dhw/ccs/dementia-strategy/

[13] Smetanin, P., Kobak, P., Briante, C., Stiff, D., Sherman, G., and Ahmad, S. *Rising Tide: The Impact of Dementia in Canada 2008 to 2038*. RiskAnalytica, 2009.

[14] Health Association Nova Scotia. *Access to Quality End of Life Care in Nova Scotia: A Vision for the Future.* Presentation by C Marshall to Department of Health and Wellness Hospice Palliative Care Steering Committee, Halifax, Jan 23, 2013.

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Health System Capacity

The increase in demand for home care services is also being driven by a number of health system capacity issues including the need to:

- **Reduce the number of hospital beds currently being filled by those waiting for long term care.**
  The client profile of those waiting in hospital is similar to those waiting at home, yet over 90% of hospital-based clients will go into a Long-term care (LTC) facility. Of the clients waiting in hospital, less than 10% had home care services in place prior to admission and 34% were found to have a caregiver in distress.[15]

- **Reduce the wait list for those in need of long term placement in a facility.**
  DHW data shows that 75% of people on the LTC waitlist need assistance with housework/meal preparation, and only 30% need more than limited assistance with personal care activities. These services are offered by the Home Support program yet over 40% of people on LTC waitlist are not receiving DHA Home Care.[16]

- **Meet the growing demand and reduce the waitlist for home care services in the community.**
  While clients can receive up to 150 hours of home support each month, almost half of clients are assessed as needing less than 20hrs per month and only 11% of clients receive over 80 hours per month. Of the clients accessing home support service, 20% have a caregiver in distress.[17]

This suggests there is greater opportunity to provide home care services to enable people to return home from hospital or remain home longer.

Caregiver Capacity

While home care has the potential to save the system money through reduced costs associated with institutional care, the importance of the role of family/friend caregivers cannot be understated. A major factor in assessing an individual for access to home care services, rather than long term care or remaining in an ALC bed while awaiting placement, is the availability and capacity of a family/friend caregiver to supplement the support provided through home care. According to CIHI, 98% of home care clients in Canada are also receiving care from family/friend

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[15] Continuing Care Branch, Department of Health and Wellness (2013). *What We Hear…What We Know ….What We're Doing…What Can You Do?* [PPT Slides] Presented at Spring 2013 Forum.

[16] Ibid.

[17] Ibid.

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caregivers[18] and 23.3% of those caregivers are seniors themselves.[19] The 2007 market value contribution of family caregivers is $24-$31 billion.[20] Thirty-one percent (31%) of Nova Scotians – roughly 290,000 people in this province – give some form of unpaid care to another person with a long-term condition or temporary illness[21]. This is compared to 28% nationally.

In order for home care to be an effective solution in helping seniors with chronic conditions to remain at home longer, caregivers must be adequately supported. Data shows that as the level of need for care increases, the increase in home care service hours provided varies marginally when compared to the significant increase in service hours required by the family/friend caregiver. Coincidently, there is a marked increase in the proportion of family caregivers reporting distress.[22]

Caregiver stress is a significant factor identified in Nova Scotia as well. As mentioned earlier, of the clients waiting in hospital on the long term care wait list, less than 10% had home care services in place prior to admission and 34% were found to have a caregiver in distress, suggesting opportunity for intervention through the provision of services to prevent hospital admission. This also suggests caregiver stress may be a key driver of hospital admissions. Of clients accessing home support services, 20% have a caregiver in distress, yet most clients do not receive even close to the 150 hours of service possible. Again, while this requires more analysis, this suggests more hours of service might reduce caregiver stress. In 2013, DHW Home Care policy was relaxed, enabling clients/families increased usage of respite care so perhaps this will influence reported caregiver stress levels in the future.

Several studies have also shown that lack of knowledge of home care services, what they provide, and how they can be accessed, on behalf of both health care providers and the public, have contributed to patients being placed in an ALC bed.

Caregiving has an emotional (stress, burnout), physical (lifting, long hours), and financial (job/wage loss, lack of income replacement, costs of providing care such as transport, drugs, etc.) impact and many caregivers do not have the capacity to provide care, especially for a prolonged period. Some caregivers are elderly or ill themselves. Family/friend caregivers do not

[18] CIHI (2010). Supporting Informal Caregivers—The Heart of Home Care. https://secure.cihi.ca/free_products/Caregiver_Distress_AIB_2010_EN.pdf
[19] Change Foundation (2011). Because this is the Rainy Day: a discussion paper on home care and informal caregiving for seniors with chronic health conditions. Retrieved from: http://www.changefoundation.ca/library/because-this-is-the-rainy-day/

[20] Keefe. J. (2011). Supporting Caregivers and Caregiving in an Aging Canada. Institute for Research on Public Policy

[21] Statistics Canada (2013). Caregivers in Canada 2012. Retrieved from: http://www.statcan.gc.ca/dailyquotidien/130910/dq130910a-eng.htm
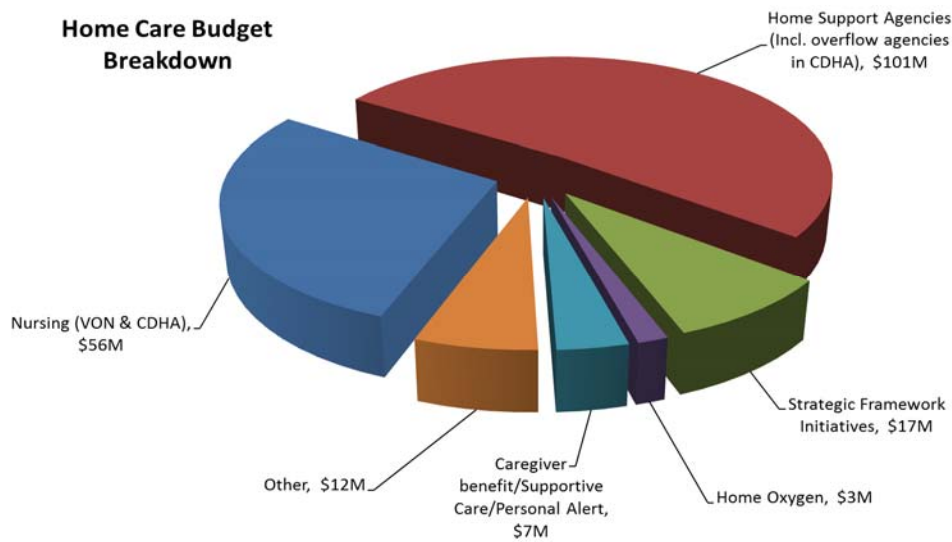
[22] Health Council of Canada (2012). Seniors in Need Caregivers in Distress: What are the Home Care Priorities for Seniors in Canada? Retrieved from: http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

work in shifts as do other health care providers and providing care on a 24-7 basis can take a heavy toll. With respect to the financial cost of care, research indicates that 15% of caregivers take unpaid leave from work in order to care for an elderly relative.[23] In 2007, Canada saw $1.28B in lost productivity due to missing work.[24] Clearly, given the demonstrated contribution of family/friend caregivers, efforts must be made to provide them with necessary and adequate support through effective public policy, access to services and supports, and recognition of financial and other impacts of caregiving.

Current Home Support Programs

The type, range, and funding levels of current services offered will influence whether a person can receive the care they need at home. The province of Nova Scotia, through the DHW Continuing Care Branch, offers several programs to support individuals and their caregivers at home. These are described in more detail in Appendix "C". The provincial Home Care budget for 2013-14 was $196,146,000 representing 5% of the overall DHW budget. The level of funding allocated to each area is reflected below.

Figure A – Break Down of Home Care Budget

Home Care Budget Breakdown

- Home Support Agencies (Incl. overflow agencies in CDHA), $101M
- Nursing (VON & CDHA), $56M
- Other, $12M
- Caregiver benefit/Supportive Care/Personal Alert, $7M
- Strategic Framework Initiatives, $17M
- Home Oxygen, $3M

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[23] Health Council of Canada (2012). Seniors in Need Caregivers in Distress: What are the Home Care Priorities for Seniors in Canada? Retrieved from: http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

[24] Conference Board of Canada (20120. Home Care in Canada: An Economic Footprint. Retrieved from: http://www.conferenceboard.ca/temp/c5693ab5-92ef-4f1e-9294-8b3c3a3f91d6/12-306_homeandcommunitycare_prt.pdf

The Home Support program provides personal care (assistance with daily living), housekeeping, nutritional/meal preparation, and respite care. As can be seen in Table 1, personal care accounts for the largest proportion of home care hours used in the vast majority of DHAs. The amount of nutritional care, housekeeping and respite care varies across the province and can be influenced by other community offerings, for example Meals-on-Wheels which is available in certain DHAs. Ever-changing client and caregiver needs will also dictate service requirements.

There is also significant variability among DHAs in the distribution of these four services. Personal care varies from 37% to 60% across the province with the average being 47% provincially. Nutritional care ranges from 11% to 34% with an average of 23%. Housekeeping varies from 8% to 23% with the provincial average being 12%. Respite care ranges from 11% to 29% with the average being 18% across the province.

Table 1:

Distribution of Home Care Services Provided by DHA, 2011-12

	DHA 1 %	DHA 2 %	DHA 3 %	DHA 4 %	DHA 5 %	DHA 6 %	DHA 7 %	DHA 8 %	DHA 9 %	Provincial %
Personal Care	60	47	48	37	40	30	47	47	52	47
Nutritional Care	11	12	15	29	23	26	19	34	17	23
Housekeeping	9	12	14	15	20	23	10	8	11	12
Respite	20	29	24	19	16	21	24	11	20	18

Source: Department of Health and Wellness

Strategic Initiatives

DHW also funds DHAs for programs such as the "Home First" program, which enables transition from hospital to home by putting the necessary supports in place for the client. This program is currently available in at least two DHAs. In addition, in 2013-14, DHW provided additional more flexible funding to DHAs to enable them to fund services related to Instrumental Activities of Daily Living (IADL) supporting client independence, allowing them to remain in their homes and communities. These IADL services are outside the scope of services offered under the home care program. The degree to which DHAs have been able to fund others to provide these services is unclear as data on uptake is limited to date. Neither one of these initiatives has been evaluated to assess their success, although CDHA believes the Home First program has been successful in moving people out of hospital and into home.

Home Care Sector Capacity/Current Unmet Need

Growth in Demand for Care

There has been significant growth in demand for home care services. The number of direct service hours (DSH) provided has grown 16% in the last four years as follows:

- 2009-10:   1.9 million DSH

- 2013-14:   2.4 million DSH

Nursing visits have grown 14.7% in that same time period.[25]

Wait Lists for Service

Some areas of the province have chronic, ongoing and sizeable wait lists for home care services (CDHA). The wait list is an ongoing tally of authorized but undelivered hours of service at any given point in time. A wait list for home care services is one indicator that there are clients whose needs are not being met. It can also be used as a tool for monitoring performance of the home care system, identifying which health district is in greatest need.

The wait list is most significant in the Halifax area (Capital Health District Health Authority) followed distantly by Annapolis Valley Health (DHA 3) and South Shore Regional Health (DHA 1). As Table 2 indicates, as of the week of November 2-8, 2013, approximately 250 people representing about 8600 hours of service were waiting for care. It is important to note this does not reflect clients who have never been assessed for the wait list but who may, in fact, need care (i.e. in hospital but not assessed for home care, others waiting for assessments, some never referred or unaware of home care services). This also does not reflect the type of service for which people are waiting (personal care versus light housekeeping for example). Further, the initial absence of a consistent approach to collecting wait list data the same way across DHAs/home support agencies created difficulties in accurately measuring the magnitude of the problem – the inability of agencies to provide care.[26] However, efforts were made on the part of DHW and DHAs to standardize data collection to ensure comparability and now clients are placed on the waitlist as soon as the service is authorized.

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[25] Department of Health and Wellness. Continuing Care Branch, Fall Forum, Nov 2013.

[26] There were variances in practices around the province with respect to adding people to the waitlist. For example, in some DHAs, clients were considered to be on the wait list only after a two week waiting period – consistent with the response time standards. In other DHAs, the wait list began immediately upon authorization of hours by the care coordinator.

Table 2: Home Support Waitlist by DHA
Nov 2 – 8, 2013

DHA	# of Clients Waiting	# of Hours Outstanding
1	17	99
2	3	42
3	43	1421
4	N/A*	N/A*
5	0	0
6	0	0
7	0	0
8	0	0
9	184	7010
Total	247	8572

* N/A = data not available.

Notes: The above only includes those clients who have been assessed by a Care Coordinator and authorized to receive service. It also excludes clients waiting for service in the alternative programs served by "overflow agencies". Source: NS Department of Health and Wellness.

In summary, demographic trends, illness rates, the availability and capacity of a family/friend caregiver, the array of programs and services available, and the capacity of these services to provide care all influence whether an individual can be cared for at home.

CHALLENGES AND RECOMMENDATIONS

The Working Group identified a number of barriers and challenges in effectively responding to rapid growth in the home support sector. Contextual information surrounding these challenges are outlined, along with recommendations designed to effectively support the change that is deemed necessary to meet the expected increase in demand.

Staffing

Supply of Home Support Staff/CCAs

Issue:

One of the primary barriers identified, and a key factor contributing to the wait list, was the unavailability of staff to provide care. Currently, CCAs are the required standard of entry to practice; staff providing care to publicly funded home care clients are required to have their CCA certification. Many home support agencies, particularly in DHA 9, report ongoing difficulties in hiring a sufficient number of CCAs to provide care.

Analysis/Discussion:

In order to meet service demands, it is necessary to understand what the current supply of service providers is – in this case Continuing Care Assistants (CCAs) - and how much service will be required. Currently, while there are statistics on the number of CCA graduates in the province (see below), data as to the number remaining in the province, the number employed, and the sector and geographic location in which they are employed is not available. This information is a critical piece in planning to meet service needs in home care.

Table 3: Certified CCAs 2000-2013

Continuing Care Assistant Program Graduates by Fiscal Year as of March 31, 2013 (Extracted by Certificate Date)						
Fiscal Year April/March	Traditional Graduates	Equivalency/CR	PLAR	Total CCA	RPL	PLAR
2000/2001	60			60		
2001/2002	298			298		
2002/2003	274	30		304	10%	
2003/2004	309	19		328	6%	
2004/2005	420	159		579	27%	
2005/2006	338	232		570	41%	
2006/2007	417	172		589	29%	
2007/2008	364	143	7	514	29%	1%
2008/2009	489	172	19	680	28%	3%
2009/2010	787	173	39	999	21%	4%
2010/2011	900	173	24	1097	18%	2%
2011/2012	678	75	35	788	14%	4%
2012/2013	775	70	29	874	11%	3%
2013/2014	599	22	30	651	8%	5%
Total Certified CCAs	**6708**	**1440**	**183**	**8331**	**19%**	**2%**

Notes: Equivalency/Course Recognition (CR) began in 2002 and Prior Learning and Assessment (PLAR) delivered its first graduate in 2007/08. Regarding RPL, CR time was reduced from 24 months to 12 months and PLAR time was reduced from 30 months to 15 months as of April 2013.

There are two options under consideration to capture this information:

- mandate the use of a registry for CCAs and/or
- implement a human resource survey to capture this information.

CCA Registry

DHW supported the creation of the CCA Registry intended to house information such as geographical location, employment status (full-time, part-time, casual, not employed) and sector of employment (Acute, Long term Care, Home Support, Residential Care Facilities, Private). However, registration by CCAs has been *optional* and efforts to encourage CCAs to register have not been successful, even when the registration fee was waived. This means that the registry does not include a complete number of available CCAs in the province. The information that such a repository could provide would enable future planning of education and location specific initiatives aimed at recruiting workers to fill a defined health human resource need.

The province of Ontario implemented a registry providing a platform for PSWs and employers to more easily access the labour market, and to provide the government with information for human resource planning. The registry is government funded and will soon be mandatory. The

implementation of the registry has been met with some opposition with concerns expressed about the potential benefits versus costs and privacy issues.[27]

HHR Survey

DHW has been working with the Home Care Network (Cost Mitigation Working Group) to develop a survey to capture more information about staff employed in the sector. This approach is being tested in one agency and the intent is to implement the survey province-wide by fall 2014, providing data extraction does not prove cumbersome or costly to the agencies. This survey has been implemented as a permanent data base in acute care and the intent is to implement it in home and long term care as well to improve health human resource planning and have better information to prepare for collective bargaining.

Recommendation 1: Build Human Resource Capacity in the Sector to Meet Client Care Needs

It is recommended that the Department of Health and Wellness in collaboration with the home care sector develop a human resource strategy to increase home support agency capacity to meet current and future needs by increasing staff levels.

1.1   Improve Data on the Supply of CCAs

In order to develop a human resource strategy for the home care sector, it is critical to know the current supply of Continuing Care Assistants (CCAs) in the health care system and the home care sector in particular. It is recommended that the Department of Health and Wellness improve data on the supply of CCAs by considering one of the following options:

- Make registration of CCAs in the current CCA Registry mandatory. It should be noted here that DHW is currently working on a policy to support mandating the CCA Registry.
- DHW work with currently funded Home Support Agencies to implement a human resource survey/database on a province-wide basis to capture the number of CCAs employed in the sector and other critical information, consistent with the work already underway.

[27] Laporte, A. & Rudoler, D. (2013). Assessing Ontario's Personal Support Worker Registry. Health Reform Observer 1(1) DOI: http://dx.doi.org/10.13162/hro-ors.01.01.02

Insufficient Staff Supply to Meet Current Need

Issue:

Wait list information shown previously clearly indicates there are client needs which are not being met. Reasons offered for this have been largely due to an inability to supply staff to meet the demand, as well as an inability to supply the staff to provide care during the specific *time* requested.

As mentioned, in Nova Scotia, staff providing services to clients of the Home Support program must be Continuing Care Assistants (CCA), provincially certified Personal Care Workers or Home Support Workers (both representing the prior education standards before the CCA education program was implemented in 2000). [28] A similar requirement for agencies providing care to private clients (direct pay clients) does not exist. The Working Group explored whether it was critical that all tasks required of home support workers be done by a CCA.

Analysis/Discussion:

Meal preparation and housekeeping tasks were identified as potentially transferable to an alternate level of worker as they are thought not to require the fullness of training offered by the CCA program. According to the information found in Table 1, these two services comprise approximately 25% of the support services offered. Allowing an alternate level of worker to perform these tasks has the potential to increase capacity in the home care sector workforce and reduce unmet needs for clients – potentially freeing up 25% of current CCAs to serve other clients.

Further, other types of services beyond the scope of the current home care program are needed to support people in order to remain in their homes. These tasks could include, but not be limited to, the following activities: meal preparation, housekeeping, and other services currently not within the scope of the home care program such as banking, shopping, laundry, driving/accompanying clients to appointments or assisting clients to access public transportation, yard maintenance, minor home repairs, and other tasks deemed necessary to enable a person to remain at home.   An alternate level of worker could be used for these tasks, as well as other IADLs, to support people to remain home longer than they might otherwise.

There is no national standard for this level of para-professional in Canada and the Nova Scotia CCA program is the highest in terms of education required prior to entry into the workforce. While Nova Scotia is considered a leader in the country with respect to the CCA program, lessons can be learned from the Netherlands model of home care staffing. The Netherlands has

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[28] Department of Health and Wellness' Entry to Practice Policy:
http://novascotia.ca/dhw/ccs/policies/CCA_Entry_Practice_Policy.pdf.

June 30, 2014

six levels of staff caring for clients, of varying education and training requirements. However, an analysis of both job descriptions and actual practice, suggests that there is overlap between some workers, and that four levels of care providers would be more desirable[29]. Regardless of the specific number of care providers, this example illustrates that the implementation of alternate level of worker is a possible option for consideration. Development of such a worker would need to consider and clearly define its scope. Further, a proposal for training and pilot testing such a worker was developed for DHW/sector consideration by Queen's County Home Support and VON Canada Nova Scotia in 2006.[30] This could be informative in any future program design.

While an alternate worker should be an option available throughout the province, implementation should be flexible based on regional and local needs. It is acknowledged that while an alternate worker may be a solution for areas with heavy wait lists, it may not be for other areas. The choice to use an alternate level worker should consider fiscal responsibility and cost efficiency and other factors. For example, it may be counterproductive to send two individuals into a home (a CCA for personal care and an alternate worker for meal preparation) given the associated transportation costs in more geographically distant areas.

The Working Group is conscious of the Joint Health Professions statement on task shifting that espouses the principle that "assistive workers should not be employed at the expense of unemployed and underemployed health professionals". In some areas of the province, an alternate worker may not be needed if it results in unemployment of CCAs; CCAs should not find themselves unemployed or underemployed system-wide while an alternate level of worker role expands. Given the current demand for CCAs in the province, this may not be concern.

The Working Group further suggested that:

- education costs associated with the position be affordable and sustainable
- education requirements be based on and integrated within the existing CCA curriculum to maximize efficiency and build on the high quality program that already exists, reducing potential startup costs.
- the FutureWorx Environmental services program model be examined for applicability
- on-line training capabilities be explored, especially for people living in rural communities. There could be an option for free of charge or reduced rate in exchange for a return of service guarantee. This would address some of the distribution issues with HHR in home care, and is also an economic development scheme for rural areas- people living, training and working in the area.

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[29] Arts, S., Kerkstra, A., Huyer Abu-Saad, H & van der Zee, J. (1998). A job profile of home helps in the Netherlands. *Health and Social Care in the Community* 6(6), 397–406

[30] "Proposal for Pilot of Supportive Care Aide" submitted by region of Queens Home Support and VON Canada Nova Scotia, Oct 2006

- the Home Support Worker training from 1989 be reviewed as it was based on a social model (mostly homemaking, socialization, housekeeping), and delivered in 4 hour blocks.

With current waitlists and an expected increase in demand for services, an appropriate number and mix of staff will be required. Current staffing models may not be optimal and should be explored.

1.2   Explore an Alternate Level of Worker

In order to meet the current and projected demands for care in the sector, and acknowledging the existing shortage of CCAs in the sector, it is recommended that a Working Group, comprised of the Department of Health and Wellness, Home Support Agencies, and others as appropriate, be formed to explore the development of an alternate level of worker to provide additional human resources to meet care needs – an alternate level of staffing for an extended menu of services.

Introduction of an additional level of worker should build on, and be incorporated within, the existing CCA curriculum.

Personal care and respite would remain outside the scope of this alternate worker (and retained by the CCA). The role of the alternate level worker could include, but not be limited to, the following activities: meal preparation, housekeeping, and other services currently not within the scope of the home care program such as banking, shopping, laundry, driving/accompanying clients to appointments or assisting clients to access public transportation, yard maintenance, minor home repairs, and other tasks deemed necessary to enable a person to remain at home. Support for IADLs is consistent with the DHW IADL funding initiative as well, as a pool of people capable of providing such services may not be readily available.

Recruitment into the CCA Program

Issue:
Recruitment of staff to work in home care is a significant challenge, especially in rural areas.

In May 2006, DHW rolled out a 10-year strategy for Continuing Care in Nova Scotia.[31] The strategy emphasized more economical and flexible programs such as home care, respite care and palliative care in homes and communities and also called for the creation of 1,320 new long-term care beds over 10 years. As part of this strategy, DHW undertook a number of initiatives to increase the supply of CCAs both to prepare for an anticipated increase in the number of long

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[31] Nova Scotia Continuing Care Strategy: http://www.healthteamnovascotia.ca/files/Continuing_Care_Strategy06.pdf

term care beds and increased demand for home care services. These initiatives included bursaries, attracting foreign workers and those from other Canadian provinces to Nova Scotia by recognizing existing credentials and facilitating access to education to meet credentialing requirements through the Recognizing Prior Learning (RPL) process. As a financial incentive to attract people into the CCA program, beginning in the fall of 2006, DHW offered a bursary to students wanting to take the CCA program in the amount of $4000 or 70% of the tuition costs for the program (whichever was lower). However, the bursary program was terminated at the end of fiscal 2013.

The availability of funding to support the CCA program (subsidizing or eliminating the cost to students) was affected by two developments. Firstly, the most recent Federal-Provincial Labour Market Agreement (LMA) expired as of March 31, 2014 and funding for programs ran out mid/late 2013. These Agreements, in place since 2009, typically span 2 to 5 years and are designed to fill skills gaps and address local market needs. The Federal Government advised provinces that they would like to replace these agreements with a new Job Grant Program, a direction not supported by many provinces. While some provinces have concluded negotiations with Federal Government regarding the terms of the Jobs Grant and Skills Development Funding, to date (May 2014), Nova Scotia has not concluded negotiations. Hence, affected departmental budgets have no program funding available, some of which is targeted to the CCA program. Secondly, the discontinuation of DHW funded bursaries to supplement the LMA funding had an impact in that the lack of bursary funding to share the cost of the CCA program resulted in reduction/elimination of funding for CCA programs.

Analysis/Discussion:

Enrollment in CCA Programs has declined since its peak in 2010/11 and it is believed that this is a result of a number of factors – program fees, removal of the bursary, limited use of foreign workers, the time requirements and other issues limiting access to the Recognition of Prior learning (RPL) process, and others. Program fees, regardless of whether an individual goes through traditional classroom training or the RPL process, have increased since the program's inception. Anecdotally, some working group members also felt that the RPL program could improve its "ease-of-use" for participants.

The RPL process has had a positive impact on the sector increasing the pool of CCAs available; overall 19% of CCAs have been credentialed through this process (see Table 3). At one point in the early years of the program (2005-06), 41% of CCAs graduated through this process – indicative primarily of the effort of the current workforce to gain CCA certification through equivalency. However, the number of recruits trained through RPL has been declining steadily since and in the 2013-14 year, only 8% of the graduates were via RPL.

In April of 2013, the CCA Program Advisory Committee reduced the time required to become certified through both streams of the RPL process.[32] The impact of this change is too early to discern. Exploration of other options/changes may be warranted to increase uptake. For instance, the number of recruits through the Prior Learning and Assessment Program (PLAR) component of RPL represents only 2% of the total CCA graduates. Is this reasonable or can this be redesigned to increase recruitment? Apart from program redesign, can greater efforts be made to attract and support settlement and integration of foreign workers? Or attract workers from other Canadian jurisdictions? Or this province?

The impact of the removal of the bursary has not yet been fully identified either. However, preliminary data[33] suggests 2013-14 enrollments are down by 33%, the same rate at which students received bursaries in the prior year, suggesting that the removal of the bursary reduced by a third the number of new CCA students being trained for work in the continuing care sector. While the feedback as to the success of the bursary program is debated, what is clear is that enrollment dropped once the program ended.[34]

A reduction in supply of CCAs at a time when the home care sector is seeking to expand to meet demand for care will only exacerbate staff shortages. In order to meet current and projected shortages in the number of CCAs working in the home care sector, it is critical to attract new recruits to the field.

1.3   Develop a CCA Recruitment Strategy

In order to meet current and projected shortages in the number of CCAs working in the home care sector, it is critical to attract new recruits to the field. It is recommended that the Departments of Health and Wellness and Labour and Advanced Education, in concert with Home Support Agencies/employers, the Continuing Care Assistant Program Advisory Committee, educational institutions offering the program, and other relevant stakeholders, develop a recruitment strategy to ensure a sufficient supply of CCAs to meet rising demands in this sector.

A mix of tools to recruit new entrants – financial incentives/bursaries, reduction/ subsidization of education costs, reduction of barriers to entry and the time frame CCAs

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[32] The Recognition of Prior Learning process consists of two components: Course recognition (CR) and Prior Learning and Assessment (PLAR). An individual interested in CCA certification may qualify for one of the two methods. CR time was reduced from 24 months to 12 months and PLAR time was reduced from 30 months to 15 months as of April 2013.

[33] Supplied by Pam Shipley, Manager of the Continuing Care Assistant Program, Health Association Nova Scotia (Fall 2013).

[34] It should be noted that the bursary option did not work effectively everywhere in the province – largely in rural areas, and Working Group members are not unanimous in supporting a return of the bursary program in its original form. Some employers could not guarantee that there would be a position available at the end of the education period. As well, some students preferred not to have an explicit return for service agreement with a specific employer. In some areas, employers did not enforce this condition of funding requiring students to pay back their bursary, recognizing that the sector shares staff (staff move among home and long term care agencies).

have to complete their education, increased use of the Recognizing Prior Learning (RPL) process, and the like – could be explored, based on prior learnings to date. This work should seek to identify the barriers to entry and successful completion and potential solutions to attract staff to work in this field. Measures should expedite entry of new staff into the field, given the urgency of the current situation.

Retention of CCAs

Issue:

Staff retention is an issue in the sector as factors such as wages/stability of income, working conditions, and the opportunity to work elsewhere influence retention rates, along with other factors.

Analysis/Discussion:

Historically, home care has had to compete for CCAs with long term care where staff income is more predictable and the work environment is stable. The addition of new long term care beds into the system is said to have made recruitment and retention of CCAs in home care more difficult. The demand for similar workers in acute care (known as Care Team Assistants or Acute Care Assistants) is also expected to increase. So one sector does not lose staff at the expense of the other, system planners have attempted to maintain roughly equivalent compensation levels for these workers in all three settings (acute, long term care and home care).

The retention of CCAs in the home care sector often is hindered by the capacity of home support agencies to offer guarantees of income. In order to retain staff, CCAs need a sustainable level of income. As a sector, there is a need to find a balance between mitigating financial risk associated with "guaranteed hours" and recruiting and retaining workers.

A significant portion of the sector has either guaranteed hours (Northwood and VON both have guaranteed hours representing approximately 40% of the sector) or some form of guarantee such as a guaranteed schedule, although the way in which the guarantee works differs. In addition, VON supplements with casual staff. Both Northwood Homecare and VON report an increase in staff retention, recruitment, recognition, engagement, satisfaction, and client satisfaction. However, there is a cost to this approach; staff are paid for hours of care not delivered which increases the budget.

Research indicates for the home care sector generally, there are other influencing and mitigating factors which affect retention in the home care sector (see Table 4). These factors need to be considered when developing any recruitment and retention strategy. It is recommended that service providers capitalize upon mitigating factors when appropriate as these can help to alleviate some of the challenges associated with factors such as a lack of recognition.

Table 4: Retention Factors [35]

Influencing factors	Mitigating Factors
Low wages	Relationships with clients
Lack of benefits	Deriving reward from helping others
Lack of stable work hours	Positive relationship with supervisor
Lack of recognition	Satisfactory working conditions
Lack of team-based approach	Wages & benefits
Inter-sectoral recruitment	Participation in decision-making

It is important to highlight that clients and their families are directly impacted by the challenges that home support agencies face in recruiting and retaining employees. For instance, client service hours may need to be adjusted or reduced if there is not sufficient staff to provide the service(s). This could also affect agencies' ability to ensure continuity in CCA/client assignments. As a general principle, clients prefer to have consistency when it comes to the CCAs they have providing their care.

1.4   Promote Staff Retention and Workforce Stability

It is recommended that home support agencies and the Department of Health and Wellness work toward creating a work environment which promotes staff retention and workforce stability, including measures which support income stability for staff, along with flexibility as reflected an appropriate mix of staffing (full, part time and casual). Agencies need to be agile and nimble enough to be able to quickly and cost effectively adjust staff hours to meet fluctuating demands while staff need to have a reliable and predictable source of income. It is acknowledged that every hour of service is not a billable hour; some measure of inefficiency (i.e. staff paid for cancelled hours) will be necessary given the nature of the service. (In acute and long term care, staff are paid whether a bed is occupied or not). It will be necessary to balance the need for optimal cost-efficiency and workforce stability.

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[35] Keefe, J., Knight, L., Martin-Matthews, A. & Legare, J. (2011). Key issues in human resource planning for home support workers in Canada. *Work, 40*, 21-28.
http://www.msvu.ca/site/media/msvu/Key%20issues%20in%20human%20resource%20planning%20for%20home%20support%20workers%20in%20Canada.pdf

Funding and Service Delivery

Issue:

In Nova Scotia, the home care program funds four specific services (meal prep, housekeeping, personal care, and respite) with policy parametres/ceilings on hours. While other programs exist for caregiver support, self-managed care, supportive care, bed and equipment loan, home oxygen, personal alert, medication dispenser, and others (See appendix C), these each have unique eligibility requirements and clients are required to "fit" the program.

A broader array of services or menu of options beyond the programs currently offered is needed to support people to remain at home longer. Working Group members cited cases of either non-existent service options forcing people to go into long term care or inflexible policies or funding rules such that even if options were available, they could not be offered to clients – even if these options were less expensive than the alternatives. As a result, people sometimes do not receive the supports they need, and/or are forced into less than optimal care situations from their perspective (e.g. forced to leave their homes) or more costly living/care arrangements to the health care system.

In addition, a significant initiative to transform the way in which care is delivered to persons with disabilities is also contemplated in this province. The Department of Community Services has announced their intent to rely much less on large congregate residential housing centres and move people into the community in integrated housing developments. It is envisioned that care will be provided by new providers and mainstream services such as home care. New service needs for this population must be met with new services and more flexible ways of offering and funding these services to meet client needs. Working Group members were encouraged to consider this population in their deliberations and to include DCS, persons with disabilities, and representatives from this sector in planning moving forward.

Analysis/Discussion:

There is evidence that providing a broader array of service options will enable people – especially seniors to remain their homes longer. Only a small proportion of the elderly have care needs so intense that residential care is the only safe option.[36] The inability to perform the light instrumental activities of daily living, such as housework, transportation, meal preparation, medication management, and grocery shopping, is the typical catalyst for a long-term care placement.[37]

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[36] Williams, A.P., Challis, D., Deber, R., Watkins, J., Kuluski, K., Lum, J.M., Daub, S. (2009). Balancing institutional and community-based care: why some older persons can age successfully at home while others require residential long-term care. *Healthcare Quarterly*, 12(2), 95-105.

[37] Ibid.

While there have been attempts to introduce some needed flexibility and innovation into the system – home first, transition funding in CDHA, and IADL funding as described earlier – these too are limited in their scope, application, and take up by DHAs. When it comes to meeting the housing/supportive housing needs of Nova Scotians, it becomes more difficult as assisted housing options are limited (and not part of the publicly funded continuum of care) and program budgets do by policy not permit flexibility to provide services to clients, even where those services might be less expensive than what policy does permit. Greater flexibility to meet client needs was the prevailing theme.

Throughout the continuum of care, the objective remains to provide the right care in the right place and at the right time. Beyond the traditional offerings of the Home Support program such as personal care, housekeeping, respite, nutritional care, clients may need additional support for IADLs such as managing money, shopping/assistance with errands, transporting or accompanying clients to appointments, assisting clients to access public transportation, grounds maintenance, minor home repairs, snow shovelling, etc. Program eligibility and funding varies from program to program and some require service level agreements between the DHAs and the clients themselves. In some cases, these are barriers to the client accessing the service(s) and making the decision to go into long term care.

With respect to funding, in Canada, home care is funded both publicly and privately and delivered by for-profit and non-profit providers. Publicly-funded clients receive care in one of two ways: 1) either through a contracted home care agency paid for by the government; or 2) through a home care agency paid for by the client who receives a monthly stipend from the government to "shop" for home care that best meets their needs (sometimes referred to as "self-managed care").

Several funding models were found in literature. At the federal level, there is Veteran's Independence Program where financial assistance is provided to eligible clients to obtain services such as grounds maintenance, housekeeping, personal care, access to nutrition, and health and support services provided by a health professional. Funds are allocated directly to the client or paid directly to registered health care and service providers on behalf of the clients. Funding follows the client, not the program. This program has reported success with respect to client satisfaction, ability to remain at home, and cost. Of the 108,000 recipients assisted in 2009/10, 91% report the program enables them to remain at home, meets their needs (86%), reduces admittance to long term care (to 4 %), and the average per recipient expenditure of VIP at home was only $2,716 compared to $9,483 for intermediate care and $13,486 for LTC community care. [38] The type and degree of innovation in funding home care varies across

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[38] Veterans Affairs Canada (2011). Evaluation of the Veterans Independence Program (VIP) Final - July 2011. Retrieved from: http://www.veterans.gc.ca/pdf/deptReports/2011-eval-vip/2011-eval-vip.pdf

provinces. Alberta and British Columbia, for example, are beginning to use assessment tools as the basis for remuneration.

The Working Group heard the approach taken by Saskatchewan is to permit authorization of services up to the cost equivalent of a long term care bed in order to support clients to remain at home.

In the United States, Medicare funds home care through Activity Based Funding (ABF). ABF – sometimes also referred to as patient-focused funding – allocates funding to a hospital based on the type and volume of services they provide, adjusted for the patient population they serve. In Europe there is wide variation in terms of private and public funding and delivery of home care but there is a trend towards limiting public funding mechanisms to meet with increasing demand. Two common mechanisms include withdrawing public funds from home support services like housekeeping and providing clients with cash-limited payments or vouchers to use with the service of their own choosing, including informal caregivers. Shifting a share of the financial burden onto individuals and families, co-payments have been utilized in different ways (i.e., charging flat rates or means-testing).[39] Denmark, has intentionally not built a new nursing home since 1987, favouring instead investment in formal care delivery in the home. Every citizen has a universal right of access to home care and an allotment of hours/dollars to use at their discretion. There is no means or needs testing; it is funded as acute care is funded here. Everyone over the age of 75 is entitled to two proactive home care assessments a year.[40]

Flexible programs, modeled somewhat as "one-stop shopping" centres for all things related to home care, have proven effective in other jurisdictions. For example, the United States' PACE (Program of All Inclusive Care for the Elderly) Project and Quebec's système de services intégré pour personnes âgées en perte d'autonomie (SIPA) provides multidisciplinary teams with prefixed budgets to serve individuals' needs without prescriptive guidelines. These all-encompassing programs typically result in needs-based, tailored, "downward substitutions".[41] The model makes the interaction with the health system a more pleasant one, and ensures the most appropriate supports are being put in place to serve an individual's unique situation. An all-encompassing program would make care planning easier for a multi-disciplinary team or clinical lead, as the most pertinent supports would be available for authorization or recommendation to clients and patients.[42]

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[39] UBC Centre for Health Services and Policy Research (n.d.). Activity based fundingd: Home care. Healthcare Funding. Retrieved from: http://healthcarefunding.ca/activity-based-funding/home-care/

[40] Schulz, 2010

[41] Williams, et. al., 2009

[42] As cited in Health Association Nova Scotia in collaboration with the Cape Breton District Health Authority and the Nova Scotia Department of Health and Wellness. Removing Barriers to Receiving Care at Home: A Perspective from the Cape Breton Region, Focusing on Hospital to Home, 2013.

Recommendation 2: Expand Array of Services, Increase Flexibility to Access Services, and Examine Current Funding Approach

Given our aging population and a growing body of evidence indicating that people can remain home longer with the right supports, it is recommended that both a broader array of services be offered and that more flexible funding mechanisms to improve access to these services be implemented. As well the existing funding model for Home Support Agencies should be examined to ensure it is based on actual costs of care, and information about how budget adjustments for client volume changes are currently calculated should be provided to agencies to ensure clarity of understanding.

2.1   Expand Array of Services and Increase Flexibility to Access Services

A broader array of services could be offered through the home care program and coordinated through the Care Coordinators. Some additional services could be offered by existing home support agencies, either directly or by subcontract to a third party, or independently of the existing agencies. This could include support for IADLs such as managing money, shopping/assistance with errands, transporting or accompanying clients to appointments, assisting clients to access public transportation, grounds maintenance, minor home repairs, snow shovelling, and the like.

It could also include provision of and/or more flexible use of funding to access a broader array of housing options, such as assisted living, improved access to personal alert systems and community-based programs, convalescent care, and more options for self-managed and supportive care. The guiding principle is that funding and systems should be enabling and supportive of client choice. People should not be made to fit programs; rather, programs should be designed to with enough flexibility to meet people's needs in an integrated way. These solutions are often more cost-effective than existing options.

It is recommended that the Department of Health and Wellness work with their DHA counterparts, home support agencies, and other community-based agencies, to design and implement such an approach. It is also recommended that, as different and more flexible models of care are contemplated, agencies and organizations serving persons with disabilities, along with the Department of Community Services, be engaged in this work. It is further recommended that consideration be given to involving seniors, recipients of care and their families/caregivers in this discussion to ensure a client perspective is a central focus.

Current Funding Approach

Issue:

In Nova Scotia, there are two streams of funding in the Home Care Program. The majority of Home Support Agencies base their annual budget on a projection of need within their jurisdiction – referred to in this document as "government funded". In DHA 9, there are also several Home Support Agencies from whom DHW purchases services at an agreed cost per hour (sometimes referred to as "overflow agencies"). The latter serve both public and privately funded clients.

Some "Government-funded" home support agencies suggest the current level of funding provided by government is not reflective of the actual costs of providing care, particularly since government's expectations of service have changed. There is pressure to provide care on a 24 hour basis, 7 days a week, provide a quicker response, provide the necessary level of RN supervision without adequate compensation, facilitate hospital transfers on weekends, and so forth).

Analysis/Discussion:

Budgets have been based on historical funding patterns which some agencies believe are not reflective of current service demands. Better measures of capacity of the sector to provide care are needed. In particular, there is a need for better understanding of the indirect costs involved in providing home care. Efforts are underway to develop metrics or benchmarks which identify the relationship between indirect costs to direct costs, i.e. standardized metrics such as supervisor to employee or direct service hour ratios; schedulers to visits, etc. to develop funding/staffing models for the delivery of care. Further, current methods of DHW funding volume increases cover only direct costs of care, yet higher client volumes affect indirect costs as well (schedulers, supervisors, and other costs). The process for seeking funding adjustments for volume is not universally understood among HSAs either and this process does not lend itself well to advance planning for subsequent years. Some agencies do feel able to hire more staff based on future client volume projections, in case DHW does not approve the funding for these positions. A joint planning process to cover expected projected increases would be preferable. Funding should include a method of automatic increase to cover administrative staff as volume increases during the budget year.

As demand increases, technology advances and wages increase, cost containment has become a priority for all areas of the health sector. This is driving the implementation and experimentation of new funding models that drive efficiency. Work is being done to identify cost drivers in the delivery of home care in order to mitigate these costs. Initiatives have been undertaken by the sector to minimize costs such as bulk purchasing, development of a common strategic positions in collective bargaining to achieve common cost containment objectives, sharing of best practices/improving management practices (e.g. attendance management), and so forth.

2.2 Re-examine Existing Funding Model for Home Support Agencies

It is recommended that the Department of Health and Wellness, in collaboration with the Home Care Network, re-examine the funding model by which home support agencies are funded to deliver services in the province to ensure the system is sustainable, and reflects the actual cost of providing care.

2.3 Increase Understanding of Process for Obtaining Funding Increases

There is concern that not all agencies understand the basis upon which increased funding for volume increases is made.

It is recommended that the Department of Health and Wellness offer an education session on Home Support agency budget preparation and business planning which would include review of the process for adding additional administrative staff as client volumes increase/decrease.

Evidence/Meeting Unmet Need/Wait List Management

Better Utilization of Evidence for System Planning

Issue:

During this project, it became evident early on there is a lack of comparable data from which to make decisions. In order to support good planning and decision-making, additional evidence is required to understand both the demand for services and supply of staff to provide services. Information identifying the magnitude of service demand/"unmet need", as well as the type of services needed to support people to live in their homes longer and/or receive care at home, is critical. Data is also needed to determine how many staff are required to deliver this care as well as what mix of tools and mechanisms have been most effective in increasing the workforce supply in this sector. Further, while some Districts have pilot-tested/implemented new programs and approaches, they have not been subject to evaluation. While recommendations have been made within this report to address some of these deficiencies, more data is required.

Analysis/Discussion:

In order to ensure the sector is able to meet the rising demands for care, efforts to build an evidence base upon which to make decisions is required. Evidence as to the nature of supports required by people to remain in their homes, the supports required by their caregivers, the magnitude of unmet needs (including the size of the current wait list for home care services, the time clients are waiting without care), the time spent in hospital when care might have been provided at home, the assessment of existing funding models and the development and evaluation of new funding and service delivery models, is necessary for system planning in the future.

Can more people be effectively and safely cared for at home? What are their needs and how can they best be met? What service delivery mechanisms and funding approaches need to be put in place to do so? What works and what doesn't? What resources (staff, funding, technology, etc.) are required to ensure service delivery agents have the capacity to provide this care? A much more robust system of data collection, monitoring and evaluation is necessary and one which engages all sector players – DHW, DHAs, HSAs, and others as appropriate – in system planning.

Wait List Measurement and Management

As discussed earlier, consistency of measurements is important for effective monitoring of the wait list. A wait list for home care services is one indicator of unmet need and one tool, among many, for monitoring performance of the home care system and its ability to respond to public need. It is critical that our measures be both valid and reliable. As practices vary around the province as to what constitutes a wait list, and the point at which a wait list begins (immediate upon authorization of service hours or two weeks after), it is critical that a common definition be developed and clarified. (Update: It should be noted that the Wait list definition has been clarified to begin as soon as service is authorized). It is also important to measure both hours of authorized but undelivered service as well as the number of clients awaiting service. The type of service for which clients are waiting would also be of interest.

As we know, there are wait lists in many DHAs – some constant and some periodic. With the number of complex cases increasing and client needs and preferences becoming more specific, clients can be waiting for traditional home support services for an unacceptable length of time. Issues including geographical location, specified hours of service and/or language preference can prohibit or delay the ability for Home Support Agencies to provide the necessary services in the expected time frame. A plan to more actively serve these clients is required. This may require flexibility on the part of clients, Home Support Agencies and the DHAs on how the service is delivered and in some cases funded.

It is important to recognize that the wait list is dynamic. As such, it should be reviewed periodically to ensure that the client still requires the service (has not gone into a Long Term care facility, put other options in place or passed away). More active management of the wait list should expedite the delivery of care to people waiting for service.

Recommendation 3: Better Utilization of Evidence for System Planning, Improved Wait List Measurement and Management

It is recommended that additional efforts be made to define data needs and gather evidence to inform planning and decision-making. Further, evaluation should be embedded within this strategy to ensure we know what works and what does not in meeting increasing demands for care at home. Efforts should also be made to improve measurement and management of the wait list as follows:

- **Improve Measurement/Develop Common Definitions of the Wait List**

  It is recommended that the Department of Health and Wellness clarify the definition of the wait list, its starting point, and other wait list metrics, and the process by which the data will be gathered, reported, shared, and utilized.[43]

- **Develop Response Time Standards**

  It is recommended that the Department of Health and Wellness and District Health Authorities, in collaboration with the Home Care Network, collectively develop response time standards to govern the response times of each party at various intervals in the process to clarify expectations and facilitate a smooth functioning system.

- **Improve Management of the Wait List**

  In order to ensure people have access to care as soon as possible, it is recommended that District Health Authorities more frequently monitor and update the wait list. Improved communication between Care Coordinators and home care agencies will support more active management of the wait list.

Communication and Use of Technology to Support Better Sector-Wide System Planning and Service Delivery

Communication for System Planning

Issue:

Working Group members identified the lack of opportunities for more frequent dialogue among and between DHW, DHAs, and home support agencies as problematic, impeding the identification and joint resolution of sector-wide system issues.

Analysis/Discussion:

Often decisions made by one affect the other – sometimes in deleterious ways, or have unintended consequences which may be unknown to others. System issues may arise and the ability to resolve them collectively is hampered by the absence of a regular mechanism to address them. Regular dialogue helps promote understanding of each other's environment, challenges, and pressures and helps build trust and goodwill to the benefit of mutual clients. Working together can result in better, more effective and efficient ways of doing business and more effective joint planning and service delivery.

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[43] Note some of these initiatives have begun since project inception.

Recommendation 4: Improve Communication, Use of Technology to Support Better Sector-wide System Planning and Service Delivery

It is recommended that the Department of Health and Wellness, DHAs, and home support agencies develop the mechanisms, tools and technology to more actively engage in joint system planning, problem identification, and resolution to enhance service delivery.

4.1 Establish Opportunities for Ongoing Sector-wide Planning and Dialogue

The effective design and delivery of home care services requires the engagement of all three of the primary players within the home care sector: home support agencies, the Department of Health and Wellness, and District Health Authorities. To ensure good integrated system-wide policy, planning and service delivery, allow the opportunity for issue identification and resolution, and promote ongoing collaboration and dialogue, it is recommended that the co-chairs of the Home Care Network have regular and ongoing discussions with their colleagues at the Department of Health and Wellness and District Health Authorities. Specifically, the following would be important strategic linkages[44]:

- Co-chairs, Home Care Network and the DHW Executive Director of Continuing Care

- Co-chairs, Home Care Network and Chair, DHA Directors of Continuing Care Group

- Local/DHA Home Support Agency directors dialogue with local/DHA Directors of Continuing Care

Opportunities for periodic dialogue with the following would also be useful:

- Co-chairs, Home Care Network and the DHA VPs Community designates as lead for Continuing Care (as required)

Better Utilization of Technology

Information technology (IT) has the potential to improve the quality, safety, and efficiency of health care.[45] The timely communication of client's changes in health status is one example where increased use of technology would benefit the client.

Issue:
DHA Care Coordinators and home support agencies have been reliant on outdated paper-based

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[44] Note that some of these initiatives have begun since the initiation of this project.

[45] http://medpac.gov/publications%5Ccongressional_reports%5CJune04_ch7.pdf

fax systems of transferring information to each other. DHA Care Coordinators transfer information related to client care plans and service hours authorized to home support agencies, and client updates are transferred to Care Coordinators when client health status and service hour needs change. It would be much more expedient to electronically transfer this information. Efforts have been underway for some time to pilot test this transfer.

Analysis/Discussion:

Technology can also assist in improving productivity by allowing for rapid changes to schedules/rescheduling of cancelled visits, sharing of case plans, and the like which can improve care and allow service providers to maximize their staff resources. As well, this technology can also support the health and safety and employees. Home care utilizes a model of service wherein CCAs often work by themselves and in remote areas of the province. This presents various safety concerns and better utilizing technology can help to mitigate the risks associated with this type of service delivery. Mobile telephone software was being rolled out in 2013-14 in publicly funded home care agencies to achieve efficiencies and support employee safety. Case plans can also be uploaded if agencies wish.

Tele-Homecare Monitoring and Self-Management

Recent innovations in home care have introduced technology to empower clients to become more engaged in actively managing their care with the support of home care staff who remotely help monitor the health status of clients electronically. This has been used successfully in other areas of Canada in management of chronic care. Technology offers the potential for better case management by Care Coordinators and support via home care agency staff/RN supervisors. Tele-homecare monitoring and self-management may be even more pertinent to rural settings where services may be less accessible. Tele-homecare monitoring allows a nurse to observe and monitor multiple clients from a centralized station which reduces anxiety of clients and enables them to self-manage their care. Nurses indicate the program reduces the burden on a limited HHR supply, resulted in a reduction of avoidable use of ER, decreased hospital re-admissions, and reduced travel times and costs for nurse.[46]

Technology can also greatly assist in providing data to be used for evidence based decision making. It is anticipated that much of the HHR survey data in home care referred to earlier can be extracted from home care data base systems (Procura, SAP) for example. Additional metrics on cost drivers and quality indicators can support agency management decision-making as well as system planning.

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[46] Canadian Homecare Association. (2009). Bringing it all home: Telehomecare in the Northern Lights Health Region. High Impact Practice. Retrieved from: http://www.cdnhomecare.ca/media.php?mid=2267

4.2   Recommendation: Make Better Use of Technology

It is recommended that the Department of Health and Wellness, working with home support agencies, undertake the following initiatives to make better use of technology to improve access to information to support quality improvements and enhance decision-making.

- Enhance/enable electronic exchange of client-related information between DHA Care Coordinators and home support agencies.

- Continue to support use of software and mobile telephone technology to achieve efficiencies in care delivery and enhance occupational health and safety for home care staff.

- Explore innovative uses of technology to support greater capacity of individuals, together with their health care providers, to monitor and manage their health at home.

Client Awareness of Services

Issue:

Clients are not always aware of the services available to them. This issue relates to awareness of home care services generally and of the specific programs for which they may be eligible.

Analysis/Discussion:

With respect to public awareness, efforts to increase public understanding of home care have been underway for some time by Health Association Nova Scotia Continuing Care Council which sponsors an annual Continuing Care Awareness campaign to inform the public about both long term care and home care. DHW also launched a continuing care public awareness campaign in the fall of 2013, which included TV ads, an updated website, and new fact sheets on continuing care programs and services. These campaigns could provide a foundation for further work in developing a communication strategy.

Public understanding of the many programs offered and their potential eligibility for them requires more active intervention at the individual level as program eligibility rules can be complex. It has been reported by members of the Working Group that at times, it may be several weeks before community Care Coordinators are available to meet with clients, leaving clients unaware of available supports in the interim. It should be noted that even when informed, clients may not be interested or fully understand a service and what it has to offer. It is a shared responsibility among DHA Care Coordinators and Home Support Agencies to inform clients of community-based services that may be helpful to them.

4.3   Better Inform Clients of Services Available

It is recommended that DHA Care Coordinators and Home Support agencies provide clients with information about services that may be helpful to them, at the earliest possible opportunity. This may be in the form of print materials and/or a discussion of needs and program eligibility requirements, and support to access services. Development of a checklist of programs and services is recommended as a helpful tool for care providers to use as a reference to ensure they inform clients about what may be available to them.

Case Management

The National Case Management Network defines case management as:

"… A collaborative, client-driven process for the provision of quality health and supportive services through the effective and efficient use of resources. Case management supports the clients' achievement of safe, realistic and reasonable goals within a complex health, social and fiscal environment" [47]

Issue:

Care Coordinators are experiencing challenges managing the current home care caseload in the time available, which can result in service delays, slower response times than desired, and clients may not get services when they need it. Or clients may have excess service hours they no longer need – resulting in inefficient use of resources. This also exacerbates the wait list when other clients on the wait list might benefit from those care hours. As demand for service rises, eliminating organizational inefficiencies and streamlining the case management function will become more and more critical. Further, increasing case complexity has placed more onerous demands on Care Coordinators' time. Clients with comorbidities/multiple health conditions who require multiple services from multiple providers take up increasing amounts of Care Coordinator time. Yet case management done well will ultimately save time and costs by potentially avoiding hospital admission, and improve client health outcomes. Enabling Care Coordinators to do more intense case management for those high needs cases would better utilize their clinical skills; designating others to manage the less complex cases would expedite case processing.

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[47] National Case Management Network (2009). Canadian Standards of Practice for Case Management. Retrieved from: http://www.ncmn.ca/Resources/Documents/Standards.pdf

Analysis/Discussion:

Exploring ways home support agencies could help manage cases/expedite changes on care plans might alleviate the burden on care Coordinators as well leaving them free to manage more complex cases. For example, suggestions made by home support agencies regarding changes in client needs are not always able to be acted upon by the Care Coordinator in a timely fashion. Changes to a client's care plan may take time to implement due to Care Coordinator caseload capacity. This can create resource issues within home support agencies as well as leave other clients with unmet needs. While home support agencies currently advise Care Coordinators when client hours should be increased or decreased, the case load of Care Coordinators does not permit them to respond immediately. For example, often when clients leave hospital, their care needs (and service hours authorized) are high but reduce significantly before a reassessment can be done, or a client may suddenly require more service hours if she/he experiences a fall. Allowing home support agencies to make these changes in service hours would increase the agility of the system.

The development and maintenance of good relationships between HSA staff and Care Coordinators will also help improve understanding and resolve client and system level issues. A more collaborative process involving VON nursing, home support, and Care Coordinators may also help resolve challenges in care planning and management.

Recommendation 5: Improve Case/Care Management
To ensure role optimization of staff, expedite changes to client care plans, and improve case management, it is recommended that:

5.1 Enable Care Coordinators to do More Intense Management of Complex Cases

District Health Authorities revamp the case management system by providing more intensive case management to those cases with a multiple providers and/or greater complexity, applying a higher level of clinical skills to those cases which need it most.

5.2 Allow Home Support Agencies to Change Service Hours

The Department of Health and Wellness amend home care policy and processes to empower home support agencies to make changes to service hours authorized/care plans, within certain parametres (e.g. within 10% of hours authorized?), with notice to Care Coordinators, in recognition that home support agency staff are in the best position to know when clients' needs change. Allowing the home care delivery system to respond more quickly will meet client care needs more expeditiously, free up service hours for potential use by other clients, and enable Care Coordinators to devote more time to management of more complex cases.

5.3 Allow Home Support Agencies to Change Care Plans/Authorize Additional Services Beyond the Current Scope of Home Care Services

The Department of Health and Wellness allow home support agencies to change care plans/authorize additional services beyond the current scope of home care services to meet client needs, beginning with personal alert systems and bed loan programs. This could be built upon as services and processes expand.

5.4 Build Relationships and Enhance Communication

That DHAs and home support agencies actively seek out opportunities at the local level to build interagency relationships, directly communicate about cases, share concerns, identify and resolve issues, and clarify expectations so that care provided is optimal and systemic issues are addressed. Case management is supported by good collaborative relationships among the agencies involved in the delivery of that care.

5.5 Orientation of New Staff

That home support agencies and District Health Authority Continuing Care explore opportunities for joint orientation of new staff enabling each to better understand the other's role and challenges. Visits to home support agencies should be embedded in orientation for new Care Coordinators. Similarly, orientation of new home support agency management and supervisory staff should involve cross fertilization and visits to the Care Coordinators' work sites.

Change Management

Issue:
Changing the focus of care from facility-based to "home first" will require a significant philosophical and cultural practice shift among care recipients and their family/friend caregivers, physicians, and health care providers. This "shift in thinking" will require a proactive change management strategy in order to be successful.

Analysis/Discussion:
Clients and caregivers may need to adjust their expectations of service as well as their willingness to become engaged in active management of their own health care. A strategy which encourages the public to become active partners in management of their health to proactively maintain their independence into old age could also help to minimize or delay utilization/need for home care services.

Health care practitioners and physicians often lack awareness of the services home care offers, and in the interests of patient safety, can therefore be reluctant to support clients leaving hospital to go home, preferring long term care instead. Education and peer leadership may also be required to change thinking and practice in support of providing care at home.

Further engagement and integration of primary care physicians into home care would also improve client care.

A change management strategy closely linked to a communication strategy should help introduce and implement new processes, new policies and education surrounding the provision of home care services in general. Change Management is the process that begins with senior leaders who engage key stakeholders and employees – it should be developed early, and adapted as necessary.

> *"Although the home can be a cost-effective and preferred place for service provision, the prevailing philosophy in practice is that frail seniors are most appropriately cared for in a long-term care environment."*
>
> - Removing Barriers to Receiving Care at Home, April 2013

Understanding the need for change and taking ownership of the change are important points in successful implementation of change.

A key element of this process would be to collectively (with sector partners) clearly define and articulate the vision, philosophy, goals, and direction of the approach to provide more care at home.

Recommendation 6:   Develop and Implement a Change Management Strategy

It is recommended that a change management strategy be developed to both inform stakeholders of nature of the change(s) to support a shift to a "home first" philosophy to enable people to remain at home and to develop successful implementation strategies. Stakeholders include but are not limited to first and foremost the clients, their support system (friends, family), leaders in the health care sectors, physicians, managers and health care providers.

Caregiver Strategy

Issue:

Many people will not be able to remain at home without the care of family, friends, or significant others. The availability and capacity of caregivers is a key influential factor in determining whether a person can remain at home. Caregivers require support to fulfill this role.

Analysis/Discussion:

As indicated previously, the vast majority of home care clients in Canada also receive care from family caregivers, a notable proportion of which are seniors themselves. In addition to the economic impact of lost productivity on both caregivers and businesses, caregiver stress has been identified as a significant concern as well, contributing to both hospital and long term care admission. The need for caregivers to be supported to meet the physical, emotional, and financial demands of caring for another has been well documented. Clearly, given the demonstrated contribution of family/friend caregivers, efforts must be made to provide them with necessary and adequate support through effective public policy, access to services and supports, and recognition of financial and other impacts of caregiving.

Recommendation 7: Develop a Caregiver Strategy

Given the critical role played by friend/family caregivers, it is recommended that DHW in concert with Caregivers Nova Scotia, the Home Care Network, and other interested parties as appropriate, develop a strategy to support caregivers to provide care to loved ones at home which addresses the physical (provision of respite, personal care), financial (income replacement, coverage of costs of caring for another person at home), and emotional (respite, support programs) aspects of caregiving. Enhance income support to caregivers, for example, through an income replacement program, perhaps modelled on the caregiver benefit, which is simpler to access and more comprehensive than the federal benefit available only to those who pay into employment insurance and which has limits and restrictive eligibility rules. Equipping caregivers with the capacity to provide support will be a key linchpin in the success of any strategy to support the provision of care at home.

CONCLUSION

Home care can offer clients the services they need to remain in their homes safely and in good health. It is a critical component of the health care system and one which can alleviate pressures in other parts of the health care continuum. By staying in their homes with the proper supports, people may not need to enter a long term care facility, or stay in hospital while awaiting admission to long term care, or may be able to delay admission to long term care. Adequately equipping home support agencies to deliver the services required in the future will be essential in order to ensure the right care can be given in the right place at the right time.

The demand for home support is increasing due to a number of factors and in order to meet that demand, there are a number of system challenges that need to be addressed. These challenges are identified along with recommendations for improvement in strategic areas. Some recommendations will require further work to determine their feasibility and implementation processes, while others can begin immediately.

Implementation Plan

In order to move forward with recommendations, support open dialogue, a shift in thinking among those involved in the delivery of home care, it is suggested that DHW, DHAs, and the Home Care Network co-host a Continuing Care Change Management Summit with home care managers and supervisors, and others, to discuss the ideas in this report and opportunities to improve the delivery of care at home.

Further work with sector partners to identify priorities and develop an action plan to implement the recommendations will be necessary.

Nova Scotia is seen as a leader in Home Care across Canada and the recommendations provided are intended as a call to action to ensure Nova Scotia remains in this position. Providing a broader array of services and supports to enable people to remain home and improving access to existing home care services will be critically important to enable home care to meet the current and projected future increases in demand for care. Receiving care at home is also consistent with public preference. "When they look ahead to future living arrangements that go with aging, Canada's baby boomers see staying in their own homes and paying for home care as the best option."[48]

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[48] http://www.cbc.ca/news/business/canadian-boomers-want-to-stay-in-their-homes-as-they-age-1.2224171

June 30, 2014

APPENDIX A – DEPARTMENT OF HEALTH AND WELLNESS FUNDED HOME CARE SERVICE PROVIDERS BY DISTRICT

District	Provider(s)
1 – South Shore	• Lunenburg County Home Support • Region of Queens Home Support
2 – South West Nova	• VON Tri-County Home Support • Yarmouth/Argyle Home Support Services • Digby/Clare Home Support Agency
3 – Annapolis Valley	• VON Annapolis Valley Home Support
4 – Colchester East Hants	• VON Colchester East Hants Home Support
5 – Cumberland	• VON Cumberland Home Support
6 – Pictou	• VON Pictou County Home Support
7 – Guysborough Antigonish Strait	• Antigonish & Area Homemaker Services • Guysborough County Home Support Agency • Inverness County Home Support Society
8 – Cape Breton	• Cape Breton County Homemakers Agency • City Homemaker Service Society • New Waterford Homemaker Service Society • Northside Visiting Homemaker Service Society • Victoria County Home Support Service Society
9 – Capital	• Red Cross Home Partners, NS Region • Northwood Home Care • Revera Home Health* • Bayshore Home HealthCare* • RJF HealthCare* • We Care Health Services (as of December 2013)* • Closing the Gap Healthcare Group(as of December 2013)*

*Denotes home support agencies where services are purchased from DHW; all others are funded through annual budgeting process.

APPENDIX B – WORKING GROUP COMPOSITION

Co-chairs:

Helen Marsh, Executive Director, New Waterford Homemaker Service Society

Michele Lowe, Executive Director, Northwood in the Community

Representing the Network:

Sandra Bauld, Northwood
Ruth Morrison, Executive Director, Victoria County
Chris Baert-Wilson, Director, Community Health, Atlantic Canada, Red Cross
Cheryl Richard, Branch Manager NS, Revera Home Health
Allan Chalmers, VP Operations, RJF Healthcare
Sharon Crane, Agency Director, Cape Breton County Homemakers
Georgia Lloyd, President, Always Home Homecare Ltd.
Dawn MacMillan, VON

Representing DHW:

Carolyn Maxwell, Director

Representing DHAs:

Lindsay Peach, VP Community, CBDHA
Wendy McVeigh, SSDHA

Health Association Nova Scotia Support Staff:

Carolyn Marshall – report author and group facilitator
Chuck McDow
Kathryn Yuill
Carol Salkin
Mary Lee

June 30, 2014

APPENDIX C – NOVA SCOTIA HOME SUPPORT PROGRAMS

Program	Description	Staffing requirement
Home Care	**Home Support** A range of personal care and home support services are available. Personal care services help the client with daily living tasks, such as dressing/undressing, bathing, toilet use, feeding, and help with mobilization. Home Support Services also help the client with tasks, such as light housekeeping, laundry, and meal preparation. In-home respite services for caregivers are also available. There may be a cost, depending on your income. **Nursing** Home Care nurses provide a variety of nursing services in the client's home, such as, nursing assessment, health teaching, health monitoring and treatment. Direct nursing care in the home can include activities, such as intravenous therapy, dressing changes, catheter care and assistance with medication management. Nova Scotians can receive services at home free of charge.	Continuing Care Assistants, Provincially certified Home Support Workers
Respite Care	In addition to respite available through the Home Care program, facility-based respite care is available for $34 a day.	Continuing Care Assistants, Provincially certified Personal Support Workers
Caregiver Benefit	The Caregiver Benefit recognizes the important role of caregivers in their efforts to assist loved ones and friends. Intended for caregivers of low income adults who have a high level of disability or impairment, as determined by a home care assessment. Those who qualify can receive a benefit of $400 a month.	Client decision

Self-Managed Care	The Self-Managed Care Program allows people with physical disabilities to direct and manage their own care, including hiring their own care providers and developing their own care plans.	Client, Care manager (if applicable)
Supportive Care	The Supportive Care Program supports eligible Nova Scotians with cognitive impairments by providing them with $500/month for Home Support Services and up to $495 for snow removal services.	Client substitute decision-maker
Home Oxygen Service	Eligible Nova Scotians can receive oxygen and oxygen equipment but may contribute to the costs, depending on their income.	Not applicable; home oxygen vendors supply equipment
Medication Dispenser Assistive Technology	The automated dispenser helps you take the right medication at the right time and reminds you if you haven't taken your pills.	Not applicable
Personal Alert Assistance	The Personal Alert Assistance Program provides financial assistance to eligible, low-income seniors. The program provides up to $480/year to reimburse for the purchase of a personal alert assistance service.	Not applicable
Seniors Community Wheelchair Loan Program	This program is designed to help low-income seniors 65 or older and in need of a wheelchair for basic daily activities and to remain in their homes.	Not applicable; contracted provider supplies equipment

Source: Nova Scotia Department of Health and Wellness website http://novascotia.ca/dhw/ccs/live-well-at-home.asp

APPENDIX D – REFERENCES

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