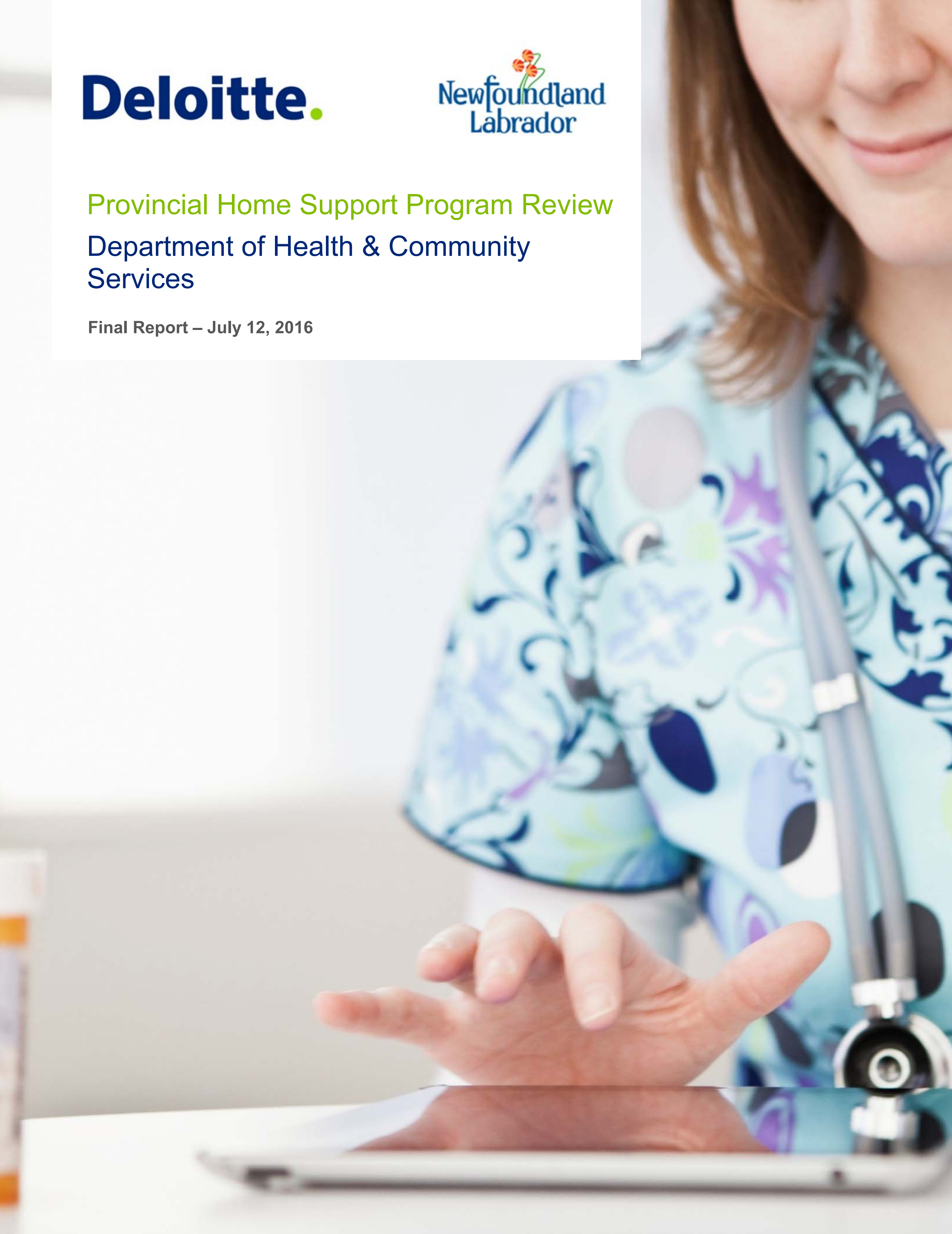

Provincial Home Support Program Review

Department of Health & Community Services

Final Report – July 12, 2016

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Executive Summary

Background

The Provincial Home Support Program (PHSP) is part of a wider array of community support services and is intended to enable eligible individuals who require assistance with activities of daily living to remain independent in their homes and communities. Ideally, the provision of home supports would prevent, delay or provide a substitute for institutional placement or acute care admission. The Program is experiencing significant demand and funding growth which has led to the need to identify options to improve its effectiveness and gain program efficiencies.

Scope and Approach

Deloitte Inc. (Deloitte) was engaged by the Department of Health and Community Services (HCS) to complete a comprehensive review of the PHSP to determine whether it is operating as efficiently and effectively as possible, to identify opportunities to improve the Program, and to inform changes required to help ensure its future sustainability. Moreover, the opportunities for improvement outlined in this report also take into consideration that the Program is integral to the sustainability of the broader health system and impacts adjacent programs and services.

The review consisted of four phases of work over a 16-week period and was guided by a Steering Committee comprised of program leadership from HCS and the four Regional Health Authorities (RHAs). The review was completed through an iterative process, involving extensive consultations with internal and external stakeholders, a jurisdictional scan and literature review, data collection and analysis, and regular meetings and several workshops with the Steering Committee. Over 315 individual stakeholders representing HCS, the RHAs, clients, home support workers, agencies, industry associations, bookkeepers, and client advocacy groups were engaged throughout the review.

Jurisdictional Scan and Literature Review

To inform the review from a leading practices standpoint, a jurisdictional scan and literature review was completed. Primary and secondary research methods revealed:

- Performance metrics demonstrated by British Columbia, Alberta, Saskatchewan and Nova Scotia suggest their programs are the most mature of the Canadian provinces;
- There are key differences and similarities in how home support services are administered and delivered in Newfoundland and Labrador compared to these jurisdictions. Most notably, the comparator jurisdictions have:
  - Simpler financial eligibility criteria and streamlined assessment processes;
  - Defined home support worker (HSW) qualification and educational requirements; and,
  - Established performance management systems;
- The role of home support services in enhancing health system performance is evolving as these provinces are:
  - Starting to rely more on outcomes and measurement with a shift toward paying for outcomes, not simply hours of service; and,
  - Progressively utilizing home supports and other community care programs as a means to address capacity and cost effectiveness challenges in other care settings;

- Home support workers scope of practice is expanding with a focus on improving coordination with professional clinical teams;
- The efficiency and continuity of care delivery are being enhanced through technology; and,
- Transactional activities are being centralized to leverage economies of scale and reduce costs.

In addition, the review identified that the leading models of community-based care support are able to improve client outcomes through:

- The creation of integrated teams and multi-sector partnerships around clients to help them receive care closer to home;
- Utilizing technology in new and innovative ways to help caregivers and health providers communicate better and monitor clients remotely; and,
- Shift expertise and expand scopes of practice.

Current State Review

An in-depth review of the current state of the Program was completed across its four key areas: (i) Intake and Referral, (ii) Assessment, Planning, and Co-ordination, (iii) Home Supports Delivery, and (iv) Monitoring and Policy Development. The current state review considered business processes, staffing models, service delivery models, funding models, Program eligibility, and policy standards to identify opportunities to improve the efficiency and effectiveness in each of these areas. The key findings from this aspect of the review are as follows:

- There is significant variation between the RHAs in delivering most aspects of the Program[1];
- These variations are also present in Program utilization, referrals, approvals, exemptions and workloads which suggests inequitable access to the Program across the Province;
- The predominant clinical assessment tool used was found to have several limitations and the approval of supports may be above the minimal level required to maintain client independence;
- Although the financial assessment is considered to be important to determine eligibility for subsidized home support services and an appropriate and equitable co-pay, some staff and clients of the Program consider the financial assessment process to be resource intensive, burdensome and invasive, especially the Needs Test;
- The integration of home support services with other community support programs and services is limited;
- Monitoring and oversight of home support services delivery is lacking across both agency-based and self-managed care options;
- Home support workers lack a defined set of qualifications and a viable career path relative to other occupations. This creates challenges in staff attraction and retention and adversely impacts the consistent provision of quality supports;
- The Provincial Operational Standards including Program goals are dated and are in need of revision; and,
- The Program's data collection and Program measurement are lacking in several areas as there is limited ongoing attention to Program performance and client outcomes.

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[1] It is important to note that some of the variation may be a result of differing data availability and reporting abilities across regions. In many areas, standardized data was not available so the best available data was used to analyze program areas.

Through a telephone survey conducted with 131 clients, the Program was rated highly in meeting the needs of its clients, which suggests a high degree of effectiveness of the Program. While client satisfaction was largely consistent across RHAs, adults with disabilities reported lower satisfaction relative to other client groups across all measures.

While the results of the client survey were encouraging, and there is a general consensus among stakeholders that the Program is meeting its goals, the review identified evidence suggesting the Program is not fully meeting its goals as set forth within the current policy framework. Despite clients having a significant degree of choice in how their independence is supported by the Program, inconsistency with respect to the appropriateness of approved support hours and the application of policies across regions and client groups was observed.

Future Demand for Services and Vision

As increasing demand for home support services was one of the key factors that precipitated the review of the Program, a predictive model of demand was developed to inform Program planning and the assessment of future fiscal sustainability. Based on factors such as shifting population demographics, public health trends, and historical cost escalation, it is estimated that overall Program caseloads will increase by approximately 14% over the next five years. Moreover, without policy intervention, this change in demand will result in a $53 million increase in annual subsidy expenditures and additional RHA resources to administer the Program. The magnitude of the forecasted increase in Program caseloads and expenditures and the prevailing fiscal climate create a powerful case for change. Consequently, the Steering Committee developed a new vision and a set of guiding principles for the Program on which to build the opportunities for improvement and align the participation of stakeholders.

All citizens of the Province have access to the home support services they need to help them remain independent in their homes and communities, avoid unnecessary hospitalization and long-term care placement, and maintain their well-being.

Furthermore, the attainment of this vision will be informed by a set of monitoring and evaluation indicators, the most critical of which include:

- Reducing the time for clients to be assessed and receive supports;
- Increasing the percentage of eligible populations accessing the Program and avoiding institutional placement;
- Increasing the number of clients with individualized community inclusion plans; and,
- Increasing family and caregiver participation in the development of the client's service plan.

Improvement Opportunities

In total, 25 opportunities to improve the Program were identified along with an implementation strategy and roadmap. The opportunities that represent the highest return on implementation effort include:

- Enhancing clinical assessment tools and implementing hours-based service limits to more accurately define and communicate client care needs;
- Improving the hand-off of service plans to care providers to improve the continuity of care and eliminate redundant reassessments;
- Delegating reassessments to supervised RHA paraprofessionals to improve RHA staff productivity and service capacity;
- Streamlining financial assessment processes to improve RHA staff productivity and service capacity;

- Optimizing financial eligibility criteria and client co-payments to improve resource allocation and enhance Program sustainability;
- Implementing service levels into agency agreements to improve accountability, oversight, and focus on client outcomes; and,
- Implementing a performance management framework to guide Program monitoring, evaluation and policy changes.

These opportunities were vetted with the Steering Committee, and there is confidence that the report represents a realistic set of improvements for the Program that will impact its clients and those who deliver home support services over the next five years and beyond. Moreover, policy options exist for HCS to improve the effectiveness and efficiency of the Program so as to mitigate the financial and staffing implications of the projected demand for home support services.

Finally, the Program is a critical element of the Provincial Long-Term Care and Community Support Services Strategy. In fact, it is a fundamental building block of the services being delivered under the strategy. It is viewed by clients, their families and key Program stakeholders as a valuable program to support seniors and adults and children with disabilities to remain in their homes and live independently. It has the added value of supporting the RHAs in avoiding unnecessary hospitalizations and allowing some patients to go home as opposed to being placed in a personal care or LTC facility. Therefore, the need to have the most efficient and effective Program going forward in the face of an aging society and more individuals with complex needs is paramount. This review of the PHSP represents a unique opportunity for the Province to drive change in an integral area of the health care system, demonstrate fiscal stewardship and realize improved citizen health and wellness.

1. Introduction

1.1. Background

The Department of Health and Community Services (HCS) is committed to supporting individuals to live in their homes and remain independent through the Provincial Home Support Program (PHSP or Program). Moreover, the Program represents a significant investment by the Government of Newfoundland and Labrador (GNL) and is an integral component of the Province's Strategy for Long-Term Care and Community Support Services. Table 1 below summarizes key elements of the Program.

Table 1: The PHSP at a Glance

Philosophy	To provide individuals with the supports and services they require so they may choose to live as independently as possible within the community. To the extent possible, services are provided in an accessible and equitable manner within the fiscal capabilities of the Province and region.
Goals	• That individuals who meet Program admission criteria have the support services they need to live and develop fully and independently within the community in keeping with their assessed needs. • That individuals have choice in how they live. • That the PHSP be equitable for all eligible population groups across the Province.
Key Clients	Home support services are primarily offered to Seniors (age 65+), Adults with Disabilities (AWD), and children with disabilities receiving the Special Child Welfare Allowance (SCWA).
Service Levels	• Subsidized home support services are limited by a financial ceiling of $3,325 per month for seniors and $4,750 per month for adults with disabilities. • Palliative care home support is provided for up to 28 days; there is also end-of-life home supports available. • The Acute Short Term Home Care Program is available across the Province to avoid admission and facilitate early hospital discharge; the Community Rapid Response Program prevents admission to acute care; the Home First pilot supports medically discharged patients to go home or wait there for LTC placement.
Program Eligibility	Individuals must be a resident of the Province, must have a demonstrated clinical need, and be unable to self-fund care in order to be eligible for the Program. The interRAI Home Care Assessment System (RAI-HC) is the standard provincial clinical assessment tool that is used to determine eligibility and home support needs for seniors and adults with physical disabilities. The assessment is interdisciplinary and focuses on client need, which in turn informs service plans managed under the PHSP. The Adult Needs Assessment is used to determine eligibility and home support needs for adults with intellectual disabilities, while a number of other home-grown tools are used across the RHAs for children with disabilities.
Funding Model	The four RHAs receive block funding and they have the flexibility in approvals of subsidies. Clients are required to contribute to cost of care based on sliding-scale determined through an income assessment. Some block funding arrangements are in place under the Paid Family Caregiver option.
Service Delivery Model	Services are delivered through three service delivery channels: agency-based care, self-managed care (SMC) and more recently, paid family caregivers.

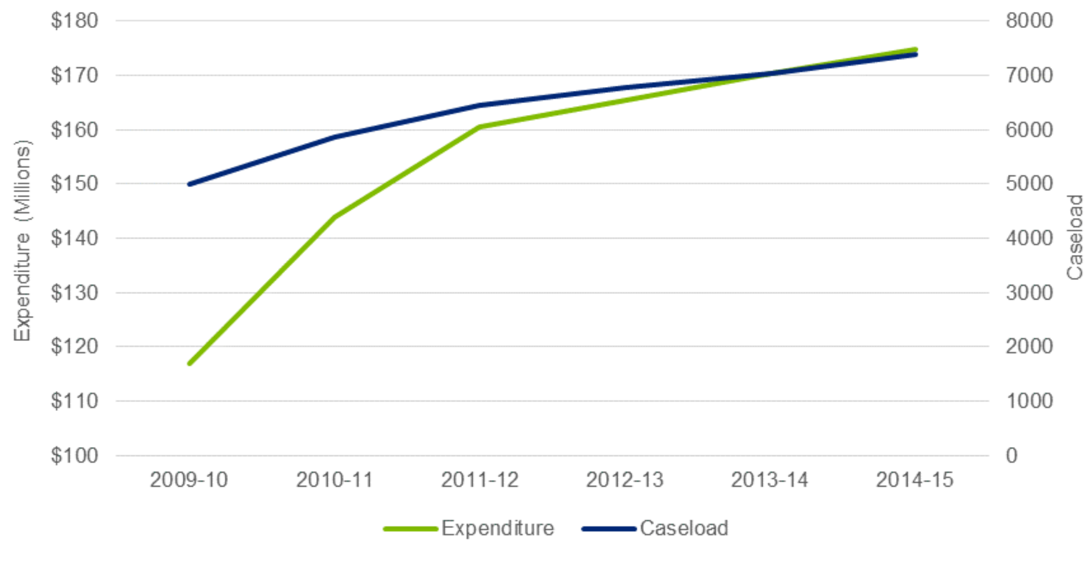
The Program currently serves over 7,100 clients throughout the Province with an annual expenditure of $175 million (in FY 2014-15). The distribution of clients and spending along with other related information across the RHAs is summarized in Table 2 below.

Table 2: Key Program Metrics by RHA (FY15-16)

Metric	Eastern Health	Central Health	Western Health	Labrador-Grenfell Health
Population Served FY15-16	317,340	93,114	77,816	37,959
Estimated Total Target Population[2]	56,410	21,925	17,600	4,935
Total Caseloads FY15-16[3]	3,555	1,641	1,733	268
Caseload per Capita	1.1%	1.8%	2.2%	0.7%
Total Expenditures (FY14-15)	$91.4M	$40.9M	$35.7M	$6.8M
Expenditures per Capita	$288.12	$439.25	$458.41	$179.28
Agency Locations	42	12	9	2
Target Population per Agency Location	1,343	1,827	1,956	2,468
RHA FTE Resources (FY15-16)[4]	124.2	71.5	70.0	28.0
Caseload per RHA FTE Resource[5]	28.6	22.9	24.8	9.5

The Program has grown substantially since its inception in the 1980s and has experienced a significant increase in caseloads since changes were made to the financial eligibility standards in 2009-10 and in response to growing demand and a greater complexity of client needs. Figure 1 below illustrates the magnitude of growth in Program spending in recent years, particularly for seniors.

Figure 1: Growth in Program Caseloads & Expenditures (FY09-10 to FY14-15)



[2] Seniors, AWD and SCWA

[3] As of October, 2015

[4] FTE resources represent the total number of intake resources, community health nurses, social workers, home support coordinators, and financial assessors. This figure does not reflect the percent of time these resources dedicate to the Home Support Program, but is the total number of FTEs who have responsibility for duties within the Home Support Program

[5] This figure only reflects caseloads for clients receiving Home Support. These employees also manage other Community Support clients not availing of Home Supports.

The current Provincial Operational Standards were released in 2005 while the revised Financial Assessment Policy in 2014. There have also been other program and policy changes at both HCS and the RHAs that are influencing the uptake of the Program, including the introduction of the Paid Family Caregiver option, Palliative and End-of-Life Home services, Short-Term Acute Home Support Services, and the 'Home First' program being piloted in Eastern Health. Pressure on the Program to continue to adapt and support more individuals is constant, while the challenge of sustainably delivering services across a vast geography remains. Consequently, HCS in collaboration with the Regional Health Authorities (RHAs), sought to conduct a comprehensive review of the Program to determine whether it is achieving its desired goals, and serving and responding to a changing environment in the best way possible.

1.2. Project Objectives and Scope

Deloitte Inc. (Deloitte) was engaged by HCS to complete a comprehensive review of the Program to determine whether it is operating as efficiently and effectively as possible, to identify opportunities to improve the Program, and to inform changes required to help ensure the future sustainability of the Program. The concept of financial sustainability is of particular importance given the recent growth in program spending and the prevailing fiscal challenges faced by the Province.

As such, the PHSP was reviewed with the following in mind:

- **Effectiveness:** the provision of high-quality, appropriate and accessible supports that enhance the ability of clients to remain independent in their homes and communities; and,
- **Efficiency:** the administration of the Program in the most cost-effective, resource appropriate and timely manner that enhances the Province's ability to sustainably support its clients.

The Program is part of a wider array of community support services and is intended to enable eligible individuals who require assistance with activities of daily living to remain independent in their homes and communities, potentially preventing, delaying or providing a substitute for institutional placement or acute care admission. As such, the recommendations and opportunities for improvement outlined in this report also take into consideration that the Program is integral to the sustainability of the broader health system and impacts adjacent programs and services. Within these overall objectives, HCS outlined 13 project deliverables for Deloitte to address as outlined below in Table 3.

Table 3: Review Deliverables

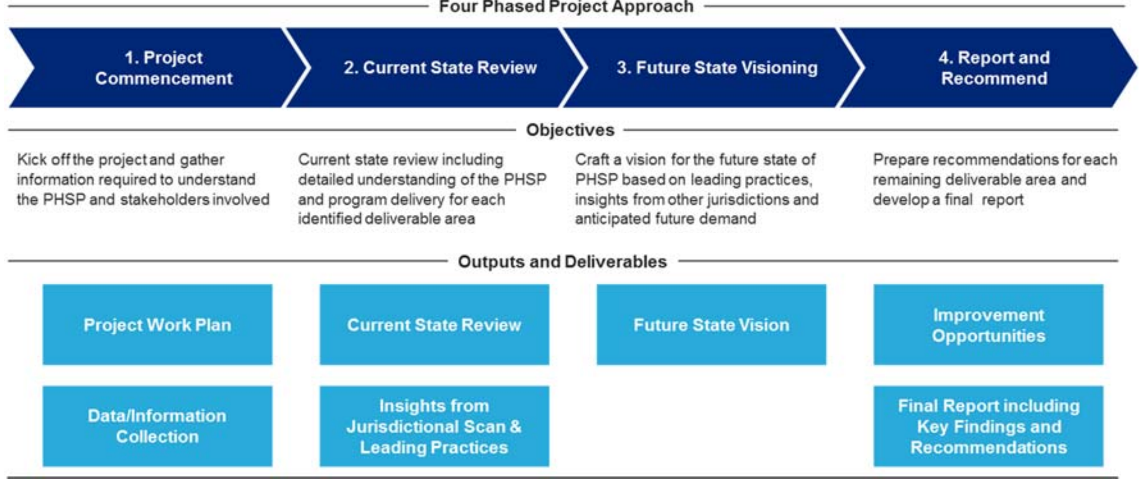
Deliverable		Description
1	**Jurisdictional Scan & Literature Review**	Complete a jurisdictional scan and literature review regarding the provision of home support services to inform best practices and recommend, if necessary, changes to the PHSP's established standards and policies to reflect best practices.
2	**Program Eligibility**	Review current eligibility criteria and recommend, if necessary, changes for improvement.
3	**Future Service Demand**	Examine recent growth trends (since 2009) and identify contributing factors and project future demands for service.
4	**Business Processes**	Review current business processes and make recommendations, if required, to improve/streamline current processes to create efficiencies.
5	**Staffing Model**	Review the current staffing model and make recommendations, if required, to ensure the most effective, efficient utilization of staff, working within their scope of practice, in the delivery of the home support program.
6	**Service Delivery Model**	Review the current service delivery model with comparisons to other service delivery models and make recommendations, if required, to reflect best practices in the provision of home support services.
7	**Funding Model**	Review the current funding model with comparison to alternate funding models and make recommendations regarding the optimal funding model to ensure sustainability of the Program while providing quality services to clients.

Deliverable		Description
8	**Policy Compliance**	Review RHA compliance with established standards as either defined in the Provincial Home Support Program Operational Standards (November 2005) or with policy direction as provided by the Department subsequent to the Operational Standards as related to the delivery of the PHSP.
9	**Program Goals**	Determine if the Program is meeting its intended goals as outlined in the Provincial Home Support Program Operational Standards (November 2005), and if not, changes required to meet the goals.
10	**Policy Standardization**	Identify any inconsistencies in home support policies across the four RHAs and make recommendations, if required, to facilitate the delivery of a provincially standardized program.
11	**Monitoring & Evaluation Indicators**	Identify appropriate indicators for ongoing monitoring and evaluation of the home support program.
12	**Implementation Strategy**	Develop an implementation strategy for any recommended program changes.
13	**Summary Reports & Presentation**	Prepare a summary of the jurisdictional scan, review findings and recommendations in a detailed written report, including an executive summary with an accompanying MS PowerPoint presentation.

1.3. Approach

The review consisted of four phases of work over a 16-week period and was guided by a Steering Committee comprised of program leadership from HCS and the four RHAs. The review was completed through an iterative process, involving regular status updates and workshops with the Steering Committee. The objectives and outputs for each phase of work are highlighted in Figure 2 below, with a detailed project approach and schedule provided within Appendix A.

Figure 2: Project Approach



2. Jurisdictional Scan and Literature Review

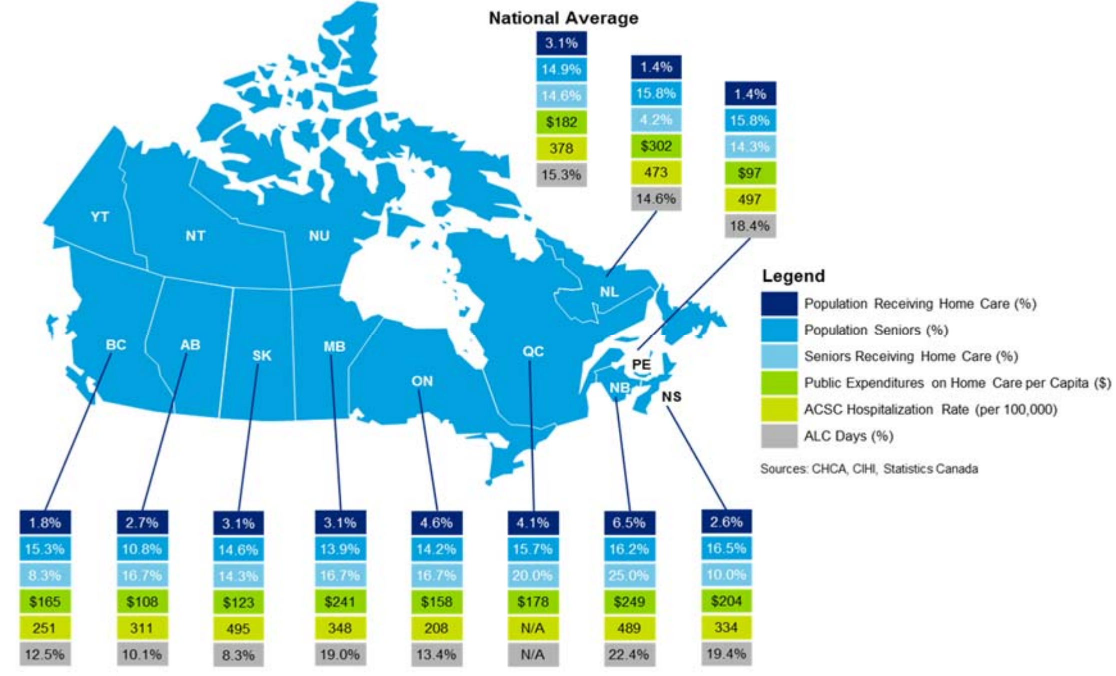
To inform the review of the PHSP from a leading practices standpoint, a jurisdictional scan and literature review was completed. This work sought to identify the most relevant insights for the PHSP through progressively refined research questions and qualitative analysis methods that included:

- Review of key program metrics across the Canadian provinces to identify jurisdictions for focused analysis;
- Detailed review of policy documents and consultation with program leadership in select Canadian jurisdictions to understand policy intent, strategic direction, and the design of home care and support programs;
- Review of recognized and accredited leading practice models of community-based care;
- Review of academic literature pertaining to leading practices for the assessment of clinical needs; and,
- Consultations with Deloitte's Global Health Care Practice and select other subject matter experts.

2.1. Broad Review of Canadian Provinces

Initially, the jurisdictional scan sought to achieve focus by assessing high-level program performance metrics demonstrated by other Canadian provinces while remaining cognizant of demographic and geographical comparability. The Portraits of Home Care, published by the Canadian Association of Home Care, represented the most comprehensive and standardized data set for identifying select jurisdictions to understand in detail. Key metrics for each Canadian jurisdiction across a range of home care and support service performance indicators are summarized below in Figure 3.

Figure 3: Key Home Care & Support Service Performance Metrics by Canadian Province (2013)



In conducting this broad scan of Canadian provinces, the review identified the following key findings that span program accessibility, cost effectiveness, appropriateness, and capacity:

Accessibility:

- The utilization of home care and support services is highest in New Brunswick, Ontario, and Quebec; and,
- The proportion of the population aged 65 and over in Newfoundland and Labrador is comparable to other jurisdictions; however, other jurisdictions have higher rates of home care and support utilization amongst the senior population.

Cost Effectiveness:

- While faced with similar geographical challenges to Newfoundland and Labrador, per capita home care expenditures are significantly lower in Alberta and Saskatchewan; and,
- Per capita home care expenditures in Prince Edward Island are approximately one-third of Newfoundland and Labrador, with a comparable rate of program utilization.

Appropriateness and Capacity:

- Hospitalization rates for conditions appropriate for treatment in an ambulatory care setting are the lowest in Ontario, British Columbia, and Alberta; and,
- Alberta and Saskatchewan report the lowest Alternate Level of Care (ALC) days across the Canadian provinces.

As a result of this broad scan, and on the balance of program performance, demographic and geographic comparability, British Columbia, Alberta, Saskatchewan and Nova Scotia emerged as the most relevant Canadian jurisdictions to look toward and understand in greater detail.

2.2. Focused Jurisdictional Research

Consequently, primary and secondary research methods were employed to further understand the structure of current programs and the policy direction of these select jurisdictions. Additionally, subject matter experts in Deloitte's Global Health Care Practice were consulted to identify alternative practices and emerging trends outside of Canada. This follow-up research, profiled in greater detail in Appendix B, revealed:

- Key differences and similarities in how home support services are administered and delivered:
  - While comparator programs share common objectives with the PHSP, Nova Scotia and British Columbia, in particular, demonstrate a highly specific emphasis on addressing unmet client need;
  - Like Newfoundland and Labrador, home support services in other jurisdictions are delivered to a variety of client groups under a common policy framework;
  - The interRAI Home Care Assessment System (RAI-HC) remains the standard and predominant client assessment tool for the Seniors client population. However, little standardization exists in clinical assessment instruments across jurisdictions for Adults with Disabilities and Children with Disabilities. Other jurisdictions, like Newfoundland and Labrador, typically utilize custom in-house tools for these client segments;
  - Significant variability exists in the service delivery options available, with Newfoundland and Labrador offering more choice in service delivery than most jurisdictions reviewed. For example, self-managed care for home supports has been evaluated in British Columbia but has not yet been implemented;
  - Provinces such as Alberta and Nova Scotia have more formal relationships with home support agencies, have contracted these services through competitive procurement processes and have implemented service level agreements;
  - Other jurisdictions have streamlined their financial assessments for subsidy eligibility to be based exclusively on net income (as defined by line 236 of the client's Federal Income Tax Return); and,
  - Significant variability exists in the qualification requirements for Home Support Workers. Nova Scotia, for example, requires graduation from an approved program and the completion of a standardized examination.

- The role of home support services in enhancing system performance is evolving:
  - Newfoundland and Labrador are among other Canadian jurisdictions evaluating the role of home-based supports within the context of the wider health care system;
  - Program leadership in other jurisdictions have identified an ever increasing role for non-clinical supports as means to alleviate capacity pressures on institutional settings and to meet fiscal stewardship objectives; and,
  - While the mandate to push clinical services into the community in some jurisdictions is clear, program structures and the delivery of home support services are still evolving.
- A focus on outcomes and measurement:
  - Consultations with other jurisdictions revealed a significant focus on program and system outcomes monitoring and reporting;
  - For example, Vancouver Health Authority has developed a comprehensive program monitoring and evaluation framework which has become the provincial standard in British Columbia. The framework includes indicators that span: availability, access, continuity, competency, communication, and efficiency; and,
  - Moreover, policy making in British Columbia (Home First) and Nova Scotia (Caregiver Benefit) is being guided by empirical research that seeks to identify the most cost-effective care setting based on client needs and care level.
- An emerging shift toward paying for outcomes, not simply hours of service:
  - While home support programs in Canada still maintain a funding model based on service hours (and client co-pay where applicable), a trend toward paying for client outcomes in community-based care is emerging; and,
  - Under such a model, service providers would be responsible for a defined client caseload and would receive a set amount of funding for each eligible client. Payment schedules would be tied to service providers achieving defined client quality outcomes (e.g., rate of residential placement, rate of acute care service access, etc.), thus creating greater incentives to support client wellbeing and independence;
  - For example:
    - Nova Scotia and Ontario are presently exploring expanding service level standards in home care and support agencies contracts to include outcomes-based funding;
    - Private sector care organizations in Arizona State who are responsible for coordinating continuing long-term supports receive a capitated Medicaid rate. The set amount for each enrolled individual (regardless of home or residential status) is an incentive to keep their clients healthy and avoid higher care costs; and,
    - The New Brunswick Medical Society have recently announced a memorandum of understanding with their provincial government to modernize the delivery of family medicine. Under the agreement, the model of physician payment is set to be redefined with the specific goal of reducing unnecessary use of walk-in clinics and emergency room services.
- Expanding home support worker scope of practice and a focus on improving coordination with clinical teams:
  - Home Support Workers (HSW) or comparable non-professional staff in other jurisdictions are experiencing an expanding scope of practice to include client surveillance, participation in care planning and the completion of delegated clinical tasks;
  - With appropriate training and with client specific protocols, home support workers in other jurisdictions can:
    - Administer select topical and oral medication; and,

    - Conduct simple procedures such as small non-sterile dressing changes, simple catheterization and basic ostomy management (e.g., tube cleaning, bag replacement).
  - Additionally, investments to strengthen community-based care and programming continue to grow, particularly for rehabilitation services (e.g., Occupational Therapy/Physiotherapy) and achieving greater integration with primary care.
- Improving the efficiency and continuity of care delivery through technology:
  - In the absence of universal Electronic Health Records, consultations identified a number of tactical technology enablers that improve the continuity and efficiency of home support delivery, including:
    - Point of Care devices for scheduling, communicating care plans, and tracking service hours;
    - Comprehensive electronic RAI-HC assessments;
    - Care coordinator notifications when Program clients are admitted to acute care;
    - Integration portals across in-patient clinical information and community case management systems;
    - Wearable technology and remote patient monitoring; and,
    - Automated electronic access to income information through the central government taxation agency.
- Centralization of transactional activities to leverage economies of scale:
  - AHRC, the largest not-for-profit organization in New York City, offers a wide range of programs, services, and supports tailored to meet needs of persons with disabilities. AHRC has successfully implemented a centralized inquiry, intake and referral process that coordinates everything that needs to be on file for a client to receive approved supports; and
  - Newfoundland and Labrador is following Nova Scotia, New Brunswick, Ontario, Saskatchewan, Alberta and British Columbia in the implementation of health sector shared services to improve the efficiency of non-clinical transactional activities (e.g., client pay, accounts payable).

2.3. Leading Models of Community-Based Care

Recognizing that home support services are one component of a larger community supports services system, it is important to consider emerging trends in this sector and their influence on home care and home supports services. As such, the jurisdictional scan and literature review also reviewed the following leading practice models of community-based care:

- Integrated Care for Complex Populations (ICCP);
- Palliative and Therapeutic Harmonization (PATH);
- Home Is Best™;
- West Prince Telehospice;
- Paperless Operations in Community Health Care
- SyMO;
- Optimization of In-Home Occupational Therapy Services; and,
- eShift.

Review of these leading models of community-based care (as explored in further detail in Appendix B) confirmed that client outcomes in the Canadian health care sector are being driven by:

- The creation of integrated teams and multi-sector partnerships around clients to help them receive care closer to home;
- Using technology in new and innovative ways to help caregivers and health providers communicate better and monitor clients remotely; and,
- Shifting expertise and expanding scopes of practice.

3. Current State Review

The philosophy underlying the Program, as defined within the current Operational Standards, has been to provide individuals with the supports and services they require to maintain their independence within the community. The Program is a component of a wider array of community support services and is intended to supplement, not replace, the support and services provided by an individual's family and their support network. Figure 4 below defines the various elements of program delivery and the respective responsibilities of HCS, the RHAs, agencies and clients that form the current program governance structure.

Figure 4: Program Areas, Process Scope & Responsibilities

Program Area	Process Scope	Primary Responsibility
Program Intake & Referral	Referral Intake	RHAs
	Redirection of Inquiries	
Assessment, Planning & Coordination	Clinical Assessment	
	Financial Assessment	
	Service Plan Development & Coordination	
	Client Payment Processing	
	Waitlist Management	
Home Supports Delivery	Agency Based Care	Home Support Agencies
	Self-Managed Care	Client
	Service Monitoring	RHAs
Monitoring & Policy Development	Program Quality Monitoring	HCS
	Policy Standards Development	

As the sequencing of program areas and processes in Figure 4 approximates a client's journey through the Program, the following section reviews the current state of each area in detail to convey the Program from beginning-to-end.

3.1. Program Intake and Referral

As seen in Figure 5, the usage rates for the Program show variation across the RHAs, most drastically with the senior population (from a high of 6.3% in Western Health to 2.6% in Labrador-Grenfell Health). As seen in Figure 6, the usage rates have increased since 2009-10 when program financial eligibility criteria changed.

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Figure 5: Program Utilization by Client Group per RHA (FY14-15)

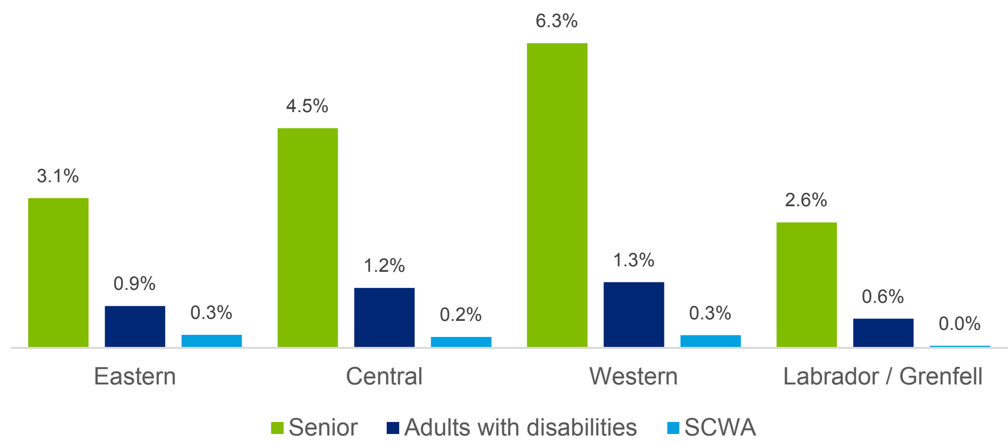
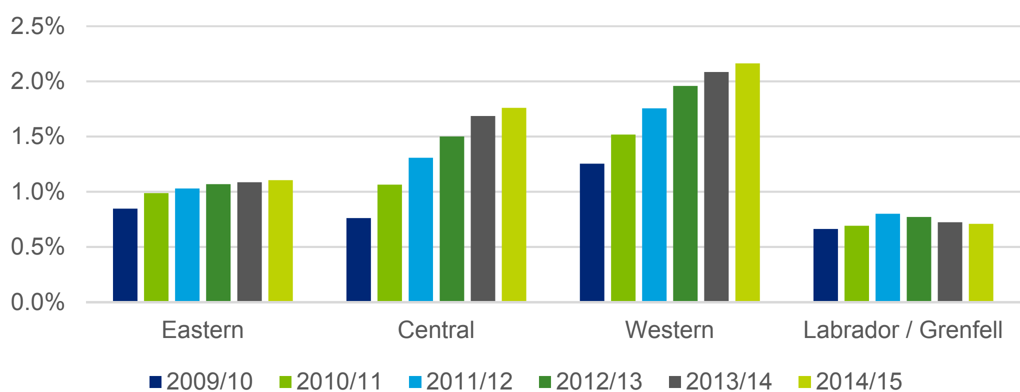
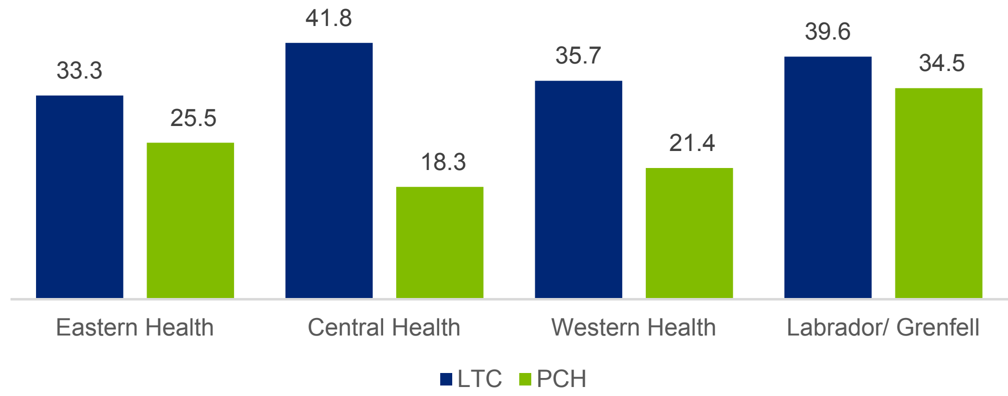


Figure 6: Program Utilization by RHA (FY14-15)



One of the factors that determine usage of the Program is the availability of alternative care arrangements such as Personal Care Home (PCH) and LTC facilities. Across the Province, there is significant variations with respect to the availability of PCH and LTC beds (Figure 7**Error! Reference source not found.**). Eastern Health has the best ratio of seniors per LTC bed at 33.3 as of 2015 (including 120 Chancellor Park beds). Central Heath has the most unfavourable ratio of seniors per LTC bed, having 41.8 seniors in the region for every LTC bed.

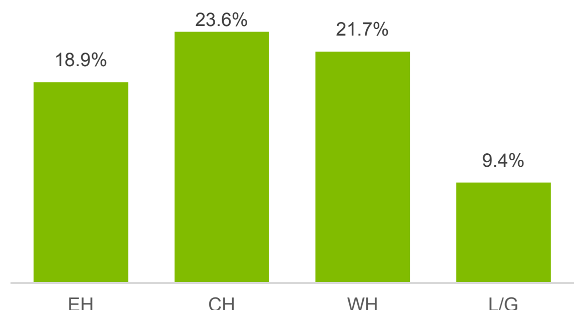
Figure 7: Seniors per LTC and PCH Bed by RHA (FY15-16)



With respect to PCH beds, Central Health, and Western Health have the best ratios of seniors per PCH bed as shown in Figure 7.

While there is no direct correlation between usage of the Program with the availability of PCH and LTC beds combined, the data suggests that where a region has lower availability of LTC beds it usually has a higher usage of the Program relative to other regions.

Figure 8: PCH Vacancy Rate by RHA



3.1.1. Program Referral Sources

As seen in Figure 9, the vast majority of referrals to the Program come from the community (on average 87% between 2009/10 and 2014/15) while referrals from hospitals averaged 10.7%. Figure 10 also indicates that Eastern Health shows the lowest percentage of community referrals, with Western Health showing the highest rate at 94.9%. Conversely, Eastern Health's referral rate from hospitals is 2.5 times that of Western Health. A likely explanation for this difference is Eastern Health's assertive promotion of the Program within its acute sector supported by its executive team.

Figure 9: Program Referrals by Source (FY09-10 to FY14-15)

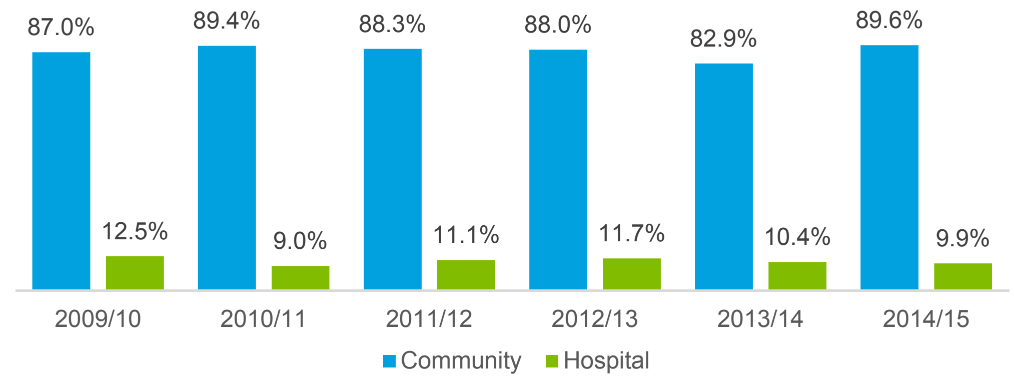
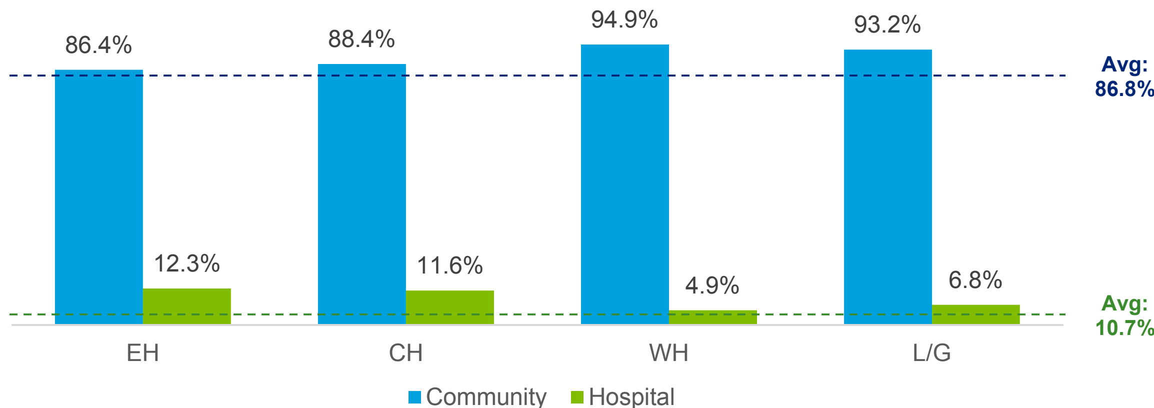


Figure 10: RHA Program Referrals by Source (FY14-15)

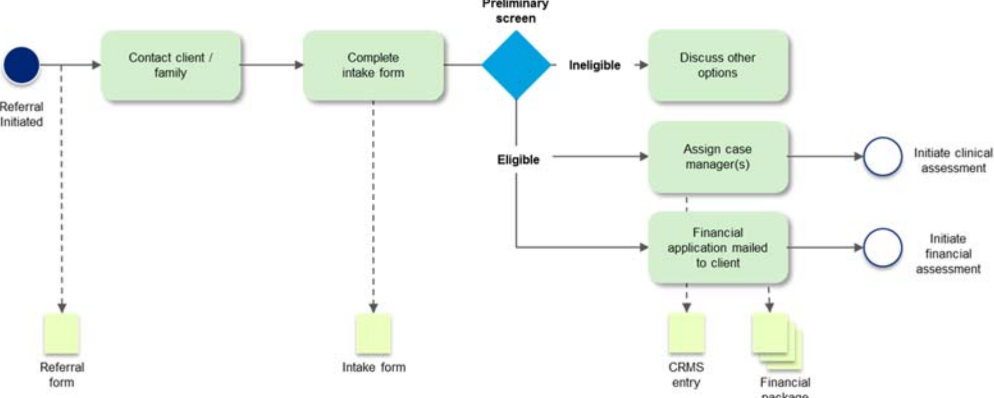


Clients are able to self-refer, and their numbers are reflected in the community referrals presented above. Information on the Program is contained on the HCS and RHA websites, though the level of detail varies, with clients often learning about the Program through family or other informal means. The level of physician referrals is perceived by many as low, but there is limited insight as to why this is the current situation given that most if not all clients in Eastern Health, Central Health and Western Health have a family physician involved in monitoring their care. Moreover, with the need to reduce inappropriate use of hospital and LTC beds, the acute and LTC care sectors would be expected to be a larger source of referrals.

3.1.2. Intake Process

Each RHA has developed its own intake and referral procedures. The data captured for the review through documentation and in consultation with RHA staff demonstrates differences in the intake process to what could be reasonably expected of a standardized business process. This raises the issue of consistency or equity of access within a provincial program. The general process can be found in Figure 11, notable key differences in which each RHA completed these components is explained in the bullets below.

Figure 11: Client Intake & Referral Process



- Eligibility screening varies across regions (based on professional judgment and different intake forms);
- The basis for assigning case managers varies slightly by region;
- Intake is decentralized among communities in Labrador-Grenfell Heath, as well as some communities in other RHAs;
- There are no staff dedicated to Program intake at Labrador-Grenfell Health;
- In Western Health, Community Health Nurses complete referral intake;
- In Western Health, an intake/financial navigator helps clients gather financial documentation required for their initial screening; and,
- In Western Health, financial packages are hand-delivered to clients during clinical assessments.

The application process involving the clinical assessment (no application form) has to be completed by a community health nurse or a social worker in the client's home, and a financial application form that is completed and submitted by the client. Initiating the 'application' process usually involves an initial phone call by the client or family member to the local RHA office. At that time, after a preliminary screening by the intake officer about the requested need of home support, a client file is opened by the RHA and an internal referral made to either a Community Health Nurse or a Social Worker who acts as a case manager for the client. As highlighted in the client survey results (discussed below in Section 3.4.1), clients do not always view the application process as being clearly communicated to them or their family member.

The review of the intake process across the RHAs raised two issues:

- The most appropriate staff member to undertake this routine task, and;

- Whether the intake function can be centralized at the provincial level to support the delivery of a standardized program.

Currently, there are different professionals with different skill sets (clinical and non-clinical) functioning as intake officers. While there are no difference in results from the varying skill sets employed (i.e., clients are admitted to the referral process appropriately), consideration has to be given to ensuring that each RHA is using the most appropriate skill set for this and every other function. For this function, it has been demonstrated that non-clinical staff can undertake portions of this function effectively. When lower skilled non-clinical staff are used, the results are lower personnel costs to the RHA as well as freed-up clinician time for more appropriate, higher-level duties. However, due to PHSP being part of an integrated set of community support services and intake to the Program aiding RHA staff who refer clients to the most appropriate services and supports, it is appropriate that the intake process be led by a clinical practitioner.

3.1.3. Improvement Opportunities

The following four improvement opportunities have been identified to support this area of the Program:

- Promotion of the Program built on a 'home is best' philosophy would help make the Program better known across the Province and improve access to the Program. This will require greater promotion across all care settings, along with clients and their families, and will assist in supporting more appropriate and timely referrals of clients to the Program;
- Consistent online resources need to be established that have the appropriate program information to aid client self-referral and navigation within the Program. These resources will assist HCS and the RHAs in promoting the Program positively and consistently across all regions of the Province;
- Improving process efficiency may be achieved by implementing a provincial centralized intake and referrals process. This change will assist in improving timely access and consistency under the Program across all regions, secondary to efforts to modernize provincial policies and standardize processes across RHAs; and,
- Improving inter-discipline collaboration among physicians, nurses and other providers in support of the Program would improve more timely referrals of clients. Achieving greater collaboration will assist in better hospital and LTC bed utilization, keep more individuals away from ERs, and result in more appropriate and timely referrals to the Program.

Further details of these opportunities are contained in Appendix C.

3.2. Assessment, Planning and Coordination

3.2.1. Clinical Assessment

3.2.1.1. Program Eligibility

Eligibility for publicly subsidized home support services is based on the need for service, financial eligibility, and place of residence. Clients must have an unmet need to be eligible for the Program, as determined by a client assessment/reassessment that is completed by RHA staff. Therefore, the completion of a clinical assessment/reassessment determines both home support needs and eligibility. The clinical assessment is then used to determine, implement and monitor a service delivery plan that is intended to align services to assessed need.

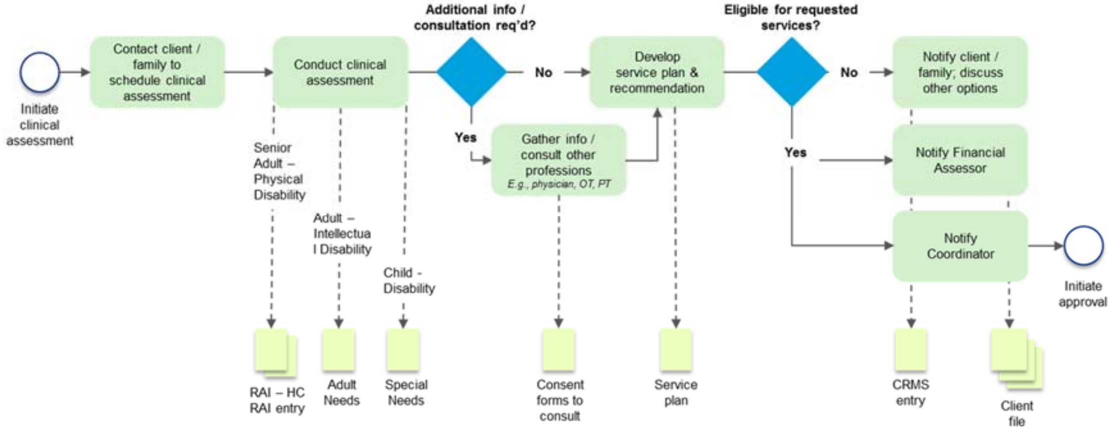
3.2.1.2. Clinical Assessment Process

Clinical assessments are generally completed by Community Health Nurses (CHN) for seniors and Social Workers (SW) for non-seniors. During the year, periodic reassessments are performed when there is a change in heath status. In addition, there is a policy mandated annual reassessment that occurs whether or not clinical status has changed. Clinical activity notes are recorded in CRMS for each client by RHA staff and include notes on client visits, clinical assessments/reassessments, and counseling. Concerns about poor quality and variability of the data entry into CRMS, as well as difficulty with data extraction and reliable reporting have been raised by RHA staff.

The clinical assessment process is a multi-step process that involves interaction between several parties and is illustrated in Figure 12. Generally, once the client has undergone the initial screen, which occurs during the referral intake process, the case is assigned to a case manager (either CHN or SW). The CHN or SW then contacts the client and schedules an onsite clinical visit to complete the assessment. The CHN or SW may need to consult with or gather supporting clinical documentation from other health professionals.

The CHN or SW will then use the completed assessment, supporting information, and their professional judgment to determine clinical eligibility for home support services and develop a service plan for the client. The Coordinator and Financial Assessor, as well as the client/family is notified of the decision. It typically takes five to ten days to schedule and complete the clinical assessment, depending on the time it takes to schedule a clinical assessment, obtain any supporting documentation from other health professionals, and for SW to get approval for certain supplementary supports (e.g., foot care).

Figure 12: Clinical Assessment Process



During consultations with RHA staff, several key business process inconsistencies across regions and pain points were identified, as described in Table 4 below.

Table 4: Clinical Assessment Process Inconsistencies and Pain Points

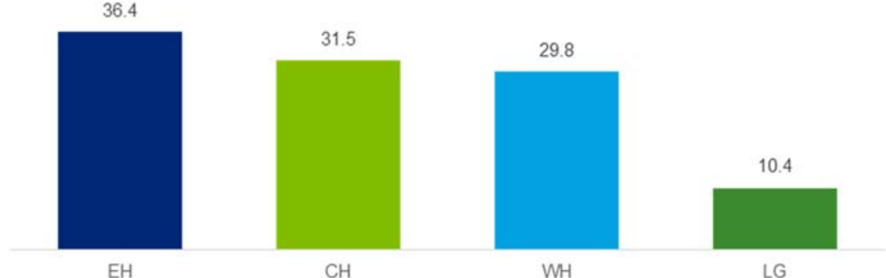
Key Inconsistencies Across RHAs
In Central Health, the financial assessment is completed prior to the clinical assessment, in order to ensure that clinical staff do not spend time and effort completing the assessment only for clients that would otherwise be financially ineligible or deny publically subsidized home support services. In all other regions, the clinical assessment is completed prior to or in tandem with the financial assessment, as mandated in the Operational Standards.
Requesting family or other informal caregivers to be present during the clinical assessment is not routinely or consistently carried out by the RHA staff. This is important as some clients (i.e., clients with dementia or cognitive impairment) may not be able to accurately communicate their condition or need.
The RAI–HC clinical assessment tool is not fully rolled out in all communities throughout the Province.
Approaches and guidelines for developing service plans vary across regions. The PHSP Operational Standards does not recommend provincial guidelines for the development of service plans. Central Health is currently the only region that has established a regional guideline to help RHA staff develop service plans based on client need, as assessed through a clinical assessment.
Frequency and reliability of CRMS entry of clinical information varies between and across regions. There is a lack of provincial or even regional standards that dictate the quality and frequency of entries into CRMS. During stakeholder consultations it was discovered that, although most key clinical activities (such as counseling clients, conducting clinical assessments) are recorded in CRMS, this is not always the case.
RHA staff have reported that discussions of alternative options to publically subsidized home support services with clients/families do not always occur.

Key Pain Points
Developing service plans may require obtaining supporting documentation or consultation with other health professionals. This may include a formal diagnosis from a physician for adults with disabilities and SCWA clients and referrals to or information from OTs or PTs, depending on the client need.
Social Workers cannot perform the assessment to determine if a client qualifies for foot care, which is a supplementary benefit. As such, the paper work goes to the Community Health Nurse to complete the clinical assessment to determine if the client needs specialized foot care and is then returned to the Social Worker. This results in delays in the completion of the clinical assessment and service plan.
The complete 'client file' (clinical assessment/reassessment, service plan, supporting clinical documentation and activity notes) is fragmented across several systems, including CRMS, RAI MDS–HC, and a paper file.
The information systems used by the Departments of Advanced Education and Skills (AES) and Health and Community Services are not integrated. Therefore, Special Assistance Program (SAP) clients that require publically subsidized home support services need to be manually keyed into CRMS, even though they may have already been keyed into the AES system.
Clients that are deemed financially (or clinically) ineligible do not consistently receive counseling or education on other service or program options across regions or RHA staff, as there is a lack of provincial standards on referring to other services and programs.
Individuals who provide services to clients (HSWs, agencies, and other informal caregivers) receive little to no communication from RHA staff on client needs as determined through the clinical assessment. Western Health is currently the only RHA that shares client profiles and comprehensive RAI reports with agencies.

3.2.1.3. Workload and Scope of Practice

To compare clinical staff workload across RHAs, the number of clinical assessments and reassessments performed per CHN or SW FTE per year was used as one possible indicator. Because data on the total number of clinical assessments and reassessments performed by each RHA is not readily available, annual caseload data was used as a proxy for the minimum number of assessments/reassessments performed in one year.[6] There is significant variability related to clinical staff workload across the RHAs. In FY2014/15, Eastern Health demonstrated the highest 'clinical assessment productivity' level, as indicated through highest number of clinical assessments and reassessments per CHN or SW FTE per year (see Figure 13). Western Health and Central Health have comparable CHN and SW FTEs as well as comparable clinical assessment productivity levels.

Figure 13: Clinical Assessments per FTE per Year by RHA (FY2014-15)



It should be noted that that all clinical staff work across Community Support Services, including, but not limited to wound care, palliative and end of life care, and residential monitoring of Personal Care Home, Alternate Family Caregiver, ILA and Coop clients. Only a percentage of clinical staff time is dedicated towards the PHSP.[7] Moreover, in addition to completing clinical assessments and reassessments, clinical staff are responsible for a number of tasks as illustrated in Figure 14. CHNs and SWs are assuming similar

[6] OCIO Annual Caseload data was used as proxy for minimum number of clinical assessments and reassessments performed in FY2014/15, assuming that each client received at least one assessment or reassessment

[7] In FY2014/15, the percentage of time dedicated to the PHSP for clinical staff across RHAs was as follows: (1) Western Health, 50% for CHN and 60% for SW; (2) Central Health, 40% for CHN and 70% for SW; and (3) Eastern Health, 25% for CHN and 65% for SW.

responsibilities with respect to the PSHP, spanning referral intake, redirection of inquiries, clinical assessment, service plan development and coordination, providing counselling and intervention services to clients, monitoring and participation in policy standards development. Although waitlist management is identified as part of the clinical staff's role as per their respective job descriptions, waitlist management for PHSP is not implemented in the RHAs.

Figure 14: Scope of Practice by Discipline

Generally, SWs are assigned as case managers for the non-senior population due to the additional allowances, supplementary benefits, and community inclusion needs that this client segment requires. There are some supplementary benefits that SWs cannot recommend, including foot care. For such requests, a CHN must approve or request the specific services.

3.2.1.4. Service Plan Development and Coordination

In order to deliver the most effective and efficient care, it is important to start with a holistic view of a client's health and functional status, and use this understanding to develop an appropriate service plan that is tailored to the client's needs. As such, the foundation for effective, appropriate and sustainable care planning and delivery is a comprehensive, reliable, and well-organized client assessment that helps service providers understand the:

- Type and level of services required;
- Appropriate recommendation regarding the living situation; and
- Restorative (rehabilitation) services that may be effective, if any.

The interRAI Home Care Assessment System (RAI-HC) is the standardized and automated assessment tool that is used by RHA staff to determine home support needs and eligibility for seniors and adults with physical disabilities. The Province is still in the process of rolling out the RAI-HC, which will include ensuring all regions are using the electronic RAI-HC and all CHNs and SWs using the RAI-HC receive training on how to carry out the assessment, interpret the assessment output and translate this output into an appropriate service plan in a manner that is objective, reliable and consistent across assessors.

From 2006 to 2012, the Province invested approximately $3.9 million for implementation of the RAI-HC in order to assist staff in the long-term care and community supports services system and to ensure that eligible individuals are offered the most appropriate service options.[8] The RAI-HC therefore represents a significant investment to the Province. As such, a high level analysis of the RAI-HC was carried out in order to determine strengths and opportunities for improvement for the RAI-HC assessment, based on the characteristics of a strong health assessment described in Appendix D.

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[8] Close to Home: A Strategy for Long-Term Care and Community Support Services 2012

To carry out this analysis, each RHA randomly selected case files that included a completed RAI-HC assessment, corresponding service plan, and any supporting clinical documentation or activity notes. A total of 46 anonymized case files were reviewed by clinical subject matter experts for each client population served by the Program.[9,10,11]

The findings of the case file review were consistent with the strengths and opportunity areas that RHA leadership and staff voiced throughout stakeholder consultations and are summarized in Table 5 below.

Table 5: Strengths and Opportunities for Improvement for the RAI-HC Tool

Strengths	Opportunities for Improvement
Well established tool: A number of trials across several countries establish good validity and inter-rater reliability of RAI-MC items.	**Organization of information:** The most consistent way to understand a senior's well-being is to present well-ordered information about the drivers of their functional dependence, including cognition, mobility, and social circumstances. Although many of these domains are captured in the RAI-HC, the information is not presented in an organized fashion.
Comparability with other jurisdictions: Since most other Canadian jurisdictions use the RAI-HC to assess home care and support needs for seniors, there is potential to compare and benchmark against similar programs in other jurisdictions.	**Under emphasis on the importance of the functional implications of cognitive deficits:** There is a lack of approved clinical "staging" frameworks to differentiate clients based on stage of dementia, frailty or cognitive impairment. In addition, independent and objective sources of information should be used (informal caregivers, objective scales) rather than reliance on client self-report.
Standard scales for status and outcome measures: The assessment includes various scales and indices that can be used to evaluate the individual's clinical status and produce outcome measures that can be used to produce standardized service plans.	**Time consuming, labour intensive and expensive:** Completing the RAI-HC assessment on site takes approximately three hours, not including time for preparing the assessment, travel, completing RAI-HC comments and the development of a recommended service plan. However, based on interviews with other jurisdictions, assessment time can be expected to decrease to 2 -2.5 hours with sufficient experience and training with RAI-HC.

Different clinical instruments are used to determine needs and eligibility for adults with intellectual disabilities and children with disabilities. The Adult Needs Assessment (2008) is a paper-based tool used across the RHAs to assess the needs of adults with intellectual disabilities. There is no standardized assessment instrument that is currently used for children with disabilities across the RHAs. Each region assesses functional needs of children with disabilities using supporting clinical documentation from professionals (e.g., physicians) and any regional assessment that has been developed in-house.

A similar analysis of case files was carried out for adults and children with disabilities that are participating in the PHSP. A total of 46 anonymized case files were reviewed by a clinical subject matter expert for the disabilities population.[12] The case files included the completed clinical assessment, corresponding service plan, and any supporting clinical documentation or activity notes. Overall, many of the limitations and issues that emerged through the analysis of the RAI-HC assessment instrument are applicable to the assessments used for the adults and children with disabilities. In particular, there seemed to be great subjectivity in approval of services and hours, rather than approval of hours based on an objective analysis of unmet client needs. In addition, IQ scores have been used to determine eligibility for some services.

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[9] Seniors: Dr. Laurie Mallery – Head of the Division of Geriatric Medicine and the Director of the Center for Health Care of the Elderly at the QEII Health Science

[10] Seniors: Dr. Paige Moorhouse – Staff Physician, Division of Geriatric Medicine, Queen Elizabeth II Health Sciences Centre & Associate Professor – Division of Geriatric Medicine, Dalhousie University

[11] AWD and SCWA: Dr. Sandra Luscombe – Clinical Assistant Professor of Pediatrics, Janeway Children's Hospital and Rehabilitation Centre

[12] Adults and children with disabilities: Dr. Sandra Luscombe, - Clinical Assistant Professor of Pediatrics, Faculty of Medicine, Memorial University; Physician, Janeway children's Health and Rehabilitation Centre

However, according to the clinical subject matter expert as well as changes to the DSM – V, this is not a helpful measure of an individual's ability to function in society or the level of assistance they may require. Therefore measures of functioning are more appropriate to assess level of care needed for adults and children with disabilities.

Developing and coordinating an appropriate service plan in a consistent and objective manner is limited by a number of factors in addition to the challenges identified above related to the clinical tools. There is a lack of provincial standards or guidelines on how to reliably and consistently *translate* assessment findings into a service plan that is tailored and appropriate for the client's needs. The lack of such standards makes it more difficult for RHA staff to develop an objective service plan that is solely based on unmet client needs. In fact, based on the case file review described above, it appeared that hours were approved based on client preferences rather than objective process for approving hours. In addition, administering and interpreting RAI-HC results requires training and familiarity with the tool. As the Province continues to roll-out the RAI-HC and provide the required training to CHNs and SWs, it is expected that their ability to administer and interpret results in a timely and consistent manner will improve. Finally, two different disciplines are responsible for administering and interpreting the clinical assessment (i.e., CHNs and SWs). In order to ensure consistent administration and application of the tool, cross-professional training is required.

In order to understand the current appropriateness of recommended service levels based on the assessment output, a total of 46 anonymized case files were reviewed by clinical subject matter experts for each client group. Based on the information available from the case files that were reviewed for seniors, 52% (12 out of 23) indicated a level of over-estimation of client needs that were associated with the approval of hours of support in excess of what is minimally required to maintain client independence and safety. On average, 24.3% more service hours were recommended than independently assessed as necessary across these 23 case files. Moreover, out of the seniors' case files reviewed, only 17% (four out of 23) clearly demonstrated approved hours that were commensurate to the clients' needs.

The RAI-HC and supporting case documentation of the remaining seven case files (30%) lacked sufficient information for the appropriateness of hours to be reliably assessed. For adults and children with disabilities, although a majority of the case files reviewed demonstrated approved hours that were commensurate to the clients' needs, some lacked sufficient information for the appropriateness of hours to be reliably assessed. Moreover, subject matter expert review of case files for persons living with disabilities suggests significant subjectivity with respect to the approval of hours and a lack of standardized assessment protocols. It was also noted that eligibility determination and service planning could be improved by utilizing evidence-based assessment method that focus on client function and considers caregiver stress.

Table 6: Appropriateness of Approved Service Hours

Client Group	Total Case Files Reviewed	Appropriateness of Approved Hours of Supports		
		Appropriate for Client Needs	Insufficient Information to Reliably Assess	Unsupported by Assessment Outcomes
Seniors	23	4 (17%)	7 (30%)	12 (52%)
AWD	20	16 (80%)	4(20%)	0
SCWA	3	2 (67%)	1(33%)	0
Total	**46**	**22 (48%)**	**12 (26%)**	**12 (26%)**

Although the sample size for the clinical case file review is small, it suggests at least for the senior population, that the approval of hours in some cases are in excess of what was minimally required to maintain client independence.

3.2.2. Financial Assessment

3.2.2.1. Program Eligibility

As mentioned above, eligibility for publicly subsidized home support services is based on need for service, financial eligibility, and place of residence. In addition to these eligibility criteria, adults and children with disabilities also require proof of a formal diagnosis to be deemed eligible for publically subsidized home support services. The completion of a financial assessment/reassessment by the RHA staff determines not only financial eligibility for publically funded home support services, but also the amount, if any, the client is required to contribute toward the cost of these services. Individuals must agree to pay the prescribed contribution for home support service before the financial subsidy is provided.

There are two types of financial assessments that are utilized for the Program, depending on the services being accessed. The Income Test is used to determine financial eligibility and contribution levels for individuals requesting Home Support services only, Special Assistance Program (SAP) services only, or both. The Needs Test is used to determine financial eligibility and contribution levels for individuals requesting other allowances or supplementary benefits at the same time as the request for home support services or while in receipt of subsidized home support services.

Financial assessments are completed by Financial Assessors (FAs).[13] Financial reassessments are performed on an annual basis at a minimum, as mandated through the Operational Standards. Financial reassessments can be requested by the client at any time if there is a substantial change in their income (e.g., changes in employment status). All financial data related to clients, including approved service hours, client contribution levels and financial subsidy levels are keyed into the Client Referral and Management System (CRMS) Pay Module, which is intended to support the financial assessment and payment processes.

3.2.2.2. Funding Model

The Program currently serves over 7,100 clients throughout the Province with an annual expenditure of $175 million (FY2014-15). HCS establishes an annual budget, allocated as block funding to each RHA for the Program. The RHAs maintain some minor discretion of the funding pool, which under certain circumstances may be channeled into other adjacent RHA programs and services. This is similar to funding models in other jurisdictions in Canada. In British Columbia for example, base global funding is allocated to each RHA on a population needs-based funding model. In Alberta, global funding is provided to Alberta Health Services.

Home support services can either be purchased privately by individuals or subsidized through public funds to a maximum financial ceiling. Clients who are able to are required to contribute to the cost of care based on a sliding-scale determined through financial assessment that examines liquid assets, income and living expenses. Client fees and subsidized co-pay are commonplace in other jurisdictions; however, the manner in which subsidy and co-pay levels are determined varies by region (described in more detail below).

Several jurisdictions within Canada and the United States are beginning to shift their focus to paying for outcomes rather than the hours of support provided. In Calgary and Edmonton for example, the number of private service providers was significantly reduced over the past several years using a formal procurement process. Service Level Agreements between AHS and the service providers established standard performance criteria that service providers are accountable for, such as missed appointments and education of workers. In Pennsylvania and Arizona, community-based long-term care organizations receive a standard capitated rate per client through Medicaid and are responsible for coordinating care services across the continuum of care for their clients. Care organizations have an incentive to ensure clients remain healthy and independent in their homes and communities and avoid higher cost care settings, such as long-term care placement and acute care. This managed care model requires strong oversight, contracts or SLAs that establish performance criteria, ongoing monitoring and reporting, and data sharing between government and service providers.

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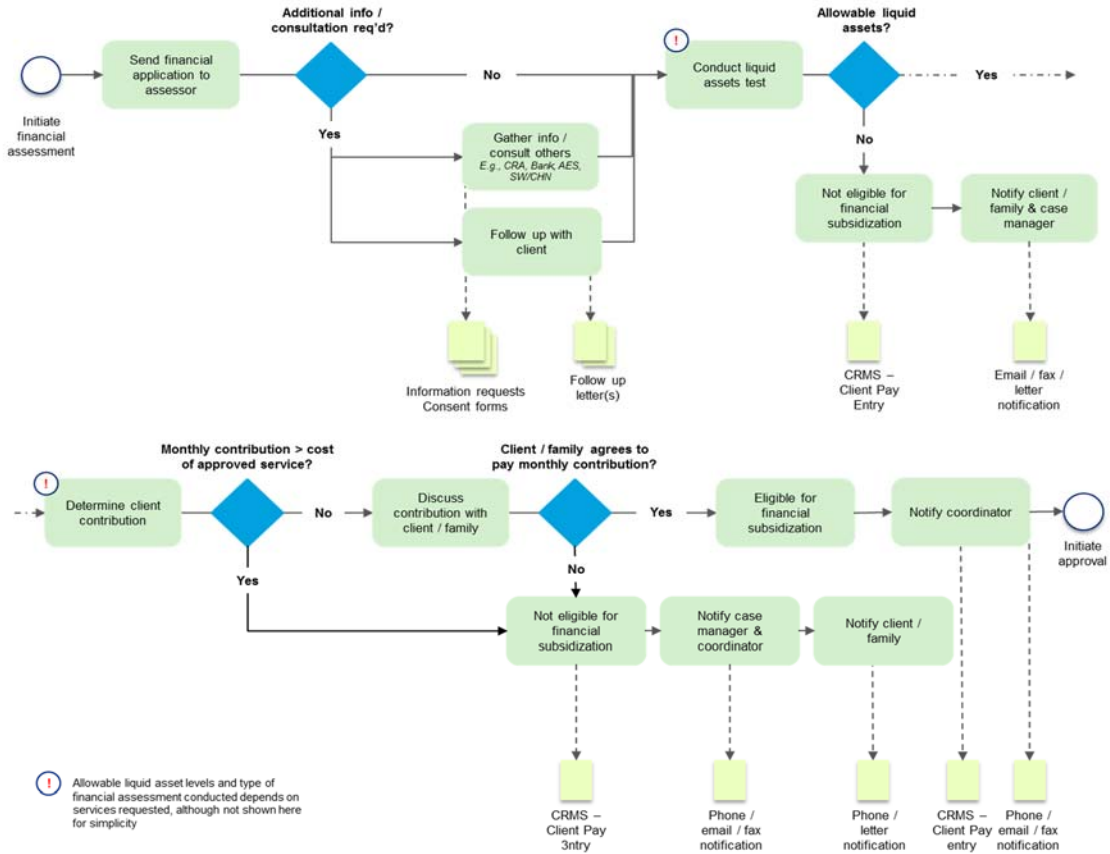
[13] Social Assistance Workers in Western Health; Financial Assessment Officers in Eastern Health

3.2.2.3. Financial Assessment Process

Although the financial assessment is considered to be important to determine eligibility for subsidized home support services and an appropriate and equitable co-pay, some staff and clients consider the financial assessment process to be complex and burdensome for both the RHA staff and clients/families. It should be noted, however, that of the two types of financial tests, the Income Test is easier to complete and less time consuming than the Needs Test, as described in Section 3.2.1.1 above. As shown in Figure 15, the financial assessment process involves numerous steps or activities and includes multiple hand-offs and decision points.

Figure 15: Financial Assessment Process



The financial assessment process is manual and mostly paper-based. In three of the four RHAs, the financial application package is mailed to the clients once they are deemed eligible through the initial referral intake screen (see Figure 11). Once the financial assessor receives all of the required documentation, they can then proceed by carrying out a liquid asset test. The allowable liquid asset levels vary depending on the programs and services being requested, as set in the Policy Manual Income Test (2015). Liquid assets that are assessed include cash, bank accounts, treasury bills, Guaranteed Income Certificates, bonds, trust accounts, stocks/investments, life insurance and others. Only individuals who have liquid assets within the allowable limits are eligible for subsidization, and a financial assessment would continue to be completed.

One of two financial tests are then completed based on the programs and services requested. The Income Test is solely based on the income reported on Line 236 of the Canada Revenue Agency (CRA) Notice of Assessment. In contrast, the Needs Test additionally takes into consideration allowable expenses. There are approximately twenty allowable expenses that are assessed, that range from mortgage, rent, Board & Lodging to Fuel subsidy, NL Power, and Special Foods. Several types of allowable debt such as insurance, personal loans, lines of credit. In addition, RRSP & RRIF contributions are also considered.

Assessment of these expenses in addition to income and liquid assets renders the Needs Test as significantly more complex and time consuming than the Income Test. The Needs Test can take up to several hours to complete. Because of emerging complex financial arrangements being pursued by more and more clients, HCS staff involvement is required to interpret financial eligibility.

It takes approximately five days to complete the financial assessment process (including time to complete Income or Needs Test and wait time) once the FA receives all of the necessary financial information required. If clients are unable to gather the financial information themselves, they may provide a signed consent form so the RHA staff can obtain the information on their behalf. However, obtaining documentation from CRA and financial institutions can lead to days or weeks of delay in the completion of the financial assessment.

During consultations with RHA staff, several financial assessment process inconsistencies across regions and pain points were identified, as described in Table 7 below:

Table 7: Financial Assessment Process Inconsistencies and Key Pain Points

Key Inconsistencies Across RHAs
While the financial package is mailed to the client after the referral intake process in most regions, in Western Health, the financial package is hand-delivered to the client by the clinical staff as part of the clinical assessment visit.
In Western Health, financial navigators are available to help clients/families gather information and answer questions related to the financial application.
Although individuals deemed ineligible (financially or clinically) are keyed into CRMS, this data is not consistently collected across regions or readily available.
Western Health implemented a quarterly Community Support Scorecard that reports on KPIs such as percentage of financial assessments/reassessments completed within five working days within receipt of information.

Key Pain Points
Performing the financial assessment is becoming more complicated: • Financial instruments for investment of assets are becoming increasingly complex and FAs have difficulty in determining what accounts for an assessable liquid asset; • FAs often have to seek advice from their managers in order to complete assessments due to this complexity, delaying the process; • Individuals are only asked to provide banking information for the last 30 days, which allows them time to divest or “hide” their assets in order to be eligible for publically subsidized support services; and, Due to the complexity of the Needs-Based Test, manager approval is required for all Needs-Based assessments in Central Health.
Unlike some Departments, RHAs cannot access information from CRA or financial institutions electronically. Requesting and obtaining this information can take weeks for RHAs. Most banks now require request for client information to be sent to their head office for privacy reasons, further delaying the process.
There is a large amount of paper correspondence between RHA staff, clients and other parties. Consent forms are collected annually from clients to obtain information from CRA, Department of Advanced Education & Skills, etc.).

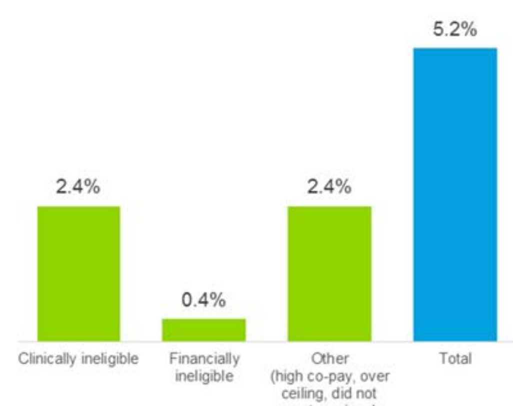
In general, determination of client contribution, if it exists, is a much simpler process in other jurisdictions. In Saskatchewan for example, client co-pay or contribution is based on their Adjusted Monthly Income, which involves the annual income, deductions, exemptions and declarations as identified in the Federal Income Tax Return. In Nova Scotia, the client contribution is determined based on net household income as identified on line 236 of the Federal Income Tax Return or Notice of Assessment and family size. In Alberta, clients are not required to be income-tested in order to receive publically funded home support services. Only in Calgary are clients asked to pay $5 per hour for home support services for a maximum of $300 a month. Alberta is considering expanding this model (i.e., $5 per hour co-pay across the board) across the Province to ensure the sustainability of the Program. There are other publically funded programs within the Province that utilize a simple financial assessment. This is the case for the Newfoundland and

Labrador Provincial Drug Program, which uses Line 236 of the Federal Income Tax Return or Notice of Assessment.

Under the NLPDP, no application is necessary if an individual is in receipt of income support. For seniors 65 years old and above and in receipt of the Guaranteed Income Supplement, there is no application as Services Canada notifies the NLPDP of the individual's eligibility with the individual only having to supply their MCP number, date of birth, and gender. They are required to pay any dispensing fee up to $6. For all others eligibility is based on a two-page application to the Program. Financial eligibility is determined based on total family income reported on line 236 (minus line 117 for low income individuals). This financial information is supplied directly to NLPDP by the CRA. Co-payments are calculated using a specified percentage based on a family's income level which is then applied to the cost of the drugs purchased.

There is limited information available about the number of clients who have been deemed ineligible for subsidized home support services and reasons for service denial are quite difficult to compile as manual searches need to be done in text fields within CRMS. However, using the information provided by Labrador-Grenfell Health, it seems that a very small number of individuals are deemed financially ineligible, or consider the co-pay too high (Figure 16).

Figure 16: Program Ineligibility & Service Denial in Labrador-Grenfell Health (FY2014/15)



In 2014/15, only 5.2% of the caseload in Labrador-Grenfell Health was ineligible or declined subsidized home support services. Only 0.4% of the annual caseload was deemed financially ineligible for subsidized home supports and 1.6% (four clients) declined services because they considered the co-pay too high. Although a similar level of detail is not available in other regions, in Western Health only one individual was deemed financially ineligible between October 2015 and January 2016 across Stephenville, Corner Brook and Port Aux Basques. This indicates that only a small percentage of the caseload is deemed financially ineligible for subsidized home support services or declines services due to a high co-pay.

There are summary indicators showing that the direct resource cost of completing financial assessments is relatively low compared to the savings generated. For example, in Central Health there is approximately $600,000 spent annually on financial assessment resources to recover approximately $1.4 million in additional client contributions. This represents approximately a 2.3x return on investment on the cost of the financial assessment resources in Central Health.

3.2.2.4. Subsidy Ceilings

The PHSP has two approaches to determining approved hours of care based on a clinical assessment: (i) approved or additional hours up to the subsidy ceiling, and (ii) approved hours above the subsidy ceiling.

The current subsidy ceiling is $3,325 per month for seniors and $4,750 per month for adults with disabilities. This is based on current agency rates and equates to a maximum of approximately five hours of agency service/day for seniors and approximately seven hours for adults with disabilities. Because self-managed care rates of pay are lower, up to an additional two hours of care a day can be provided through this service delivery model. Stakeholder consultation suggested that approving the maximum is seen as a client's 'right' and RHA staff are biased in this direction. Limitations of the RAI-HC in accurately assessing

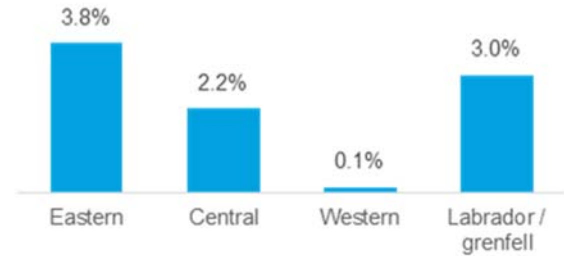
client need as well as lack of provincial standards and guidelines on translating assessed client into appropriate service plans exacerbate the subjectivity of service hour approvals. The average hours of service approved for agency-based care is 4.1, while self-managed care is 5.0, which is close to the respective maximum ceilings. In addition, the case file review also indicates a level of over – servicing that exceeds client needs.

While decisions on approved hours of care, especially those requiring an exception to the financial ceilings should be based on client need, it is often the case supported by an interpretation of Program operational standards that the determining factor is application of the financial ceilings. At the same time, additional hours of care are approved below the financial ceilings when SMC arrangements are utilized. Other jurisdictions focus on clinical assessment as the determining factor in approvals.

3.2.2.5. Exceptions

Decisions on approved hours of care requiring an exception to the subsidy ceilings is an emerging area for the Program and new standards are required. The PHSP Operational Standards (2005) allows for exceptions to be made at the discretion of RHAs, although it is not clear what the process and criteria for approving exceptions should be. Therefore, each RHA has developed its own philosophy, approach, process and criteria for approval of exceptions. This likely contributes to the significant variability that exists in the willingness of the RHAs to approve clients above the current financial ceiling, as shown in Figure 17.

Figure 17: Service Approvals above Financial Ceiling by RHA (FY2014/15)

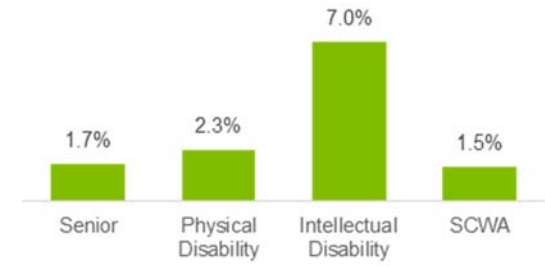


*Percentage of those assessments resulting in "new" or "increased" service

While Eastern Health approves clients above the standard ceiling subsidy (referred to as exceptions) at the highest rate of 3.8%, Western Health approves virtually no clients above the outlined ceiling, with a 0.1% approval rate. As mentioned above, lack of provincial standards and guidelines on the approval of exceptions process may contribute to the variability across regions. The quantitative analysis aligns with qualitative findings during stakeholder consultations that Western Health appears to adhere more often to the ceilings and seeks input from DHCS for any potential exceptions, while Eastern Health is more willing to approve exceptions due to the desire to alleviate acute and LTC system pressures in this region. The implementation of the Home First program and other initiatives in Eastern Health could be another contributing factor.

As shown in Figure 18, clients with intellectual disabilities receive the highest number of exceptions among the three client segments (at 7.0% vs. 2.3% for physical disability, 1.7% for seniors, and 1.5% for SCWA). In addition to stakeholder consultation, this indicates that the Program may not be providing adequate or appropriate supports that meet the specific needs of adults with intellectual disabilities. During the stakeholder consultations it was identified that whereas the senior population require traditional home supports, adults with disabilities require more community inclusion and lifestyle coaching services. In addition, adults with disabilities and SCWA require more flexibility in how they use their approved hours during the day and week.

Figure 18: Service Approvals above Financial Ceiling by Client Segment (FY2014/15)

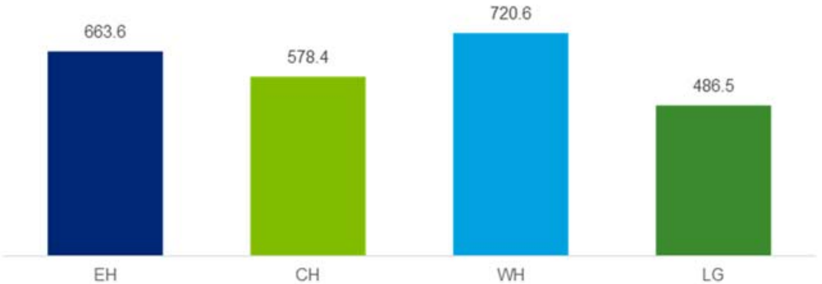


*Percentage of those assessments resulting in "new" or "increased" service

3.2.2.6. Workload and Scope of Practice

To compare financial assessor (FA) staff workload across RHAs, the number of financial assessments and reassessments performed per FA FTE per year was used as one possible indicator. Data on the actual number of financial assessments and reassessments performed by each RHA is regularly collected and therefore used. Variability related to financial staff utilization and workload exists across the RHAs. In FY2014-15 for example, Western Health demonstrated the highest 'financial assessment productivity' level, as indicated by the highest number of financial assessments/reassessments[14] per 'financial assessor' FTE per year (see Figure 19). This is the case even though Western Health and Central Health have comparable financial assessor FTEs. Based on the number of cases in each region, the high number of financial assessments and reassessments performed in a given year indicates that more than one assessment is performed per case per year[15].

Figure 19: Financial Assessments/Reassessments per FTE by RHA (FY2014/15)



This variability may be due to some of the inconsistencies in the financial assessment process across RHAs that were identified above, such as Western Health providing a financial navigator to enable clients to effectively and efficiently gather all of the information required from the RHA. In addition, Western Health's quarterly scorecard helps hold financial assessors accountable for completing assessments in timely manner.

It should be noted that FA staff work across Community Support Services and only a percentage of their time is dedicated towards the PHSP.[16] Moreover, in addition to completing financial assessments and reassessments, FA staff are responsible for a number of tasks as illustrated in Figure 14, including redirecting inquiries. As shown in Figure 19 above, FAs have a challenging workload, with between 490 to 720 financial assessments/reassessments performed per FTE per year depending on the region. As mentioned above, due to the increasing complexity of financial instruments that can be used to invest

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[14] OCIO data for actual number of financial assessments performed in FY2014-15

[15] The number of financial assessments/reassessments performed per case in FY2014-15 was 3.91 in Labrador-Grenfell RHA, 3.02 for Eastern RHA, 2.97 in Western RHA, and 2.26 in Central RHA

[16] In FY2014/15, the percentage of time dedicated to the PHSP for FA staff across RHAs was as follows: (1) Western Health, 80%; (2) Central Health, 90%; and (3) Eastern Health, 80%

assets, FAs are increasingly having to turn to their managers in order to clarify and obtain advice on carrying out the financial assessment.

3.2.3. Service Planning and Coordination

3.2.3.1. Service Plan Approvals & Coordination Processes

As illustrated in Figure 20, a coordinator reviews the completed assessment, the recommended service plan as well as the financial assessment. The coordinator may approve the home support services and hours that have been recommended, approve the recommendations with some modifications, or decline the recommendations. Once approved, the Financial Assessor and Case Manager are notified as well as the client/family are notified.

Figure 20: Service Approval and Hand-off Process

One of the key goals in providing home support services is to maintain clients in their homes and to minimize disruptions in their living arrangements. For adults with disabilities, there are often greater challenges in delivering on this goal due to their complex needs and limited Program options. For seniors, in the absence of family supports, they have to depend more and more on the Program to avoid placement outside their home. In developing a service plan the CHNs and SWs have to consider these factors when recommending hours of care.

In assessing the client's service plan the coordinator considers how access to other community supports are factored in by the CHN or SW. Examples would include availability of day programs, residential alternatives and other community services so that there are other choices for the client rather than having to rely fully on the Program for their support needs. Such examples foster sharing of scarce resources to meet multiple clients' needs; as well, they have the added benefit of counteracting the social isolation experienced by many clients in individualized living arrangements. The realities as expressed by the RHAs is that there are generally few if any options in most communities and there is limited community capacity to mount these types of alternative community supportive services.

For clients using agencies, a service referral and authorization is sent to the agencies that includes information regarding the start and end date for services, designated client co-pay if any, hours of services, and types of services required for the particular client. This communication is usually conducted by phone and followed-up with a written notice of approval. There is little to no communication between the RHA and agency about the clinical assessment or need. The clinical assessment seems to be used solely by RHAs in order to determine clinical need and eligibility. Therefore, individuals that are responsible for delivering services receive no communication regarding the clinical assessment. Only in Western Health do agencies receive a comprehensive RAI assessment summaries and client profiles. Clients who use the SMC model receive the similar information as agencies (approved service hours, co-pay) and are responsible for communicating their need to their hired support staff and bookkeeper.

Bookkeepers are often hired by clients of the Program who choose the self-managed care option and hire their own home support workers. These clients act as employers and are responsible for paying the salaries of the home support workers as well as making the required payroll deductions with the bookkeepers taking on this role for them. Again, each RHA has different processes, some partially automated, to pay bookkeepers based on timesheets submitted to them by the home support workers through the client. Other than manual audits and checks by RHA staff to ensure timesheets align to service plans and home support worker pay, there is little to no oversight of bookkeeper activities by the RHA.

There is limited flexibility in how approved hours, especially personal care hours, can be utilized by clients and agencies. As mentioned above, this is particularly challenging to adults with disability and the SCWA population, who require other allowances and supplementary supports such as community inclusion and lifestyle coaching. Expanding of the individualized funding model, which would provide a monthly budget or block funding to the client, would allow the client to use their approved hours and subsidy as they see fit. The Program would be more responsive to clients' changing needs as well.

Agencies reported that they do not have a systematic approach of scheduling HSW visits in a coordinated manner (for example by geography). This leads to increased travel times between clients, additional home support workers required to service clients, and fewer hours of service that can be provided per home support worker. Exploring approaches to allow for sharing of home support services between clients in particular geographical regions, such as Adult Day Programs and residential options, could increase sustainability of agencies and home support worker efficiency.

During consultations with RHA staff, several service approval and coordination inconsistencies across regions and pain points were identified as described in Table 8.

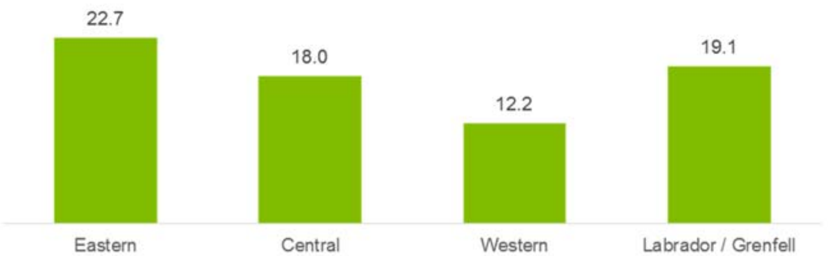
Table 8: Case Coordination Process Inconsistencies and Key Pain Points

Key Inconsistencies Across RHAs
The Operational Standards do not establish a standard provincial guideline for approval of services and hours by coordinators. Therefore, coordinators use their professional judgement to make approval decisions.
The client information that agencies receive from RHA staff varies across regions – only in Western Health do home support agencies receive a detailed breakdown of services and hours that clients require as well as a summary of the completed RAI assessment.
CRMS entries vary by RHA staff (i.e., level of detail; whether or not an entry is made for a particular activity).
Eastern Health regularly tracks and reports on a number of quality indicators that are used to assess Program performance in the region. Western Health also recently implemented a Community Support Scorecard that reports on Program KPIs.

Key Pain Points
Clients and families receive a large volume of information and documentation that they must process and complete in order to obtain services.
Home support agencies also carry out clinical assessments for each client, which they consider a duplication of effort between RHA staff and agencies.
Ability to draw on other available community supports and programs to supplement home support services varies by community (e.g., meals on wheels, adult day program).

The lack of provincial guidelines for approval of services is a likely contributor to the variability across RHAs in the average hours of services approved per week per client (Figure 21). In FY2015/15, the assessments/reassessments in Eastern Health that resulted in new or increased services saw nearly twice the average hours of services approved per client than those at Western Health.

Figure 21: Approved Client Service Hours per Week by RHA (FY2014-15)



Another contributing factor is likely the lack of provincial guidelines on translating the clinical assessment outcomes into a service plan for clients that accurately reflects their needs. The lack of provincial standards means that each RHA has adopted their own approach and philosophy to approval of services. Qualitative evidence demonstrates that Eastern Health is much more willing to approve services above the financial ceiling to alleviate acute and LTC system pressures, while Western Health follows the financial ceilings set by the province more stringently.

Finally, the higher amount of service hours approved per client in Eastern Health may be due to the region, and specifically St. John's, providing services to a larger volume of high complexity clients who require supports above and beyond what the Program currently offers. Initiatives such as the Home First pilot likely result in higher acuity, higher complexity clients requiring more home supports in order to remain at home. In addition, Eastern Health has the second highest percentage of its caseload dedicated to adults with intellectual disabilities (Figure 22), a client segment that has higher complexity needs and receives the highest percentage of exceptions (Figure 17).

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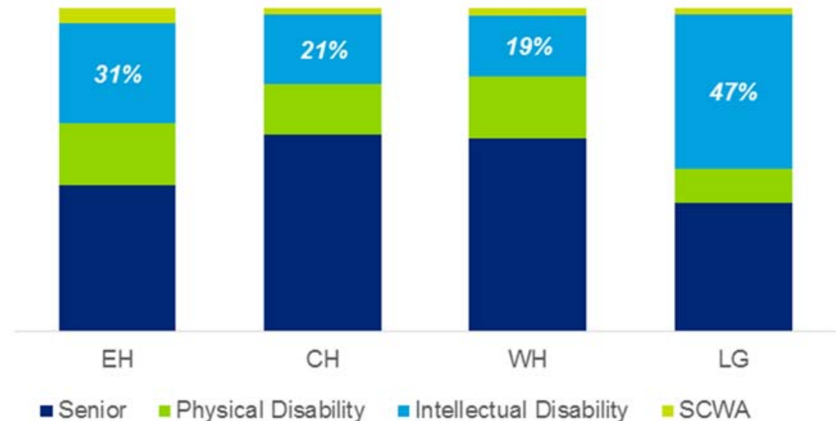
Figure 22: RHA Caseloads by Client Segment (FY2014-15)



The result of the inconsistency in exceptions and services approved across regions, due in part to the inconsistencies in service approval processes, as well as development of service plan using the clinical assessment, demonstrates that individuals with similar care needs may not receive the same level of care across the RHAs.

3.2.4. Program Expenditures

In 2014-15, Labrador-Grenfell Health spent the most for each senior served (at $18,320) while Western Health spent the least (at $16,744), as illustrated in Figure 23 below. However, on average over the past three years, the RHAs expenses for seniors have been very consistent across the Province with a low of $17,271 to a high of $17,618. For adults with disabilities, Central Health spent $32,667 followed by Eastern Health at $30,753 for each client served. Western Health spent the least at $25,916 for each client. Central Health spent the most to support children with disabilities at $20,317 per family served while Labrador-Grenfell Health spent $10,902.

Figure 23: Program Expenditure per Client (FY10/11 to 14/15)

3.2.5. Improvement Opportunities

The following nine improvement opportunities have been developed to support this area of the Program:

- Enhance clinical assessment tools and implement hours based service limits (as opposed to financial ceilings) to more accurately define and communicate client care needs. It is important for the Province to roll out the RAI-HC tool and provide training to RHA staff that are responsible for administering and interpreting the RAI-HC. Options to augment the clinical assessment tools for adults and children with disabilities in order to capture a more objective understanding of functional and adaptive need should be considered. It is critical to support the clinical assessment tools with standardized provincial guidelines for objectively and consistently translating assessment outcomes into an appropriate service plan that addresses the clients' unmet needs;
- Perform risk-based reassessment of client needs to improve CHN/SW productivity and service capacity. This would involve performing reassessments only when there is a material change in client need or condition. Client need or condition would in turn need to be monitored on a regular basis;
- Delegate reassessments to supervised RHA paraprofessionals to improve CHN/SW productivity and service capacity;
- Streamline financial assessment processes to improve FA productivity and service capacity. Performing the Income Test for all client segments would simplify the financial assessment process. In addition, being able to electronically access CRA information would streamline this process even further;
- Optimize financial eligibility criteria and client co-payment to improve resource allocation and enhance Program sustainability. Establishing the optimal income level cut-off and co-payment amount to ensure the future sustainability of the Program is involved;
- Improve the hand-off of service plans to agency and SMC providers to improve the continuity of care and eliminate redundant assessments. Providing assessment outcomes and service plans to agency and SMC providers would ensure that the individuals responsible for providing day-to-day care for PHSP clients are equipped with client information they need in order to deliver care;
- Allow flexibility through expanded individualized funding models to improve client choice and the flexibility in how hours and subsidies are utilized, especially for adults and children with disabilities. This would allow adults and families of children with disabilities to use their "budget" or "block funding" in a manner that best suits their needs;
- Expand day programs and residential options to promote the sharing of services and supports, where permitted by geographical proximity of clients. This would allow for a decrease in travel times between clients, fewer HSW required to service clients, and higher hours of services that can be provided per HSW. This in turn would help agency sustainability and improve HSW efficiency; and,
- Develop integrated care plans to improve the continuity of care across CSS program and services, and to minimize living arrangement disruptions.

Further detail on these opportunities and key considerations are provided within Appendix C.

3.3. Home Supports Delivery

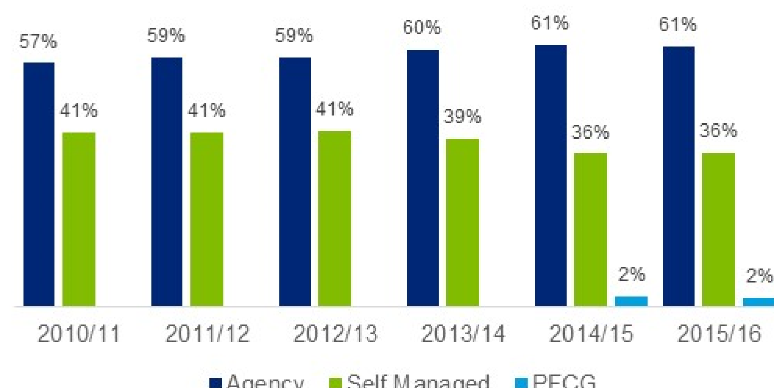
3.3.1. Service Delivery Options

While the RHAs are responsible for the administration of the Program, the delivery of home support services is a delegated function. Under the current Operational Standards, Program recipients may avail of agency based care or employ their own HSW under a SMC arrangement. With the introduction of the Paid Family Caregiving Option (PFCG) in 2014, eligible clients may access subsidized care that is provided by family members residing in the same home (excluding spouses and common law partners). Regardless of service delivery option selected by the client, the RHAs maintain responsibility for monitoring service plans and client outcomes.

Individual client choice in how they choose to live features prominently within the current Program Operational Standards. Moreover, the selection of a service delivery option is key choice available to clients of the Program. Given this, the Program offers considerable choice relative to other jurisdictions reviewed in Section 2.2. SMC and PFCG options are not uniformly offered across Canadian jurisdictions and consultations with Program leadership have cited challenges with monitoring and oversight as a key factor underlying narrower client choice.

Agency based care is the predominant service delivery option selected by clients as demonstrated in Figure 24 below, and utilization of this option has increased over the last five years. Over this same time period, utilization of SMC has declined by approximately 12% with more clients selecting agency based care or the PFCG option. This trend away from SMC is despite access to a greater number of daily service hours that is afforded by the financial ceiling as referenced in Section 3.2.1.1.

Figure 24: Service Delivery Option Utilization (FY10-11 to FY15-16)



Comparing the utilization of agency based and self-managed care across RHAs reveals some significant differences. As shown in Figure 25, the majority of clients avail of SMC in Labrador-Grenfell Health and Central Health. In contrast, clients in Western Health and Eastern Health primarily choose agency based care. Additionally, relatively higher utilization of SMC is seen in SWCA and AWD client groups compared to seniors as shown below in Figure 26.

Figure 25: Service Delivery Option Utilization by RHA (FY14-15)

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Figure 26: Service Delivery Option Utilization by Client Group (FY14-15)

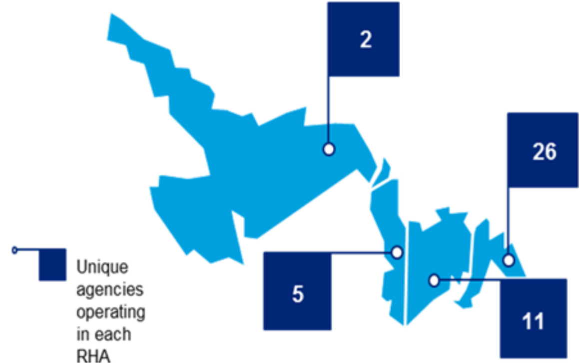
The factors underlying these regional and client group differences are discussed in the following sections that review each service delivery option in greater detail.

3.3.2. Agency Based Care

3.3.2.1. Home Support Agency Landscape

Agencies and the delegated service delivery function they fulfil are considered essential to the Program. Agency based home support services in the Province are scheduled and delivered by 39 unique agencies who are registered with the RHAs and operate under the terms set forth in the Operational Standards. Figure 27 below shows the number of agencies operating within each RHA and illustrates a fragmented agency landscape. Of the 39 privately owned unique agencies operating within the Province, only five operate in more than one RHA and none operate in more than two. Consultations with stakeholders revealed that the number of agencies servicing the Program remains relatively constant year-on-year.

Figure 27: Home Support Agencies by RHA



As agencies are subject to an annual quality audit process to assess compliance with the Program policy standards, the number of registered agencies adds to administrative workload and creates an opportunity cost with respect to direct client care. Moreover, the number of agencies operating within the Province also contributes to challenges associated with delivering a consistent Program that is equitable for all eligible clients.

As with other health care and social programs, the delivery of the PHSP is influenced by the geographical diversity of the Province and the isolation of many communities. Consultations with Program stakeholders indicate a lack of available agency-based service options in isolated communities which may adversely impact client choice. Moreover, agencies cite the attraction and retention of qualified HSW, a lack of scale and long travel times to client homes as key challenges in operating within isolated communities. These factors are understood to contribute to relatively lower rate of agency utilization observed for Central Health and Labrador-Grenfell Health inFigure 25.

3.3.2.2. Care Coordination and Communication

Following the completion of clinical and financial assessments, home support agencies receive a client file that comprises of basic client information and a service plan. Importantly, the service plans that the agencies receive do not contain the full outcomes of the clinical assessment and client information is noted to vary across RHA. While all RHAs provide a breakdown of assessed hours (e.g., personal care, household management, transportation and respite, etc.), Western Health is the only region that provides an excerpt of the clinical assessment to its agencies.

Consequently, agencies may lack sufficient client information to effectively deliver the defined level of support necessary for the client to remain independent in their home. Regardless of the challenges associated with the clinical assessment processes and instruments noted in Section 3.2.1, communication gaps and a lack of visibility on underlying client needs contributes to inefficient and ineffective service delivery.

To illustrate, it is currently common place for agencies to complete their own independent clinical assessment to provide guidance to Home Support Workers on the how to support clients' within the service hours defined by the RHAs. This duplicated effort results in increased costs of agency based care and subjects clients to a time consuming and redundant assessment. Moreover, agency based reassessment of client needs may result in the provision of supports that are inconsistent with those defined by RHA staff who have greater access to clinical information and inter-disciplinary expertise and sub-optimize client outcomes.

Further challenges in the coordination of care are also noted to exist once the service plan has been established and service delivery initiated. Consultations with home support agencies and client advocacy groups suggest insufficient monitoring of home support services by the RHAs. While policy standards demand an annual review of the client service plan and reassessment of needs, formal mechanisms for monitoring client outcomes and the effectiveness of service delivery on a smaller time scale appear to be limited. In the absence of ongoing monitoring of client outcomes and collaboration with agencies and HSWs the RHAs may miss opportunities to:

- Proactively adapt service plans to better support clients living independently in their homes; and,
- Identify early signs of client deterioration that may prompt referral to other clinical services that may be needed for maintaining client wellness.

3.3.2.3. Agency Based Home Support Workers

Home support agencies employ HSWs to fulfil the home support requirements defined by the RHAs. HSW are represented by the Newfoundland and Labrador Association of Public and Private Employees (NAPE) via 13 collective agreements. The most recent collective agreements that became effective in late 2015 resulted in:

- An increase in HSW wages over the final year of the previous agreements; and,
- Annual wage increases of 5% over the three year term of the agreements.

As shown below in Table 9, wages for HSW are lower than those for Personal Care Attendants who fulfil a similar role in residential care settings in the Province. This wage differential and a greater consistency of hours in residential care is understood to contribute to challenges associated with the attraction and retention of competent HSW. Becoming a PCA would be an attractive option for HSWs looking for career opportunities with higher wages and greater stability, exacerbating the shortage in HSWs even further.

Table 9: Comparison of HSW and PCA Wages Rates (FY13-14 to FY17-18)

Position		FY13-14	FY14-15	FY15-16	FY16-17	FY17-18
HSW		N/A	N/A	$15.05 / hr.	$15.80 / hr.	$16.55 / hr.
PCA	No Experience	$18.66 / hr.	$19.03 / hr.	$19.60 / hr.	N/A	N/A
	1 Year Experience	$19.53 / hr.	$19.92 / hr.	$20.52 / hr.	N/A	N/A
	2 Years' Experience	$20.40 / hr.	$20.81 / hr.	$21.43 / hr.	N/A	N/A

Under the Program Operational Standards, home support agencies are required to hire trained workers that meet a set of minimal training requirements that span:

- Orientation to the Program and client rights;
- The Province's philosophy of community based services;
- Communication and interpersonal skills;
- Home management skills;
- Personal care skills; and,
- First aid and infection control procedures.

Additionally, home support agencies are also required to provide regularly scheduled in-servicing and learning opportunities. However, unlike other Canadian jurisdictions that have established formal mandated qualifications for HSW, no such educational standard exists for the PHSP and agencies retain responsibility for determining the scope and delivery schedule of training programs. For example, British Columbia, Alberta, Saskatchewan and Nova Scotia all require HSW to meet minimum qualification standards through the completion of an approved program. Additionally, Nova Scotia has also introduced a standardized examination for individuals seeking to provide home care and support services.

The lack of qualification standards coupled with the wage differential between HSW and PCAs (as show above in Table 9) results in little incentive for care providers to further their skills through certificate programs like that offered by the College of the North Atlantic. Furthermore, the wage schedules set forth within the current collective agreements provide a basic hourly rate for HSW that is not segmented by experience or skillset.

Consequently, consultations with Program stakeholders revealed:

- Concerns on the quality and variability of service quality;
- Concerns on the willingness of home support agencies to provide and fund training;
- An inability for the Program be responsive to client needs through matching HSW skills and competencies to the complexity of care requirements; and,
- A lack of a defined career progression in the provision of home supports and incentives to seek higher salaries in residential settings.

To compound these challenges, it can be difficult for home support agencies, particularly those in rural communities, to provide HSW with full-time hours.

While personal care and home management support comprise the bulk of the duties fulfilled by HSW, the Operational Standards provide policy guidance with respect to delegated clinical functions. HSW are empowered to administer medications following physician approval and contingent on supervision and the provision of adequate training. Furthermore, the RHAs pursue supervised delegation of clinical duties as they seek to maximize the effectiveness and efficiency of clinical and non-clinical resources similar to other

Canadian jurisdictions noted in Section 2.2. However, these efforts to expand the scope of HSW practice are not guided by a common policy framework and may be inconsistent in their application.

3.3.2.4. Agency Monitoring and Scope of Services

As previously mentioned, home support agencies are subject to an annual quality audit to assess compliance with policy standards. While this provides the RHAs with a basic mechanism to monitor agencies, a lack of defined service levels and a systematic performance management framework obscures visibility on the extent to which Program and client outcomes are being achieved.

Currently, clients are responsible for verifying and approving hours worked by HSWs to inform invoicing and subsidy payments via a process that is largely manual and paper-based. The lack of independent verification of worked hours and clients with functional impairments or who are vulnerable creates a risk that the Province provides Program funding for services that were never provided. There are numerous verification systems which address these issues and are currently used for the home support sector within Canada. The majority of these systems are digital/telephone based and provide real-time employee verification as well as many other enhanced information monitoring and audit functionalities. Information provided to the review by an agency operating within the Province suggests that current deficiencies in payment controls may contribute to overbilling in the range of 8.5 to 11.5%. This estimate is based on the difference between approved hours that are paid, but are not worked, as there are specific controls in place to prevent individual invoices being paid more than once. While this data was not reviewed in detail or independently verified, the materiality of this estimate suggests that payment controls warrant further investigation and analysis. Moreover, it is consistent with a trend of fraud investigations that have been undertaken by the RHAs in recent years.

Beyond controls for subsidy payments, other Canadian jurisdictions achieve greater oversight and drive improved agency accountability through defined service agreements. Moreover, jurisdictions such as Nova Scotia are seeking to expand beyond service agreements and are exploring contractual arrangements where agencies are remunerated on the basis of the client outcomes they achieve.

As noted in the jurisdictional scan, capitation-based funding models where agencies are remunerated on the basis of achieving key outcomes (i.e., maintaining clients living independently within their homes) have been implemented outside of Canada in community supports programs. Finally, there appears to be the appetite for change amongst the home support agencies as some operating in the Province have expressed a desire to expand their scope of services (e.g., day care program, shared supports models) to complement the delivery of home supports.

A next step in the evolution of the Program would be to establish service levels for the home support services delivered by the agencies and have them included in service level agreements between the RHAs and the agencies in their region. These service levels would build on the current operational standards for agencies but include reference to such quality indicators as the required skill set of HSWs, monitoring of service hours provided, client/family complaints, the ongoing health status of the clients being served by the agency, among other factors.

3.3.3. Self-Managed Care

3.3.3.1. Administration

SMC is recognized by a wide range of consulted stakeholders to be critical to supporting clients living in rural and isolated communities and enabling client choice and flexibility in worker selection. Under this service delivery option, clients hire their own HSW(s) and are responsible for coordinating and managing their support services (potentiality with the assistance of a supporting person). As the PHSP is intended to supplement care provided by clients' families and support networks, family members generally cannot be employed outside of the parameters of the PFCG option. Additionally, as defined within the Operational Standards, individuals who chose SMC must comply with all processes, legislation and standards associated with being an employer and may contract bookkeeping services as required. This represents a significant responsibility for clients to take on, and may be an impediment to choosing a SMC arrangement.

While eligibility for direct funding under a SMC arrangement is subject to assessment by RHA case coordinators, consultations with stakeholders revealed concerns on the capacity of clients to hire and manage HSW. Moreover, process mapping as outlined in Section 3.2.3, identified variations in service plan hand-off for SMC clients across RHAs.

3.3.3.2. SMC Home Support Workers

Many of the challenges associated with HSW noted for agencies above in Section 3.3.2.3 also apply for SMC clients. HSW availability and qualifications are key common themes that emerged in reviewing the SMC option. Additionally, a lack of oversight by either home support agencies or the RHAs result in challenges associated with HSW training and qualifications are exacerbated for SMC clients. Stakeholder consultations also suggest that this lack of oversight may also lead to an increased risk of abuse for vulnerable clients.

3.3.3.3. SMC Monitoring

Unlike monitoring policies for agency based care, oversight for SMC is limited to financial management aspects of the Program. As such, the challenges with respect to monitoring client outcomes and the effectiveness of home support services noted in Section 3.3.2 also apply to SMC arrangements and may be exacerbated.

As per the Operational Standards, the financial records of SMC clients will be reviewed by the RHAs within the first year of the service provision at a frequency determined by the RHAs there after. Discussions with RHA staff suggest improvements in financial management may be made to ensure public funds are being spent in accordance with the terms of the clients' service plan and funding agreement. Furthermore, recent investigations into financial management compliance of bookkeepers of SMC clients have revealed discrepancies the payroll administration. Several cases have been noted by the RHAs where bookkeepers have failed to complete accurate and timely payroll remittances to the CRA and funds illegitimately withheld from care providers. It is understood that remediating actions are presently being pursued by the RHAs. If improvements in client outcomes and bookkeepers practices are to be enhanced then the RHAs will have to become more directly involved with the providers (HSW and bookkeepers). This would entail the development of standards for these providers and ongoing clinical and financial auditing processes with the application of technology solutions where possible.

3.3.4. Improvement Opportunities

In reviewing Home Support Delivery, the following ten opportunities for improving the effectiveness and efficiency of the Program were identified for HCS and the RHAs to consider:

- The establishment of agency agreements with embedded service levels to increase the Province's ability to monitor the quality and effectiveness of service delivery and client outcomes. Service responsiveness, quality, parameters for HSW training and skills development, geographical coverage, reporting and policy compliance should all be considered as part of an accountability framework that supports a standardized program;
- While the implementation of service levels into agency contracts may result in a degree of consolidation, additional steps to reduce the number of agencies may need to be considered. Reducing the number of agencies will improve the ability for the RHAs to coordinate care and monitor service delivery. Moreover, agency consolidation will create economies of scale that will improve the cost effectiveness of agencies, improve their ability to schedule services and provide full-time hours to HSW;
- Exploration of alternative funding arrangements with agencies to shift the focus from hours of care to client outcomes. Capitation based funding models, will create greater incentive for agencies to ensure the services they provide are efficient and effective as they share the risks associated with the deterioration of client outcomes;
- Improve the hand-off of service plans to agencies and self-managed service providers to enhance their ability to provide support services based on the full outcomes of the clinical assessment. This will also allow redundant needs assessments currently completed by agencies to be eliminated. This may result in relocation of resources to direct service delivery;

- Design and implement policies, processes and technology enablers that improve the ability of care providers and the RHAs to monitor client trajectory and outcomes. Doing so will enhance caregiver collaboration, will enable the timely adaption of service plans and may prevent client deterioration and subsequent access to acute care services. This will significantly increase the level of monitoring of SMC clients and enable reassessments to be based on changes in client needs and eliminate the need for periodic reassessment;
- Develop policies and processes for providing the outcomes of the clinical assessment to clients, their families and support networks to guide the provision of informal supports (regardless of whether the client joints the Program). Doing so will enhance the participation of the client in their care and maximize the value of clinical resources allocated by the RHAs in assessing client needs;
- Define HSW qualification and education requirements and strengthen monitoring policies and processes. This could entail working collaboratively with the College of the North Atlantic and other training providers to align education programs with the qualification standards;
- Segment competencies and qualifications to better reflect the variation in client support needs and improve the quality of service delivery. For example, consider using LPNs to deliver services to higher complexity clients;
- Explore expansion of provincial policy guidelines on the delegation of clinical duties beyond the administration of approved medications. Expanding HSW scope of practice (with appropriate training and supervision) in a standardized manner will improve the capacity of the RHAs other clinical community based programs and services (e.g., chronic disease prevention and management, wound care management, post-acute care follow up, assessment for placement in residential care, etc.); and,
- Streamline SMC administration to improve accessibility and the ability for the RHAs to monitor compliance to the conditions of client funding agreements.

Further detail on these opportunities and key considerations are provided within Appendix C.

3.4. Monitoring and Policy Development

This area of the Program refers to the requirement for HCS and the RHAs to monitor implementation of the Program according to approved policy and operational standards, and to make improvements to reflect changes in the clinical needs of the clients being served. There have been no substantial changes in the current operational standards manual since it was released in 2005, while there have been policy changes at the HCS and RHA levels that are influencing the uptake of the Program – paid family caregiver option, palliative and end-of-life home services, short-term home support services to avoid hospitalization, and Eastern Health's 'home first' pilot. At the same time, as demonstrated in the literature and jurisdictional scan, other jurisdictions have or are grappling with many of the same issues within their programs.

The PHSP is a Provincial Program with specific policy and program goals mandated by HCS. HCS is responsible for developing the Provincial Operational Standards and financial assessment manuals on which the RHAs and subsequently the home support agencies have their roles and responsibilities defined in administering the Program. At the same time, the RHAs derive their authority to deliver the Program through the Regional Health Authority Act though HCS (through the Minister) can direct the RHAs on implementation. While HCS and the RHAs have their defined roles, the nature of the Program issues requiring HCS interpretation and direction results in ongoing dialogue about approvals of a small segment of client applications. At the same time, HCS is concerned about consistency of approvals across the regions.

The fact that the provincial standards manual has not been updated since 2005 while societal and health policy factors for encouraging home support services have evolved is seen as a contributing factor to the current state of affairs. In the final analysis, it is not always clear as to the final authority on Program implementation, especially when interpretation of standards is required. While it is not appropriate for HCS to become involved in RHA operational matters within the Program, there are client inquiries made with HCS that require follow-up and investigation. This situation suggests an opportunity for better defined roles for both HCS and the RHAs so that both parties can devote their resources and energies to policy and program development matters within their spheres of control under the Program.

3.4.1. Client Satisfaction

One of the means to determine the overall effectiveness of the PHSP was to survey clients of the Program itself. Client satisfaction is seen as a good proxy for program effectiveness. The consultants undertook a phone survey of 131 participants, using an 11 question questionnaire during February and March 2016. The clients were drawn from lists of clients supplied to Deloitte by the RHAs according to pre-determined criteria. The clients were asked to rate their level of satisfaction with the Program. Where a client was unable to respond to a phone survey a family member acting as primary caregiver was invited to respond on her/his behalf.

The survey consisted of two introductory questions to assess high-level satisfaction with PHSP. Overall, the responses to these questions were quite positive, as shown below in Table 10.

Table 10: Overall Client Satisfaction

Question	Provincial Response
Overall, on a scale of 1-10, how would you rate your satisfaction with the Program?	8.7 / 10
Would you recommend this Program to your friends and family?	97% said “yes”

The survey also consisted of 10 questions to which the client was asked to respond based on the five-point scale defined in Table 11.

Table 11: Client Survey Response Guide

Response Guide				
1. Strongly disagree	2. Disagree	3. Neutral	4. Agree	5. Strongly agree

The survey results suggested strongly that the Program achieves one of its primary goals of allowing clients to live independently at home. The results proved quite supportive of the Program overall, with turnover in Home Support Workers and the application process noted as key challenges by clients. The overall (province-wide) results are summarized below in Table 12.

Table 12: Overall Client Satisfaction by Survey Question

Statement	Provincial Response
The Program allows you (your family member) to remain independent at home.	4.3 / 5
The application process for the Program was clearly communicated to you (your family member).	4.0 / 5
The application process for the Program was burdensome and lengthy.	2.5 / 5
The home support hours you (your family member) receive are adequate to meet your needs.	3.7 / 5
Your home care worker(s) are able to provide all your (your family member's) home support needs.	4.1 / 5
There is frequent turnover in your home support workers.	2.0 / 5
The home support services you (your family member) receive are free from any abuse.	4.3 / 5
You feel that you can voice any concerns you (your family member) have regarding any aspect of the home support services being provided.	4.2 / 5
The Program is responsive to changes in your (your family member's) needs.	3.8 / 5
The Program helps you (your family member) to access community services to help you stay at home.	3.9 / 5

3.4.1.1. Survey Results by RHA

Overall client satisfaction was highly consistent across RHAs, as demonstrated in Table 13 below.

Table 13: Client Satisfaction by RHA

Question/Statement	Eastern	Central	Western	Labrador - Grenfell
Overall, on a scale of 1-10, how would you rate your satisfaction with the Program?	8.7 / 10	8.2 / 10	8.7 / 10	8.9 / 10
Would you recommend this Program to your friends and family?	100% "yes"	94% "yes"	100% "yes"	92% "yes"
The Program allows you (your family member) to remain independent at home.	4.3 / 5	4.3 / 5	4.1 / 5	4.3 / 5
The application process for the Program was clearly communicated to you (your family member).	4.0 / 5	4.0 / 5	3.8 / 5	3.5 / 5
The application process for the Program was burdensome and lengthy.	2.9 / 5	2.4 / 5	2.3 / 5	2.4 / 5
The home support hours you (your family member) receive are adequate to meet your needs.	3.8 / 5	3.5 / 5	3.5 / 5	3.5 / 5
Your home care worker(s) are able to provide all your (your family member's) home support needs.	4.3 / 5	3.9 / 5	3.9 / 5	3.9 / 5
There is frequent turnover in your home support workers.	2.0 / 5	2.1 / 5	2.4 / 5	2.2 / 5
The home support services you (your family member) receive are free from any abuse.	4.0 / 5	4.5 / 5	4.2 / 5	4.5 / 5
You feel that you can voice any concerns you (your family member) have regarding any aspect of the home support services being provided.	4.1 / 5	4.0 / 5	4.0 / 5	4.3 / 5

Summary findings from the survey results by RHA include:

- Overall satisfaction scores are the highest in Labrador-Grenfell Health;
- The application process is felt to be most clearly communicated in Eastern Health and Central Health, and least clearly communicated in Labrador-Grenfell Health;
- The application process is felt to be the most burdensome in Eastern Health;
- Eastern Health is perceived as providing home support hours that are most adequate in meeting clients' home support needs;
- Home Support Workers in Eastern Health are the most able to provide all home support needs;
- The perceived turnover of home support workers is the highest in Western Health; and,
- Central Health and Labrador-Grenfell Health score the most favorable with respect to services being delivered free from abuse.

3.4.1.2. Survey Results by Client Type

Analysis of client survey results indicates satisfaction with the Program is lagging for Adults with Disabilities (AWD) when compared against seniors and children with disabilities accessing the Special Child Welfare Allowance (SCWA). The complete survey results broken down by client type are displayed below in Table 14.

Table 14: Client Satisfaction by Client Type

Question / Statement	Seniors	AWD	SCWA
Overall, on a scale of 1-10, how would you rate your satisfaction with the Program?	8.7 / 10	8.4 / 10	8.6 / 10
Would you recommend this Program to your friends and family?	96% “yes”	100% “yes”	100% “yes”
The Program allows you (your family member) to remain independent at home.	4.3 / 5	4.2 / 5	4.4 / 5
The application process for the Program was clearly communicated to you (your family member).	4.0 / 5	3.8 / 5	3.6 / 5
The application process for the Program was burdensome and lengthy.	2.3 / 5	2.9 / 5	3.0 / 5
The home support hours you (your family member) receive are adequate to meet your needs.	3.7 / 5	3.4 / 5	3.8 / 5
Your home care worker(s) are able to provide all your (your family member's) home support needs.	4.1 / 5	3.8 / 5	4.2 / 5
There is frequent turnover in your home support workers.	2.0 / 5	2.3 / 5	2.5 / 5
The home support services you (your family member) receive are free from any abuse.	4.3 / 5	3.9 / 5	4.4 / 5
You feel that you can voice any concerns you (your family member) have regarding any aspect of the home support services being provided.	4.2 / 5	3.9 / 5	4.1 / 5
The Program is responsive to changes in your (your family member's) needs.	3.9 / 5	3.5 / 5	3.8 / 5
The Program helps you (your family member) to access community services to help you stay at home.	4.1 / 5	3.9 / 5	3.6 / 5

Summary findings from the survey results by client type include:

- Overall satisfaction scores are the highest amongst seniors and lowest amongst the adults with disabilities population;
- The application process is felt to be most clearly communicated amongst seniors and least clearly communicated amongst the SCWA population;
- The application process is felt to be the most burdensome amongst the SCWA population, closely followed by the adults with disabilities population;
- Home care workers for SCWA clients are the most able to provide all home support needs;
- The perceived turnover of home support workers is the highest amongst SCWA clients;
- SCWA and seniors clients score the Program most favorably with respect to services being delivered free from abuse;
- The adults with disabilities population showed the lowest scores with respect to the Program being responsive to changes in their needs; and,
- The SCWA population showed the lowest scores with respect to the Program helping the client access community services to help you stay at home.

3.4.1.3. Summary and Key Observations

To summarize, the client survey was completed successfully and the results indicate a high level of client satisfaction across all populations and all RHAs. This finding reflects that the staff required to deliver the Program (from the Home Support Workers through to the RHA and departmental staff) are exhibiting the

hard work and dedication required to deliver a program that is receiving such positive reviews from all client segments in all regions of the Province. The results of the survey were also used to guide the identification of opportunities for improvement to make the Program more effective in the future.

3.4.2. Program Performance

3.4.2.1. Attainment of Goals

Currently, the Operational Standards define the PHSP's following three goals:

- That individuals who meet Program admission criteria have the support and services they need to live and develop fully and independently within the community in keeping with their assessed need;
- That individuals have choice in how they live; and,
- That the Program be equitable for all eligible population groups across the Province.

To be able to clearly determine if these goals are being met would require systematic monitoring and reporting of key performance indicators for each of the three goals. This has not been the experience with the Program. The consultants did not find any key program indicators or an overall performance framework to guide implementation of the Program or measure its performance.

There is a broad consensus that the Program is working well in terms of its primary goal but no ability to say exactly how or where it can improve outcomes. While most internal and external stakeholders believe the Program is meeting this goal, there is no independent evidence to support this view. Others have raised the question as to whether these are the most appropriate goals for the Program at this stage of its development.

As noted above in Section 3.4.1, the results of the client satisfaction survey suggest that clients believe the Program helps them live independently at home. There was limited data available to know to what extent other community supports and services are available to allow clients to engage with the broader community to support them in living independently. It is understood that clients assessed for their clinical needs albeit with some weaknesses in the current assessment tools used. When required, based on clinical need clients are provided with hours of care above the prescribed ceilings. While the Program's financial eligibility criteria are applied to all clients, they can act as a barrier to some potential clients in not receiving services; for some clients service is delayed owing to the burdensome rules, and there are instances where clients have selectively interpreted and worked around the liquid assets test to gain entry or not contribute fairly to their co-pay. Overall, the Program continues to grow meeting the needs of more and more clients.

In terms of the Program being equitable for all populations being served, the data suggests some variation across the populations and the regions. To begin, as outlined in Section 3.2.1 the clinical assessment tools vary by population and have weaknesses that lend themselves to subjectivity and variability in results within the clinical assessment process. The CRMS data that should be relied on to measure equity within client populations and across regions is not reliable, so no independent conclusion can reliably be drawn.

The Program usage data from Section 3.1 shows high variation in Program penetration, usage, referrals and approvals by client population between the four RHAs. And, the results of the analysis of the business processes for each RHA that support intake, referral, clinical and financial assessment and reassessment presented in Executive Summary show wide variation that inherently leads to inequities in the Program. Finally, the available data, as well as the issues raised related to the mode of service delivery whether by an agency or under self-managed care arrangements, suggest variation in availability by region, quality and reliability.

The review was not able to address the goal of allowing individuals to have choice in how they live. Currently, clients or potential clients of the Program have 'choice' in applying under the Program suggesting they chose to remain in their own homes with the support of the Program. They also have 'choice' in determining whether they use an agency or self-managed care arrangements to provide the home support services. The availability of alternative care arrangements such as PCH or LTC beds offers some choice but the review did not measure whether or not clients actively chose one arrangement over another and the role the Program plays in this decision.

3.4.2.2. Performance Management

There are no consistently reported key performance indicators or an overall performance framework to guide delivery of the Program or measure its success. Ad hoc program management reports have to be compiled from various information sources including RAI MDS-HC, CRMS, Meditech, RHA financial and human resource management information systems as well as HCS information systems. The lack of a systematic and integrated management information system to support timely and reliable reporting by RHAs inhibits effective program monitoring, planning and budgeting, and may result in day-to-day involvement of HCS in managing the Program.

3.4.2.3. Data Quality

The PHSP covers a large client population, involves a wide number of HCS, RHA, and agency staff and others to deliver and manage home support services, and requires significant provincial funding to subsidize its delivery.

Availability of data pertaining to the Program rests with HCS and the RHAs, and is largely reliant on the CRMS managed by the Provincial Office of the Chief Information Officer (OCIO). CRMS is the management information system that retains client data, clinical notes, and approval of hours of care. In addition, there is the CRMS Client-Pay system that records all financial transactions related to the Program. Data entry for both systems is the responsibility of each RHA.

The consultants were not able to rely on CRMS data to undertake a compliance review of client files to determine if eligibility and approval standards were applied consistently within and across each of the RHAs. Owing to the distributed nature of data entry into CRMS by RHA Community Health Nurses and Social Workers there are significant quality issues with the data captured. Conclusions related to policy compliance and standardization are drawn from the evaluation of business processes as described above.

In addition to CRMS data, a broad range of Program administrative and financial data was collected directly from the RHAs, along with caseload data. There were quality issues with some of this data that limited the ability to do an extensive comparative analyses in such areas as staffing and operating costs of the Program across the RHAs.

3.4.3. Program Governance

As a Provincial Program, the PHSP is governed by HCS under its departmental mandate. A division within the department has day-to-day responsibility for managing the Program. The division is responsible for developing and ensuring compliance with Program standards and setting the annual Program budget. The RHAs are responsible for administering delivery of the services funded under the Program. There is no accountability framework or formal reporting by the RHAs to HCS on the implementation of the Program.

While HCS and the RHAs meet formally on a periodic basis to discuss Program issues, there is no strong evidence of sharing of best business practices among the RHAs in terms of lessons learned in assessments, data entry, service planning, staffing levels, skills mix, etc. Critical variations in administering the Program have arisen (e.g., Central Health's priority is on financial assessments before clinical assessments) and in approving exceptions to the ceilings. While these variations continue HCS is seeking more standardization along with more consistency of client eligibility and approved hours of care under the Program.

The RHAs are supportive of program standardization across the regions and look to HCS for Program leadership, and they expect to have a continuing role in program governance. The need for both HCS and the RHAs to focus more on Program outcomes is recognized.

Finally, external stakeholders were consulted throughout the review of the Program. They have informed views that identified weaknesses in the Program along with suggestions that are supportive of improving its design and delivery. As well, they expect to be able to participate in the ongoing improvement of the Program.

3.4.4. Improvement Opportunities

The following four improvement opportunities have been developed to support this area of the Program:

- Implementing a performance management framework would improve the ability of HCS and the RHAs to monitor and evaluate the Program's outcomes. A focus on performance measurement will mean the Program benefits from continuous improvement as outcomes are measured regularly;
- Enhancing program governance would support the delivery of a standardized program that has clearly defined HCS and RHA accountabilities. This will assist to modernize program governance to establish clear roles, responsibilities and accountabilities for implementation, outputs and outcomes of the Program across all regions;
- The managers of the Program must be able to depend on and expect consistent use of CRMS to allow for more effective program monitoring, decision support and policy development. This approach to clinical data entry for the Program will result in CRMS data that is improved, simplified and consistently entered by clinicians across all regions to better monitor and evaluate Program and client outcomes; and,
- Policy modernization would result in the Program being guided by a new vision and set of principles to reflect the evolution of the Program since its inception and support the implementation of the improvement opportunities developed from the review of the Program. The result will be the delivery of a standardized program across all regions supported by HCS, the RHAs, and other relevant stakeholders.

Further detail on these opportunities and key considerations are provided within Appendix C.

4. Future Demand for Services

The PHSP has grown consistently over the past five years and longer – both in terms of clients served and in the level of public expenditure. The following key demand and supply factors have been identified by the Steering Committee as influencing the future direction of the Program:

Demand Factors:

- Increasing client expectations;
- Increased insurance coverage and income levels;
- Aging population;
- Changing demographics;
- In-bound seniors migration; and,
- Increasing complexity and acuity of cases.

Supply Factors:

- Aging caregivers;
- Fiscal pressures;
- Increasing influence of unions and agencies;
- Acute and LTC capacity pressures;
- Access to skilled/qualified HSW;
- Increased government accountability expectations;
- Health care system restructuring;
- Appropriate use of technology; and,
- Lack of integrated information management system.

As part of the review HCS wanted to know about the future demand for the Program and the drivers of this demand so as to be in a position to do more effective program and budget planning.

4.1. Analysis Methodology

Two future demand models have been designed to enable scenario development and sensitivity analysis by each RHA and client group. The first model is strictly for the Seniors client group, and the second incorporates both the Adults with Disabilities and SCWA populations. The models make use of historic caseloads, approved service hours, and expenditures to develop projections for each variable based on chosen inputs. CRMS data, caseload summary reports, Newfoundland and Labrador population projections (developed by the Department of Finance) and other relevant data were utilized to develop the Microsoft Excel based models. The completed models enable monthly projections through to December 2021. The models will be provided to HCS, along with the required training and instructions to understand its capabilities, to enable future services and workforce planning.

4.2. Future Demand Analysis

4.2.1. Baseline Demand

This section displays the current caseloads based on the most recent available data. It shows the current state of the Program which will serve as the baseline against which future demand can be compared. The baseline figures are based on full calendar year 2015 projections with most recent available data as of October, 2015 and are displayed below in Table 15. Additional detail on the baseline is contained in Appendix E.

Table 15: Baseline Data (2015)

Client Group	Current Caseload	Current Annual Approved Hours	Annual Cost
Total	**7,197**	**13.1M**	**$199.2M**
Seniors	3,752	5.5M	$84.3M
AWD	3,219	7.2M	$109.9M
SCWA	226	0.4M	$5.0M

Note: Caseload is as of October, 2015; Approved hours and cost to government are based on the last 12-months ending October, 2015.

4.2.2.Future Demand Estimates

The future demand models enable the analysis of many variables to build custom scenarios. For this report, three scenarios have been developed as outlined below.

1) **Low:** This assumes no prevalence growth (i.e., the current percentage of client types in the Program remains static), no increases in costs per client, and no increases in approved hours per client.
2) **Medium:** This assumes growth rates based on those seen historically for each RHA and client type. The growth rates have been chosen to normalize for any data anomalies.
3) **High:** This assumes growth rates at a premium relative to those seen historically (i.e., those used in the medium analysis) and the high population growth estimate.

Complete details on the assumptions used for each of the three scenarios are included in Appendix E.

4.2.2.1. Low Scenario

This scenario has been created to understand what the demands will be on the PHSP if there is no change in prevalence (i.e., the rate of usage across the Province), the cost per client, or the number of hours approved per client. It essentially isolates the demand change resulting from the changing demographics of the Province. This case represents what has been deemed the low scenario as the historic trends have been showing increases to all three variables (prevalence, cost, and hours). Achievement of this scenario would require changes to the Program to eliminate any increases in these variables which have been seen historically.

As seen below in Table 16, there will be a notable increase in the Seniors caseload, driven by the demographic changes in the population. Seniors case files are estimated to increase 24% from the current level of 3,752 up to 4,660. This results in an estimated $26.1 million increase in expenditure for the senior population. Caseloads within the Adults with Disabilities and SCWA client groups are projected to decrease due to the population projections, resulting in estimated cost savings of approximately $3.3 million.

Table 16: Low Scenario Data (2021)

Client Group	Estimated Caseload	Estimated Annual Approved Hours	Estimated Annual Cost	Cost Variance to Baseline
Total	**7,895**	**13.7M**	**$222.1M**	**($22.8M)**
Seniors	4,660	7.0M	$110.4M	**($26.1M)**
AWD	3,015	6.3M	$106.7M	$3.3M
SCWA	220	0.4M	$5.0M	$0.0M

4.2.2.2. Medium Scenario

This scenario has been developed by extrapolating historic trends to form an estimate for the PHSP in 2021. It is an effort to understand what demand for the PHSP Program could look like in 2021 if trends were to continue. When developing this scenario, historic rates were selected for all variables (prevalence, expenditure, and hours) based on data back to 2012. Best efforts were given to select growth rates that normalized for any data anomalies.

Under this scenario, there will again be a notable increase in the Seniors caseload, driven both by the demographic changes in the population and the historic increases in usage by the Seniors population. Seniors case files are estimated to increase 37% from the current level of 3,752 up to 5,124, as shown below by Table 17. In this scenario, the historic prevalence increases seen in the Adults with Disabilities population will also drive a slight caseload increase of 2%, from 3,219 to 3,267. SCWA will see the opposite trend due to changes in the demographics of the Province as well as the historic declining usage rate of the Program amongst the SCWA-aged population in the Province.

This scenario also assumes increases (based on those seen historically) for approved hours and expenditures per client. As a result, it is estimated in this scenario that the PHSP will incur a total cost increase of $53.4 million through 2021. The majority of this increase stems from the Seniors client group ($42.0 million), but a significant increase is evident in the Adults with Disabilities population as well at $11.9 million. The SCWA population offers a slight offset to these increases with an estimated $0.5 million in savings relative to the base case.

Table 17: Medium Scenario Data (2021)

Client Group	Estimated Caseload	Estimated Annual Approved Hours	Estimated Annual Cost	Cost Variance to Baseline
Total	**8,565**	**15.1M**	**$252.6M**	**($53.4M)**
Seniors	5,124	8.1M	$126.3M	($42.0M)
AWD	3,267	6.7M	$121.8M	($11.9M)
SCWA	174	0.3M	$4.5M	$0.5M

4.2.2.3. High Scenario

This scenario has been developed to give perspective into what demand for the PHSP Program could be if historic growth trends increase (within reason) through 2021. In this scenario, the “high” population scenario (developed by the Department of Finance) has been used and prevalence rates have been increased relative to those seen historically. Both approved hours and expenditure growth rates have been given premiums over the historic growth rates.

The output of this scenario shows quite significant increases relative to the base line scenario. As with the other scenarios, the largest increase in both caseload and cost is found in the Seniors client group. As indicated by Table 18, the Seniors caseload is expected to increase by 51% in this scenario (from 3,752 to 5,657), with expenditure increasing by $55.6 million. Adults with Disabilities also represent a significant expenditure increase in this scenario, with costs increasing by $17.6 million relative to the base case. The SCWA population represents a relatively minor expenditure increase of $0.2 million relative to the base case.

Overall, this scenario estimates a cost increase to the Program of $73.4 million by 2021 resulting from both caseload increases and increases in the cost and hours per client.

Table 18: High Scenario Data (2021)

Client Type	Estimated Caseload	Estimated Annual Approved Hours	Estimated Annual Cost	Cost Variance to Baseline
Total	**9,250**	**16.3M**	**$272.6M**	**($73.4M)**
Seniors	5,657	8.8M	$139.9M	**($55.6M)**
AWD	3,394	7.1M	$127.6M	**($17.6M)**
SCWA	199	0.4M	$5.2M	**($0.2M)**

4.2.2.4. Comparison of Scenario Outputs

In order to visualize the relative outputs of the three developed scenarios, the data has been condensed into Figure 28, Figure 29, and Figure 30 below. These figures display the Province-wide outputs of the three scenarios discussed in detail in the sections above.

Figure 28: Estimated Caseloads by Scenario

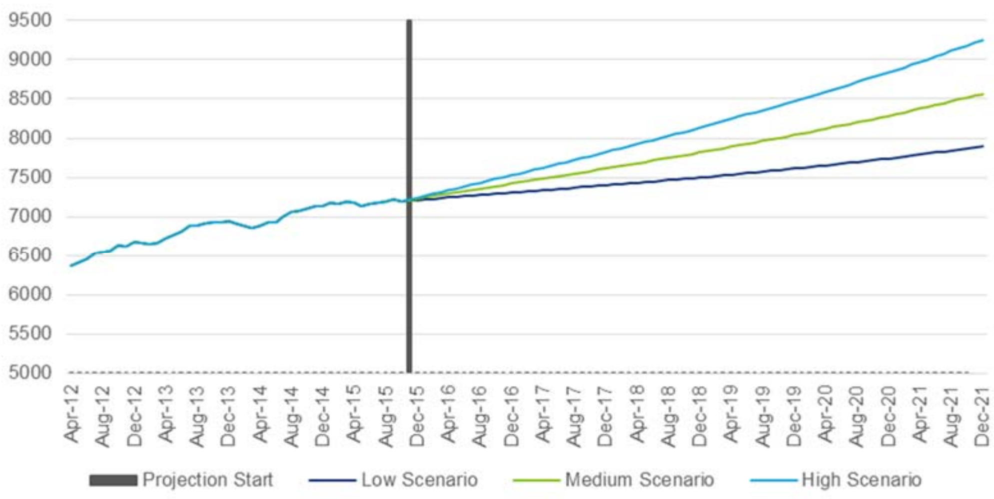


Figure 29: Estimated Expenditure by Demand Scenario

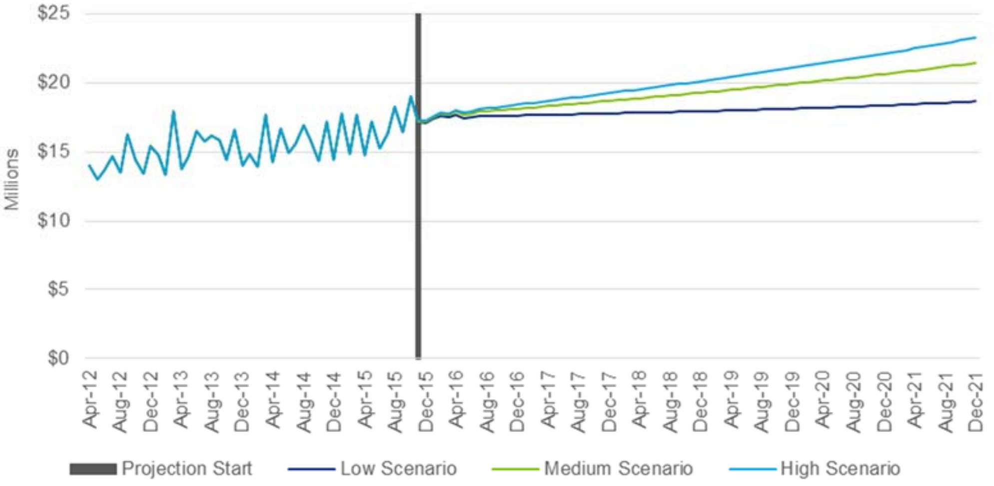


Figure 30: Estimated Approved Hours by Demand Scenario

4.2.2.5. Medium Scenario by RHA

In order to visualize the changing demands faced by the four RHAs, the medium scenario outputs have been displayed in the following figures: Figure 30, Figure 31, and Figure 32 below.

Figure 31: Medium Scenario Caseloads by RHA

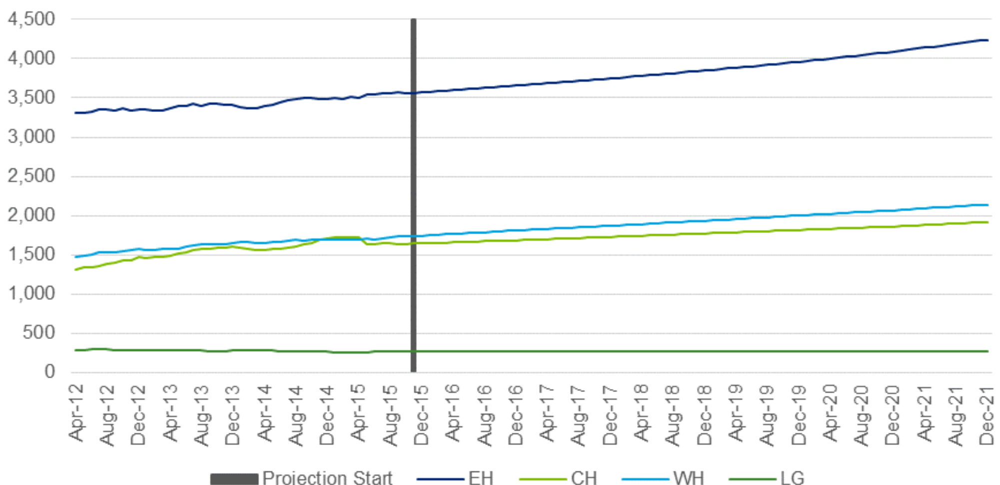


Figure 32: Medium Scenario Expenditure by RHA

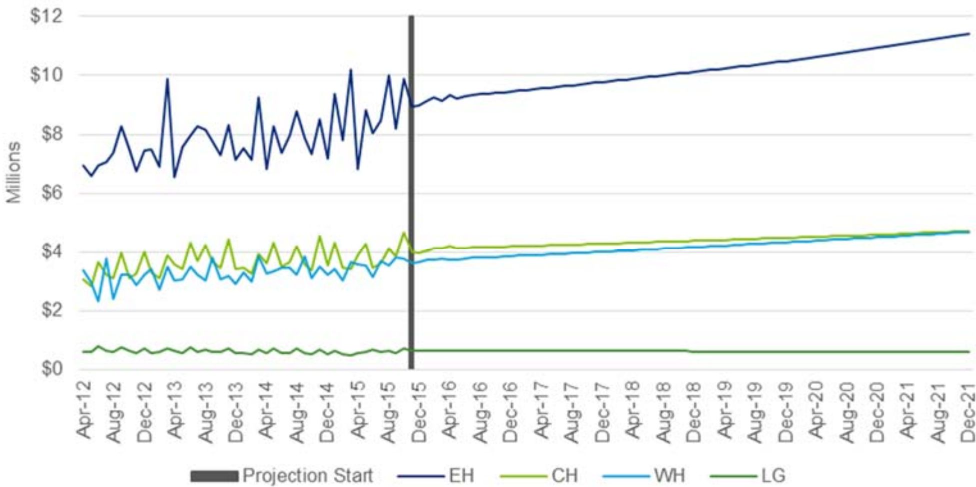
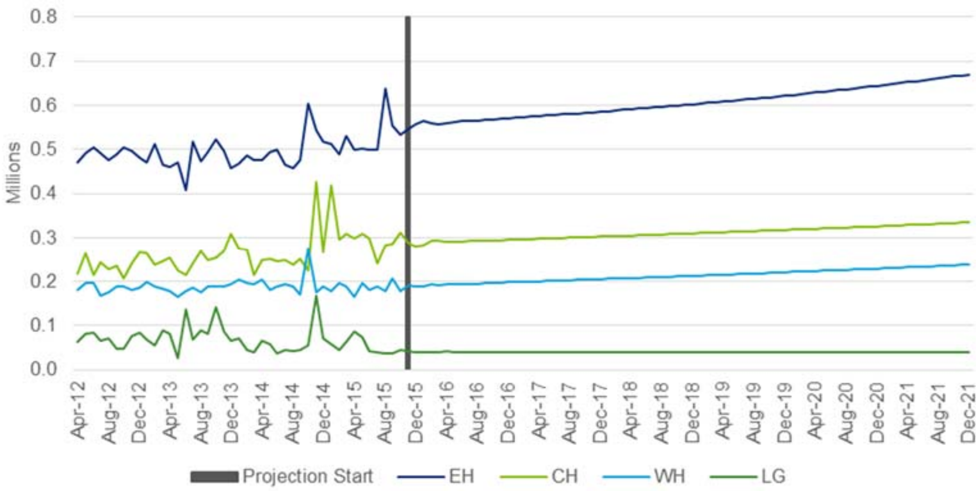


Figure 33: Medium Scenario Approved Hours by RHA



4.2.2.6. Medium Scenario by Client Group

Each of the three client types require a unique set of supports. The increase in demand through 2021 by client group will be critical to inform resourcing decisions and other Program changes in order to address these unique needs. Figure 34, Figure 35, Figure 36 below show the medium scenario outputs by client type.

Figure 34: Medium Scenario Caseload by Client Type

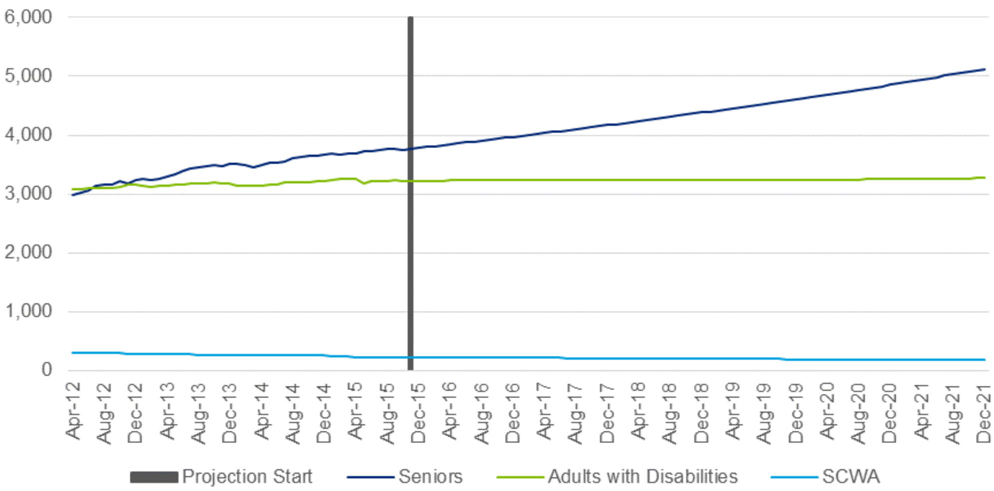


Figure 35: Medium Scenario Expenditure by Client Type

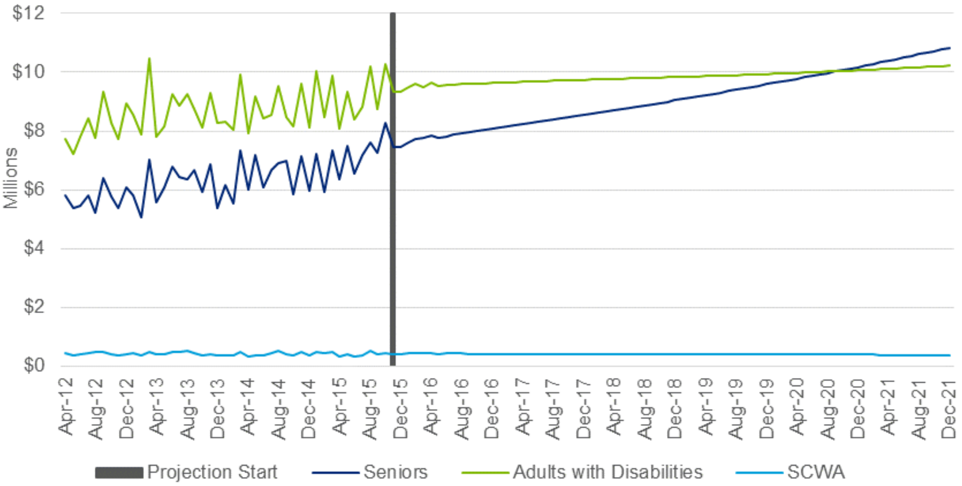
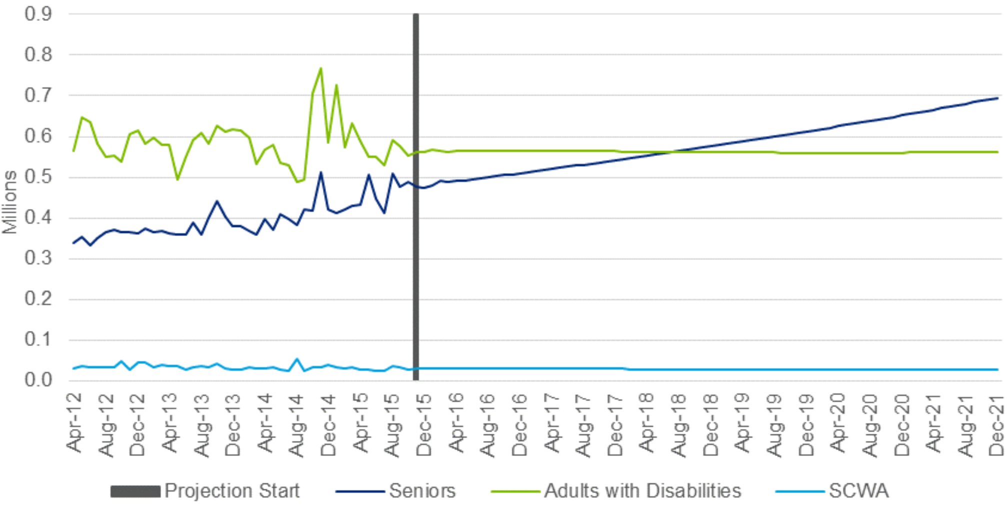


Figure 36*:* Medium Scenario Approved Hours by Client Type



4.2.2.7. Implications

A number of potential implications could stem from the increased caseloads and financial demands associated with this scenario including:

- Growth in demand for publicly funded home support services will continue to increase due to changing demographics. Without intervention, funding for the PHSP will need to increase by $22.8 million to $73.4 million over the next five years to meet this increased demand. Requirements for additional funding could be managed through:
- Changes to Program service levels and the scope of publicly funded supports; and,
- Changes to current PHSP funding mechanisms (i.e., eligibility requirements or co-pay amounts).
- Increased human resources will be required throughout the health care system, from HSW through to RHA and HCS staff:
  - Hiring enough qualified resources could be challenging unless training programs are aligned with the new demand levels and train adequate new employees; and,
  - Operational efficiencies within the RHAs will be necessary to minimize the impacts to the overall cost of Program administration and delivery.

4.2.3. Changes in Income Thresholds and Co-pay for Seniors Population

Finally, the Steering Committee wanted to understand what some potential impacts would be to the expenditures of the Program if the Income Test were to be modified for the seniors population. The 2016 budget increased the maximum client contribution from 15% to 18% of net income. As a result, Table 19 below reflects the current Income Test thresholds and client contributions.

Table 19: Current Income Test for Single Senior

Annual Exemption Threshold for a Single		$13,000
Portion of Income Between $13,001 to $18,000	Assess at:	18%
Portion of Income Between $18,001 to $23,000	Assess at:	28%
Portion of Income Between $23,001 to $28,000	Assess at:	38%
Income Between $28,001 to $150,000	Assess at:	18%

Summary of Key Observations for Future Program Demand

The output from the modelling of the available data shows:

- With no changes to the Program, the medium scenario predicts an increase of just over 1,368 clients in the PHSP by 2021 due largely to the increase in the seniors population with Eastern Health showing the highest increase in the caseload;
- With no changes to the Program, there will be a slight increase in the caseload of Adults with Disabilities; this could change if the standard of assessment for intellectual disabilities changes;
- With no changes to the Program, there will be an overall decline in the caseload for SCWA; this could change if the standard of assessment for intellectual disabilities changes;
- As more patients are transferred home as opposed to being hospitalized or placed in a personal care or nursing home, the demand for the Program will increase proportionately;
- Demand could trend downward as the incomes of seniors is expected to increase resulting in financial ineligibility under the Program; and
- Demand could fluctuate upward or downward depending on future changes to the financial assessment criteria.

In summary, the demand model illustrates quite clearly that caseloads are going to increase significantly through 2021, largely due to the demographic changes being faced by the Province. As such, without intervention, the Program costs are going to see significant increases with medium estimates predicting that the Program costs will increase by $53.4 million through 2021. In order to keep costs stable in this Program, significant policy changes and/or operational improvements will be required.

5. Future Program Vision

In light of insights gained from the current state review and the expected future growth in Program demand, the Steering Committee has identified the need and the opportunity to examine the underlying philosophy or vison and stated goals for the PHSP. It is appropriate to develop a new vision or purpose statement for the Program on which to build the opportunities for improvement and align stakeholders. With the changing demographics and future demand for services, and the need for the provincial health care system to respond to the pressures on the acute and long-term care sectors, the PHSP must adapt. Furthermore, the analysis of Program data points to needed changes in approach to how the services are designed and delivered across the system.

5.1. Purpose Statement

A purpose statement is an aspirational description of what a program would like to look like, achieve or accomplish in the mid-term or long-term future. It is intended to serve as a clear guide for choosing current and future courses of action.

All citizens of the Province have access to the home support services they need to help them remain independent in their homes and communities, avoid unnecessary hospitalization and long-term care placement, and maintain their well-being.

Given this, the proposed purpose statement, developed in close consultation with the Steering Committee, for the Provincial Home Support Program is:

5.2. Guiding Principles

While the purpose statement is deliberately broad in intent, a series of **guiding principles** will help HCS and the RHAs to interpret the purpose of the Program on an ongoing basis:

- The home support services provided will be of high quality, client-centered and based on determined need;
- Home support services will be planned in collaboration with clients, their families and other informal supports, and key health and community service providers;
- Clients will have choice in determining how home support services are delivered in their homes;
- Access to and delivery of home support services will be undertaken by the Regional Health Authorities in a timely manner;
- Home support services will help promote independence, safety, and social and community inclusion; and,
- Home support services will be fully integrated with other health and community services.

5.3. Goals and Monitoring and Evaluation Indicators

To accompany the purpose statement and to provide a means of measuring impact, a series of goals and objectives are required for the next five years of the Program. Table 20 below outlines the **proposed future goals** for the Program and associated monitoring and evaluation indicators.

It is important to consider how the PHSP interfaces with other care settings within the provincial health care system when developing appropriate monitoring and evaluation indicators. As such, a distinction has been made between monitoring and evaluation indicators that are specific to the Program and those that the Program may influence in adjacent programs and clinical services.

Table 20: Future Program Goals, Monitoring & Evaluation Indicators

<table>
<tr><th colspan="2">Goal 1: To support people of all ages to live in their home and community.</th></tr>
<tr><th>Indicator Type</th><th>Indicator</th></tr>
<tr><td rowspan="3">Specific</td><td>Reduce the time for clients to be assessed and receive supports.</td></tr>
<tr><td>Increase or maintain client and family satisfaction.</td></tr>
<tr><td>Increase the percentage of eligible populations accessing the Program and avoiding institutional placement.</td></tr>
<tr><td rowspan="3">Adjacent</td><td>Delay and decrease LTC admissions.</td></tr>
<tr><td>Decrease ALC length of stays in acute care.</td></tr>
<tr><td>Decrease living arrangement disruptions of clients.</td></tr>
<tr><th colspan="2">Goal 2: To support individuals to actively engage in the community.</th></tr>
<tr><th>Indicator Type</th><th>Indicator</th></tr>
<tr><td rowspan="2">Specific</td><td>Increase the number of individualized community inclusion plans for clients.</td></tr>
<tr><td>Increase or maintain client and family satisfaction.</td></tr>
<tr><th colspan="2">Goal 3: To support and empower families and caregivers in their role.</th></tr>
<tr><th>Indicator Type</th><th>Indicator</th></tr>
<tr><td rowspan="4">Specific</td><td>Increase utilization of family caregiver option under the Program.</td></tr>
<tr><td>Increase family and caregiver participation in client’s service plan.</td></tr>
<tr><td>Increase utilization of respite hours under the Program.</td></tr>
<tr><td>Increase or maintain family and caregiver satisfaction.</td></tr>
<tr><td>Adjacent</td><td>Decrease living arrangement disruptions of clients.</td></tr>
</table>

One of the key features of a modern program management regime is to have an appropriate performance measurement framework in place. This is currently lacking for the PHSP. If HCS wants to retain an effective program to address the ongoing home support needs of the population(s) the Program serves, then it needs a means to monitor and evaluate Program performance.

In the future, HCS in collaboration with the RHAs will need to collect the appropriate data to measure these indicators and report annually on the success in achieving them. Some of the data is currently available through CRMS, Meditech and other RHA data sources. For certain indicators, new data sources will need to be developed, and ongoing client and family surveys completed. Appendix F provides further detail on the proposed future performance management framework for the Program.

Importantly, in order to maintain the performance measurement framework, HCS will need to commit the time and resources to collect, analyze and report on the data most of which will come from existing database.

6. Improvement Opportunities

The emphasis of the review was to identify potential opportunities to improve the efficiency and effectiveness of the PHSP with a view to its long-term sustainability. These opportunities had their genesis in the findings from the current state review where the literature search and jurisdictional scan pointed to new possibilities for the Program based on experiences and leading practices in other provinces and countries. These findings were then coupled with the document review, quantitative analysis and the input received from the stakeholder consultations including the workshops with front-line RHA staff. The impact that future demand will have on the Program was also critically examined to identify opportunities to mitigate any increase in Program resources as a result.

Moreover, the identified opportunities presented in this section will each support the attainment of the vision referred to in Section 5. Some of the opportunities are specific to HCS, others relate to program delivery by the RHAs, while others impact external stakeholders such as the home support agencies, bookkeepers and other sectors of the health and community service system.

6.1. Improvement Opportunities

6.1.1. Summary of Opportunities by Program Area

Various improvement opportunities were noted as the current state of each area of the Program was reviewed in Section 3. Table 21 provides a summary of the identified opportunities and differentiates between those that improve Program:

- **Effectiveness:** the provision of high-quality, appropriate and accessible supports that enhance the ability of clients to remain independent in their homes and communities; and,
- **Efficiency:** the administration of the Program in the most cost effective, resource appropriate and timely manner that enhances the Province's ability to sustainably support its clients.

Additionally, further detail on each improvement opportunity is provided in Appendix C. This further detail includes associated monitoring and evaluation indicators as per Table 20, impacted stakeholders, key considerations and associated deliverable area as per Table 3.

Table 21: Improvement Opportunities by Program Area

Program Intake & Referral		
ID	**Opportunity**	**Improvement Type**
1	Improve promotion of the Program across all care settings to support the appropriate referral of clients to the Program.	Effectiveness
2	Establish consistent online resources to aid client navigation and self-referral.	Effectiveness
3	Establish a centralized provincial intake and application process to improve Program consistency and efficiency.	Efficiency
4	Enhance inter-discipline practitioner collaboration to improve the timely referral of clients.	Efficiency

Assessment, Planning & Coordination		
5	Enhance clinical assessment tools and implement hours based service limits (as opposed to financial ceilings) to more accurately define and communicate client care needs.	Effectiveness
6	Perform risk-based reassessment of client needs to improve CHN/SW productivity and service capacity.	Efficiency
7	Delegate reassessments to supervised RHA paraprofessionals to improve CHN/SW productivity and service capacity.	Efficiency
8	Streamline financial assessment processes to improve FAO productivity and service capacity.	Efficiency
9	Optimize financial eligibility criteria and client co-payment to improve resource allocation and enhance Program sustainability.	Effectiveness
10	Improve the hand-off of service plans to agency and SMC providers to improve the continuity of care and eliminate redundant assessments.	Efficiency/ Effectiveness
11	Allow flexibility through expanded individualized funding models to improve client choice and the flexibility in how hours and subsidies are utilized.	Effectiveness
12	Expand day programs and residential operations to promote the sharing of services and supports.	Effectiveness
13	Develop integrated care plans to improve the continuity of care across CSS program and services, and minimize living arrangement disruptions.	Effectiveness
Home Supports Delivery		
14	Implement agency agreements with service levels to improve accountability and oversight.	Effectiveness
15	Consolidate the number of agencies to improve agency sustainability through economies of scale and support monitoring of service levels.	Efficiency
16	Explore outcomes based funding arrangements to improve agency commitment and accountability.	Effectiveness
17	Implement policies, processes and technology enablers that improve client monitoring and care team collaboration.	Effectiveness
18	Define HSW qualification and education requirements and strengthen monitoring practices to improve the quality of care delivered.	Effectiveness
19	Segment competencies and qualifications required to provide home support services to improve the quality care provided to clients with complex needs.	Effectiveness
20	Expand provincial policies on the delegation of clinical duties to improve the productivity and service capacity of CCS resources.	Efficiency
21	Streamline the administration of SMC arrangements to improve accessibility, client choice and RHA monitoring of funding agreements.	Effectiveness
Monitoring & Policy Development		
22	Implement a performance management framework to improve the ability of HCS and the RHAs to monitor and evaluate Program outcomes.	Effectiveness/ Efficiency
23	Enhance program governance to support the delivery of a standardized program that has clearly defined HCS and RHA accountabilities.	Effectiveness/ Efficiency
24	Enhance the consistent utilization of CRMS to enable the monitoring and evaluation of Program and client outcomes.	Effectiveness/ Efficiency
25	Modernize Program policies to reflect revised vision, improvement opportunities and the delivery of a standardized program.	Effectiveness/ Efficiency

6.1.2. Prioritization of Improvement Opportunities

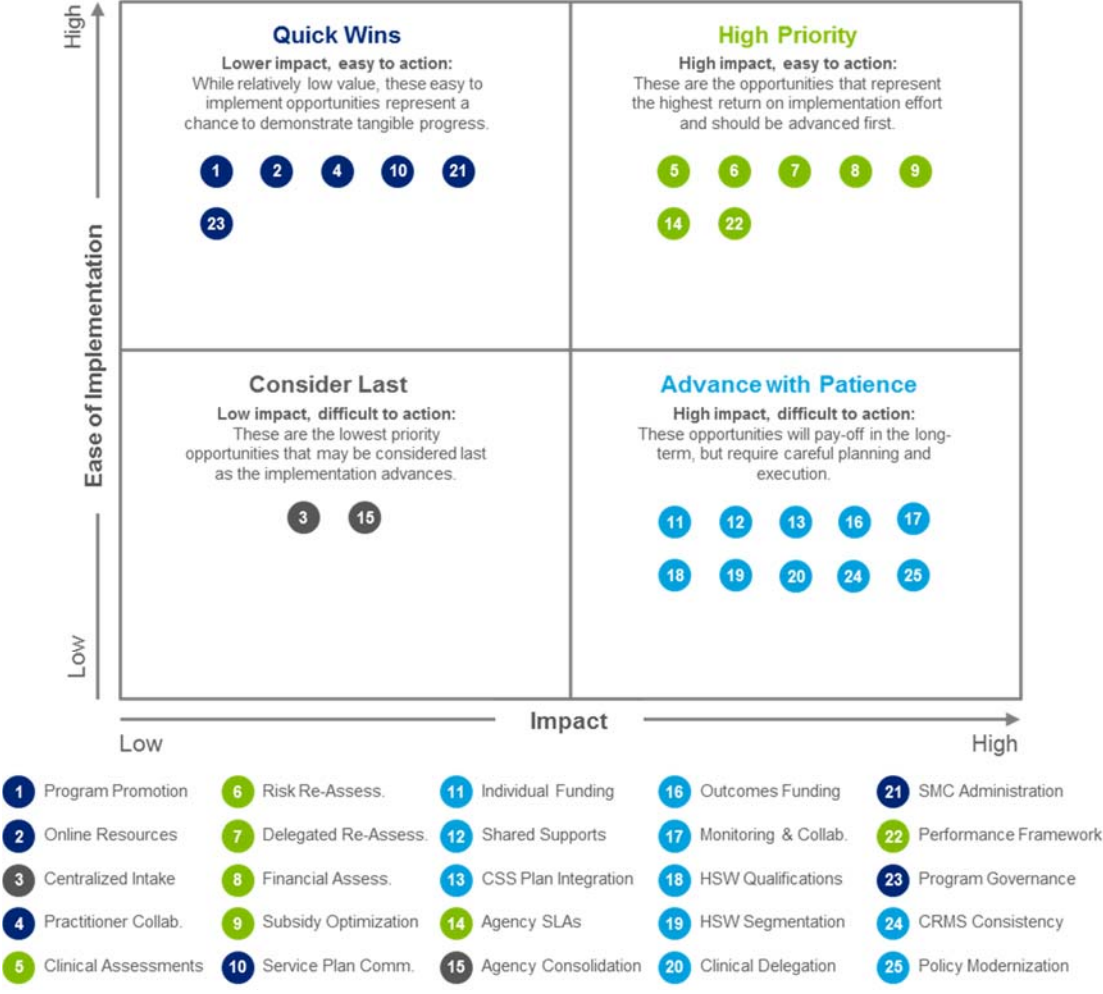
The review identified an array of opportunities across all areas to improve the PHSP, but not all are equal in terms of ease of implementation and their degree of impact on the future of the Program. As such, the improvement opportunities were prioritized on the basis of:

- **Impact:** quantifiable improvements to Program effectiveness and efficiency, alignment with Program goals and objectives, improvements to service quality and client satisfaction; and,

- **Ease of Implementation:** implementation schedule, potential need for investment, the number of stakeholder groups impacted and their readiness for change, potential resistance to change.

Figure 37 below presents this outcome of this qualitative analysis and defines four categories of improvement opportunities for HCS and the RHAs to consider.

Figure 37: Improvement Opportunity Prioritization



6.2. Future Program Sustainability

Understanding future Program financial sustainability is a particularly important outcome of the review given the recent growth in program spending and the prevailing fiscal challenges faced by the Province. Furthermore, Section 4 forecasts an on-going increase in demand for the supports provided under the PHSP that, if unaddressed, would require significantly higher funding and resources to administer the Program. While Section 6 summarizes the various opportunities to improve program effectiveness and efficiency, the question remains whether these interventions would be sufficient for the Program to meet future demand with currently available financial and human resources.

To address this important point, quantitative analysis was completed on select high priority opportunities to understand further policy options available to the Province and the impact on Program effectiveness (i.e., the application of subsidy funding) and efficiency (i.e., the RHA resources utilized in administering the Program).

To assess future Program sustainability, the medium-demand scenario as defined in Section 4.2.2.2 is assumed. Moreover, the analysis presented below represents a discrete set of policy choices to demonstrate how the future sustainability of the PHSP can be assured. It is not intended to be prescriptive or reflect an optimized future state. Prevailing social and economic policy direction that is beyond the scope

of the review may require HCS to augment its approach to balancing the demand and supply of home support services. Rather, it is a demonstration of what is possible for the Province to achieve through advancing the improvement opportunities identified in this review.

6.2.1. Future Program Effectiveness

Consistent with the analysis presented in Section 4.2.2.2, Figure 38 below illustrates the projected growth in annual subsidy expenses associated with:

- An overall net increase in services demand and Program caseloads;
- Changes in the average hours of supports associated with Seniors, with typically lower care requirements, who comprise a greater proportion of the Program's clientele; and,
- Extrapolated growth in the average subsidy cost per hour associated with HSW wage increases and other costs of service delivery.

More importantly, Figure 38 also illustrates the impact of implementing the policy interventions announced as part of the FY16-17 provincial budget and select opportunities to improve Program effectiveness identified in this review.

While annual subsidy expenditures are forecast to increase by $53.4 million in the next five years, the Province can mitigate the financial impact of increased demand for home support services through a variety of policy options.

Without intervention, an estimated $53.4 million of additional Program spending would be required in FY20-21 to meet increased demand for home support services. Rather than reach $252.6 million annual subsidy expenditures forecast for FY20-21, it is estimated that the Province can provide home supports at or below current funding levels while maintaining or improving service quality by:

- Maintaining the two-hour cap on homemaking hours announced in the FY16-17 provincial budget;
- Maintaining the maximum client contribution of 18% announced in the FY16-17 provincial budget;
- Enhancing clinical assessment tools to improve the appropriateness of hours of supports recommended and publicly funded;
- Implementing service levels in agency agreements and achieving a level of consolidation to drive cost efficiencies with home support agencies; and,
- Lowering the financial eligibility ceiling from an annual income level of $150,000 to the median provincial annual income of approximately $35,000[17].

[17] Source: Statistics Canada

Figure 38: Estimated Changes to Annual Program Subsidy Expenditures FY14-15 to FY20-21 ($M)

Table 22 below provides further descriptions of each of the estimated change to total subsidy expenditure based on projected demand in FY20-21 as presented in Figure 38. Importantly, as challenges existed in the collection of consistent and reliable information from CRMS, the RHAs, and other sources, the estimated funding implications presented should be considered both conservative and directional in nature.

Table 22: Description of Changes to Annual Program Subsidy Expenditures (FY14-15 to FY20-21)

Expenditure Item	Description and Key Assumptions
Baseline Expenditures FY14-15	• Current estimated baseline subsidy expenditures as defined in Section 4.2.2.2.
Increased Caseload	• Estimated increased in annual subsidy expenditures driven by increased demand for services, assuming no change in the current average hours of support and public funding per hour.
Change in Program Demographics	• Estimated reduction in subsidy expenditures driven by a reduced average of service hours per client resulting from increased demand from seniors relative to other client groups. • Assumes no change to the average funding per hour of service.
Subsidy Cost Escalation	• Estimated increase in subsidy expenditures driven by an increase in the average subsidy funding per hour or service. • The increase in unit subsidy cost is based on an extrapolated historical trend driven by HSW wage increases and other costs of service delivery.
Medium FY20-21 Forecast Scenario	• Forecast Program subsidy expenditures under the medium growth scenario as per Section 4.2.2.2. • Assumes no change to current policy and Operational Standards.
Cap on Homemaking Hours	• Estimated impact on annual subsidy expenditure of the two-hour cap on homemaking hours introduced during the FY16-17 provincial budget. • Based on projected caseloads in FY20-21 and assuming no change to the average funding per service hour.
Increase in Maximum Client Contribution	• Estimated impact on annual subsidy expenditure of raising the maximum client contribution from 15% to 18% of net income introduced during the FY16-17 provincial budget.

Expenditure Item	Description and Key Assumptions
	• Assumes projected caseloads in FY20-21.
Enhanced Clinical Assessment	• Estimated impact on annual subsidy expenditure of enhancing clinical assessment tools to more appropriately define client service needs (i.e., Opportunity 5). • Assumes a 12.7% reduction in average hours of support based on the review of client case files as described in Section 3.2.1 and projected caseloads in FY20-21.
Agency SLAs	• Estimated impact of mitigating escalation in the costs of service delivery by implementing service levels into agency agreements and realizing cost efficiencies associated with greater economies of scale. • Assumes projected caseloads in FY20-21.
Subsidy Optimization	• Estimated impact on annual subsidy expenditure of aligning the financial eligibility ceiling with the median annual provincial income of approximately $35,000 based on forecast caseloads in FY20-21. • Based on current income levels in the Province and of clients receiving supports under the PHSP, this equates to approximately 4.7% of case files.
Adjusted FY20-21 Forecast Scenario	• Forecast annual Program subsidy expenditures under the medium growth scenario as per Section4.2.2.2, adjusted for the full implementation of policy decisions announced by HCS and select high priority improvement opportunities identified by this review.

This analysis demonstrates that it is possible to mitigate the impact of increased demand on Program subsidies through pursuing a select number of effectiveness opportunities. While these opportunities were quantifiable on the basis of available information, it should be noted that additional improvements in Program effectiveness may be realized through advancing the full set of opportunities presented in Table 21. The impact on Program financial sustainability of many of the presented improvement opportunities may be quantified through additional data collection and analysis or may be secondary effects of qualitative improvements.

6.2.2. Future Program Efficiency

As demand for home support services increases, so will the demands that are placed on the RHA staff who responsible for administering the Program. As such, ensuring the efficient utilization of RHA resources as caseloads increase is an additional key consideration in understanding the future sustainability of the Program. Figure 39 below defines the estimated impact on RHA resourcing requirements as caseloads increase to meet the demand projected under the medium growth scenario. Without changes in business processes and staffing models, it is estimated that by FY20-21 the RHAs would require an additional 30.9 FTEs in order to:

- Manage Program intake and client referrals;
- Complete clinical assessments, develop service plans and monitor client outcomes;
- Review client financial information, assess subsidy eligibility and calculate client contributions; and,
- Monitor home support agencies.

Figure 39 Estimated Changes to RHA Resourcing Requirements FY15-16 to FY20-21 (FTEs)

More importantly, Figure 39 also illustrates the impact of implementing select opportunities to improve Program efficiency identified in this review.

The opportunity exists for the RHAs to mitigate the impact on resource requirements resulting from increased demand for home support services by implementing high priority efficiency improvements.

Table 23 below provides further descriptions of each of the estimated change to total RHA resourcing requirements based on projected demand in FY20-21 as presented in Figure 39. Similarly to quantifying the impact of opportunities to improve program effectiveness, estimates of program efficiencies should be considered conservative and directional in nature due to challenges collecting consistent and reliable data.

It is important to note that a number of improvement opportunities described in Section 6.2.1 have the potential to mitigate demand and drive lower caseloads than projected in the medium growth scenario. Consequently, the realization of improvements in program effectiveness would also have implications for the RHA resources required to administer the Program. However, given the timing and extent of implementation of these opportunities is not yet known, the assessment of future program efficiency has been completed independent of any policy changes that improve program effectiveness. As HCS develops the overarching policy framework that shapes the demand for home support services, it will be important to understand the implications to RHA resourcing requirements as program efficiencies beyond those described here may be achieved.

Table 23: Description of Changes to RHA Resourcing Requirements (FY14-15 to FY20-21)

Resourcing Item	Description & Key Assumptions
Baseline RHA FTEs FY15-16	• Total FTE resources dedicated to administering the Program as reported by the RHAs.
Increased CHN/SW Resources	• Estimated increase in CHN/SW resources required to complete clinical assessments, develop service plans and monitor client outcomes. • Assumes projected FY20-21 caseloads and no changes in management practices.
Increased FA Resources	• Estimated increase in FA resources required to complete financial assessments. • Assumes projected FY20-21 caseloads and no changes in management practices.
Increased Coordinator Resources	• Estimated increase in Case Coordinator resources required to manage client intake, Program referrals, service plan approvals and agency monitoring and liaisons. • Assumes projected FY20-21 caseloads and no changes in management practices.
Forecast RHA FTEs FY20-21	• Estimated RHA resources required to administer the Program under the medium growth scenario defined in Section 4.2.2.2. • Assumes no changes in management practices.
Risk Based Reassessment & Client Monitoring	• The estimated impact of conducting client needs assessments based on a risk-based framework that is informed by improved client outcomes monitoring. • Assumes one reassessment per case file per year and 30% of reassessments currently completed that result in no change in service levels can be avoided. • Assumes projected FY20-21 caseloads.
Delegated Reassessment	• The estimated impact of delegating reassessments to paraprofessionals, with supervision from CHN or SWs. • Based on the CHN FTE resources inferred from the difference between CHN and PCA salary and wage rates and the estimated annual hours of assessment work. • Assumes an average CHN hour salary of $34.35, wages for PCAs with at least two-years of experience (as per Section 3.3.2.3) and employment benefits of approximately 20%. • Assumes projected FY20-21 caseloads.
Enhanced Clinical Assessment	• The estimated impact of implementing enhanced clinical assessment tools. • Assumes a 25% reduction in assessment time from the current three-hour average as noted in the review of client case files. • Reduction in clinical assessment time based on achieving the typical duration seen in Alberta Health Services, a jurisdiction with greater experience with RAI-HC. • Assumes projected FY20-21 caseloads.
Streamlined Financial Assessment	• The estimated impact of implementing streamlined financial assessment processes. • Assumes a 50% reduction in the average assessment duration from two hours to one hour based on automating the collection of client income information from CRA and scaling back or eliminating supplementary assessment of client asset levels. • Assumes projected FY20-21 caseloads.
Agency SLAs	• The estimated impact of implementing agency service levels and achieving a degree of agency consolidation. • Based on a 10% reduction in coordinator resources to reflect reduced compliance monitoring and issue remediation workload. • Assumes projected FY20-21 caseloads.
Adjusted Forecast Scenario FY20-21	• Forecast total RHA resource requirements under the medium growth scenario as per Section 4.2.2.3, adjusted for the implementation select high priority efficiency improvement opportunities identified by this review.

As with the assessment of future Program sustainability from an effectiveness standpoint, this analysis demonstrates that it is possible to mitigate the impact of increased demand on RHA Program resources.

While these opportunities were quantifiable on the basis of available information, it should be noted that additional improvements in program efficiency may be realized through advancing the full set of opportunities presented in Table 21. The impact on Program financial sustainability of many of the presented improvement opportunities may be quantified through additional data collection and analysis or may be secondary effects of qualitative improvements.

6.3. Implementation Strategy and Roadmap

The consultants have developed an implementation strategy roadmap built on the matrix developed to support prioritization of opportunities as presented above. The proposed roadmap has five phases, as follows defined in Table 24.

Table 24: PHSP Improvement Opportunity Implementation Strategy

Phases	Steps	Anticipated Timeframe
Phase 0		
Acceptance of Opportunities	HCS Senior Management endorses report.	Year 0 Q0
	HCS establishes internal Implementation Committee and sets terms of reference for a provincial committee.	
Engagement of RHAs	RHAs invited to sit on Provincial Implementation Committee.	
Engagement of External Stakeholders	HCS shares report with home support agencies and seniors and disability organizations.	
	HCS invites external stakeholders to sit on Provincial Implementation Committee.	
	HCS posts report on its website.	
Phase 1		
Implementation of *'Quick Win'* Opportunities	Provincial Implementation Committee begins verification of these opportunities and establishes plan for implementation.	Year 1 Q1
	RHAs begin implementation.	Year 1 Q1 & Q2
	RHAs report on status of implementation.	Year 1 Q2
Implementation of *'Top Priority'* Opportunities	Provincial Implementation Committee begins verification of these opportunities and establishes plan for implementation.	Year 1 Q2
	RHAs begin implementation.	Year 1 Q2 & Q3 & Q4
	RHAs report on status of implementation.	Year 1 Q4
	HCS issues interim PHSP performance report.	Year 1 Q4
Phase 2		
Implementation of *'Advance with Patience'* Opportunities	Provincial Implementation Committee begins verification of these opportunities and establishes plan for implementation.	Year 1 Q4 Year 2 Q1 & Q2
	RHAs begin implementation.	Year 2 Q2
	RHAs report on status of implementation.	Year 2 Q2
	HCS issue full PHSP performance report.	Year 2 Q2 & Q3

Phase 3		
Implementation of 'Consider Last' Opportunity(s)	Provincial Implementation Committee begins verification of these opportunities and establishes plan for implementation.	Year 2 Q3 & Q4
	RHAs begin implementation.	Year 3 Q1
	RHAs report on status of implementation.	Year 3 Q3
Change Management & Communication		
Summative Review and Reporting on Progress	HCS develops status report on implementation of all opportunities and posts on website.	Ongoing throughout

Based on this implementation strategy and the prioritization of opportunities outlined in Figure 37, the recommended sequencing of Program improvement efforts is presented in Figure 40 below.

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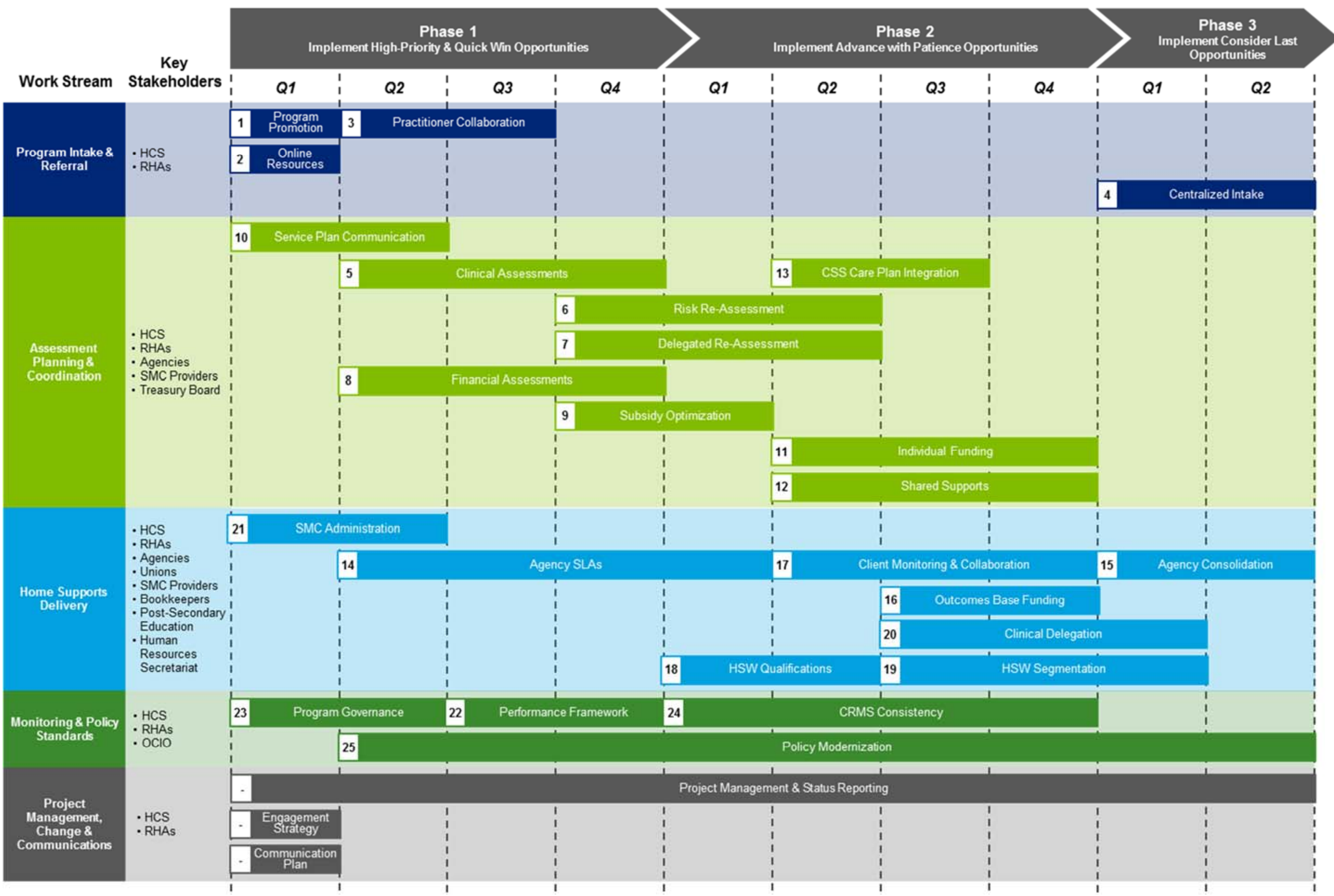
Figure 40: PHSP Improvement Opportunity Implementation Roadmap



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The roadmap outlined above will require both HCS and the RHAs to dedicate existing internal resources to initiate implementation of the improvement opportunities. Most opportunities likely do not require additional resources to implement; however, the need for specific expertise that is not readily available and the availability of Program and policy resources should be given further consideration by HCS as it mobilizes for each opportunity. Nevertheless, improvement opportunities that require new funds may be sourced from the savings to be achieved from the efficiency gains outlined in several of the opportunities. Implementation of the report will require dedicated project and change management by HCS, the RHAs, the agencies and home support workers, and this requirement will need to be built into the implementation plans for the respective opportunities.

Overall, the implementation plans need to stay on a tight timeframe in order for HCS to realize its investment in undertaking the review and for it to achieve a more efficient and effective PHSP to meet the growing demand for home support services across the Province at a time of severe fiscal restraint.

7. Concluding Remarks

The PHSP is a critical element of the Provincial Long-Term Care and Community Support Services Strategy – in fact, it is the foundation of the services being delivered under the strategy. It is viewed by all stakeholders as well as clients and their families as a valuable Program to keep seniors and adults and children with disabilities in their homes and to support them in living independently. It has the added value of supporting RHAs in avoiding unnecessary hospitalizations and allowing some patients to go home as opposed to taking up residency in a personal care or LTC facility. The degree to which the Program is successful in meeting these goals has not been measured, yet demand is increasing, and public expenditures on the Program continue to grow.

The review assessed a large body of qualitative and quantitative data and involved a wide range of internal and external stakeholders of the Program. The findings and resulting opportunities were vetted with the Steering Committee, and there is confidence that the report represents a realistic set of improvements for the Program that will impact favourably the Program, its clients, and those who deliver services over the next five years and beyond.

It will be incumbent for HCS in collaboration with the RHAs to be vigilant in moving forward on implementation of the report. The implementation strategy sets out a roadmap that if followed should see a major transformation of the PHSP that will be welcomed by clients, providers and Program staff alike. So what could the PHSP look like by 2021 if you are a client or family member, a home support agency, a home support worker, a bookkeeper, or a RHA staff member coordinating and monitoring home support services?

Some examples of these potential futuristic perspectives on the Program are:

For clients and families:

- I can quickly and easily find the Program information I am looking for online.
- I find the application process quick, simple and understandable.
- I am aware of all the services I may need in order to remain at home.
- I feel comfortable and safe at home due to simple monitoring technologies.

For home support agencies, home support workers or bookkeepers:

- We have the client information we need to provide care in a timely manner and according to their care plan.
- We communicate and collaborate regularly with RHA staff regarding client care.
- Home support workers feel they have the training and skills they require to provide high quality services.
- We understand the provincial standards and expectations established.
- We use the latest information and communication technologies to undertake our business processes.

For RHA staff:

- Financial assessments are automated, simple and fast.
- The clinical assessment helps to build a comprehensive clinical picture of each client.
- We know we are providing the services that our clients need by measuring our impact.
- Clear policy, governance and accountability frameworks are in place.

They provide a good snapshot of the possibilities for the PHSP in the future once all the improvement opportunities are implemented.

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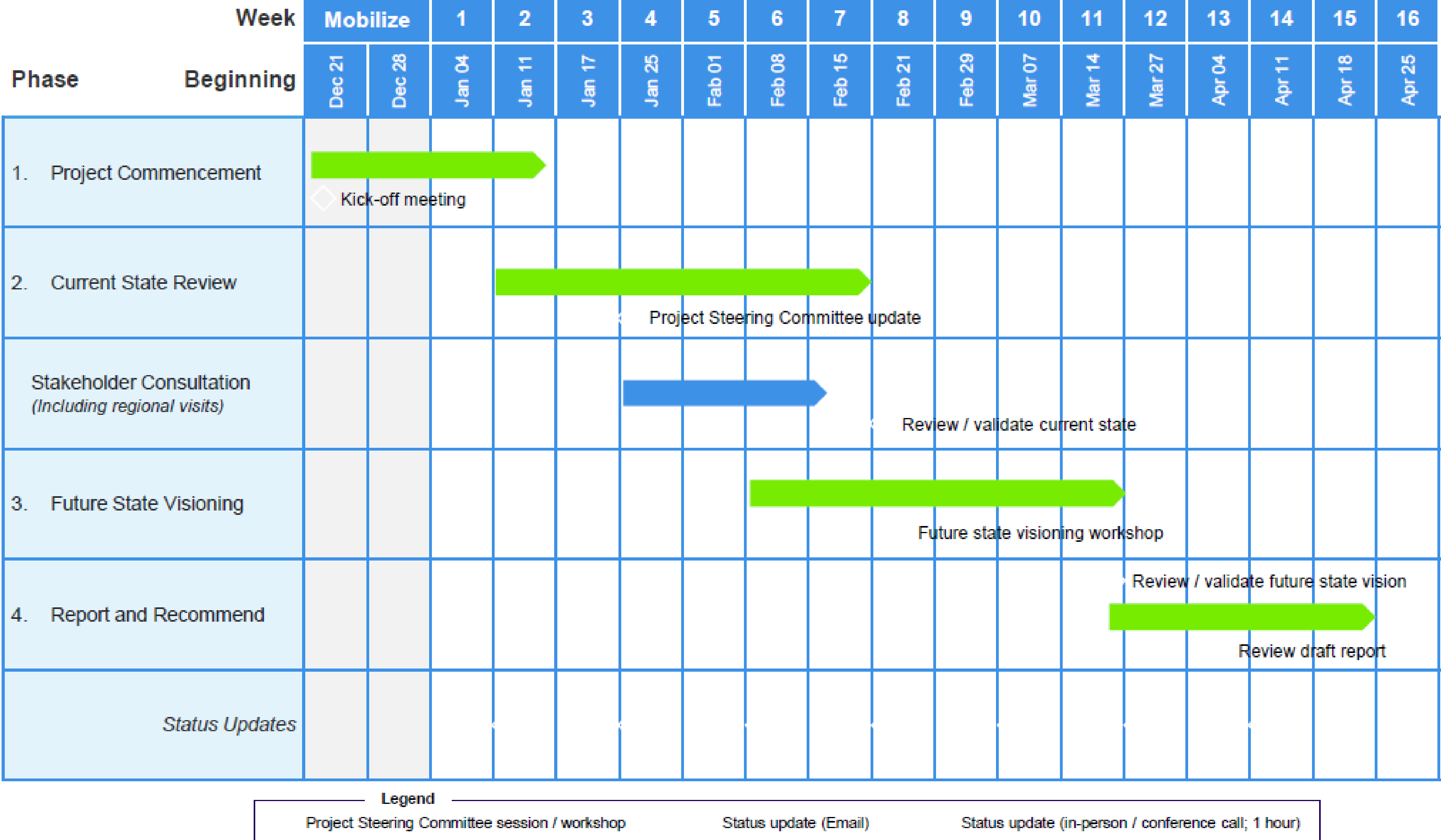
8. Appendices

Appendix A

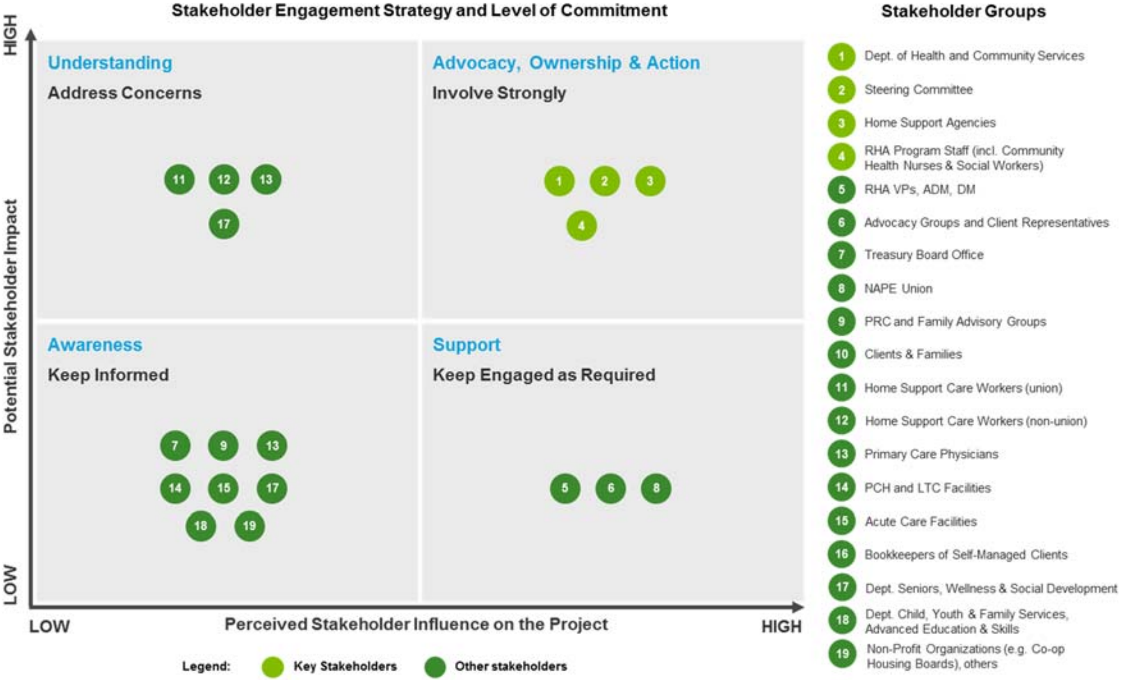
Detailed Project Approach

	1. Project Commencement	2. Current State Review	3. Future State Visioning	4. Report and Recommend
	4 weeks	6 weeks	6 weeks	4 weeks
Objective	Kick off the project and gather information required to understand the PHSP and stakeholders involved	Review the current state through the development of a detailed understanding of the PHSP and program delivery with respect to each identified deliverable area	Craft a vision for the future state of PHSP using input from best practices, other jurisdictions and based on anticipated future demand	Prepare recommendations for each remaining deliverable area and develop a final report outlining the work performed by Deloitte
Key Activities	• Hold a kick off meeting to confirm: – Project scope and approach – Data and information sources – Key stakeholders – Any parameters or constraints impacting project scope – Dates of key meetings and milestones • Review available quantitative data and background information on program • Prepare and submit initial data and information requests to gather current/baseline information on each identified deliverable area (e.g. standards and performance criteria, program eligibility, key business processes, staffing, funding and service delivery models, relevant policy and mechanisms to monitor compliance and performance) • Identify and schedule key stakeholder consultations • Finalize project work plan	• Review data and information received from data and information requests issued in Phase 1 for each deliverable area • Meet with key stakeholders to further our understanding of the current state as it relates to all in scope deliverable areas – We expect to spend approx. 2 days in each of the four health regions in the province, meeting with key stakeholders to complete this activity – Separate workshops will be held with key internal stakeholders to define the current state for key business processes • Identify, collect and review additional data and information as needed for each deliverable area to help our understanding of current state • Conduct and assemble research, literature and information on leading practices for each deliverable area • Conduct consultation sessions with other jurisdictions to leverage key insights and best practice across deliverable areas • Summarize findings of the current state across each deliverable area including: – Findings of our compliance review – Identification of any policy inconsistencies across RHAs – Projected future demand for services – Whether PHSP is meeting its intended goals	• Hold a visioning workshop with Project Steering Committee. Our relevant subject matter experts will participate in the workshop which will set out to: – Review findings of the current state as well as insights from jurisdictional scan, best practice research, literature review and key stakeholders – Focus on future vision for the following deliverable areas based on anticipated demand: program eligibility, staffing models, funding and service delivery models. • Summarize outputs from the workshop • Initiate efforts to recommend how additional deliverable areas can support chosen future state program vision (e.g. standards and performance criteria, key business processes, policy changes, monitoring and compliance) – As part of this activity we will hold future state workshops on key business processes • Prepare summary document outlining how the future state may look across key deliverable areas • Meet with Project Steering Committee to review future state vision across key deliverable areas	• Using the future state vision as a guide, craft recommendations for each remaining deliverable area that will address changes required, if any, to support the future state vision for the program. • Recommendations will also outline areas for improvement as identified and reflect the most efficient manner to deliver on the future state vision reflecting best practice where relevant • Prepare draft report that outlines work performed and recommendations for each deliverable area • Meet with Project Steering Committee to review and seek feedback on draft report • Revise draft report based on feedback • Issue final report
Outcomes and Deliverables	• Data and information request • Project work plan	• Written status updates to Project Steering Committee • MS PowerPoint document summarizing findings from Current State Review • ***Deliverable 9 (Future Demand for Services)***	• Written status updates to Project Steering Committee • MS PowerPoint document summarizing findings from Future State Visioning efforts across key deliverable areas	• Written status updates to Project Steering Committee • Draft report on evaluation findings with recommendations for ***deliverables 1-8, 10-11***) • Final report
HCS resources and info needed	• Project Steering Committee attendance at kick off meeting and initial project status meeting • HCS resources / stakeholders to provide background information and data on the program across deliverable areas • Introductions to key stakeholders, possible communication to and assistance with scheduling key stakeholder meetings	• Project Steering Committee attendance at project status meetings • Project Steering Committee and/or agreed key stakeholders to participate in key meetings and workshops to understand current state • HCS resources /stakeholders to provide data and information on the current state across deliverable areas • Introductions to counterparts in other jurisdictions (as/if required)	• Project Steering Committee attendance at project status meetings and future state visioning workshops, • HCS resources / stakeholders to provide data and information on the as and if required	• Project Steering Committee attendance at project status meetings and meeting(s) to review final report

Project Schedule



Stakeholder Engagement Strategy



Stakeholders Consulted

Name	Organization
Beverley Clarke	Department of Health and Community Services
Denise Tubrett	Department of Health and Community Services
Angie Batstone	Department of Health and Community Services
Annette Bridgeman	Department of Health and Community Services
Joanne Rose	Department of Health and Community Services
Pam Barnes	Department of Health and Community Services
Lisa Baker-Worthman	Department of Health and Community Services
David Diamond	Eastern Health
Alice Kennedy	Eastern Health
Joanne Collins	Eastern Health
Collette Smith	Eastern Health
Katherine Chubbs	Eastern Health
Karen Milley	Eastern Health
Janet Templeton	Eastern Health
Isobel Keefe	Eastern Health
Katherine Turner	Eastern Health
Morley Payne	Eastern Health
Workshop of Front-line Staff and Managers (23)	Eastern Health
Leonard Mercer	Eastern Health

Name	Organization
Jason Luff	Eastern Health
Deana Combden	Eastern Health
Kevin Durdle	Office of Chief Information Officer
Heather Brown	Central Health
Sean Tulk	Central Health
Mimie Carroll	Central Health
Karen Brown	Central Health
Karen Ropson	Central Health
Keith Parsons	Central Health
Barry Boland	Central Health
Joni Wells	Central Health
Joanne Parsons	Central Health
Workshop of Front-line Staff (11)	Central Health
Lori Moulton	Central Residential Services Board
Tina Buckle	Nunatsiavut Government
Delia Connell	Labrador-Grenfell Health
Blenda Dredge	Labrador-Grenfell Health
Beverly Woodward	Labrador-Grenfell Health
Paulette Roberts	Labrador-Grenfell Health
Marina Brett	Labrador-Grenfell Health
Ethel Byrne	Labrador-Grenfell Health
Workshop of Front-line Staff (17)	Labrador-Grenfell Health
Michelle House	Western Health
Tammy Priddle	Western Health
Cynthia Davis	Western Health
Teara Freake	Western Health
Chris Squire	Western Health
Renee Luedee Warren	Western Health
Kathy Organ	Western Health
Darlene Hicks	Western Health
Greg White	Western Health
Karen Alexander	Western Health
Workshop of Front-line Staff (19)	Western Health
Neil Tremblett	Home Care Association of NL
Diane Costello	Home Care Association of NL
Elizabeth Jenkins	Home Care Association of NL Notre Dame Compassionate Home Care

Name	Organization
Doug Jones	Home Care Association of NL
Kelly Heisz	Seniors Resource Centre
Mary Ennis	Seniors Resource Centre
Yvonne Jacobs	Seniors Resource Centre
Gail Wideman	Seniors Resource Centre
Additional participants (5)	Seniors Resource Centre
Sharron Callahan	Canadian Association of Retired Persons NL Pensioners and Seniors Coalition
Ralph Morris	NL Public Sector Pensioners Association
Neil Hamilton	NL Public Sector Pensioners Association
Doreen Noseworthy	Retired Teachers Association of NL
Alton Whelan	National Association of Federal Retirees
David Healey	Newfoundland and Labrador Association of Public and Private Employees (NAPE)
NAPE Home Support Workers (6)	NAPE
Patrick O'Shea	Family Physician
Roger Butler	Family Physician
Dawn Gallant	Eastern Health
Kim White	Coalition of Persons with Disabilities NL Network of Disability Organizations (Chaired by the Coalition)
Danielle Parrell	Coalition of Persons with Disabilities
Michael Burry	Spinal Cord Injury- NL
Don Gallant	Independent Consultant
Miles Murphy	NL Association of the Deaf
Gina Hartmann	Epilepsy NL
Gail Dempsey	Epilepsy NL
Pam Anstey	NL Association for Community Living
Gail St. Croix	NL Association for Community Living People First-NL
Angie Smith	NL Brain Injury Association
Dan Kung	Kung & Roberts
Carole Hefferton	Independent Bookkeeper
Rick Cull	Marine Contractors
Harvey Tizzard	Independent Bookkeeper
Cynthia?	Independent Bookkeeper
Michelle Keeping	Independent Bookkeeper
Anne Whelan	CareGivers Inc

Name	Organization
Matthew Head	CareGivers Inc.
Joan Reid	Reid's Circle of Care Home Care
Dwain Noel	Compassion Home Care
Nancy Boone	Compassion Home Care
Diane Strickland	Compassion Home Care
Babs Carrim	In-Home Health Care Services Ltd.
Andrea Drodge	Total Care Nursing in the Home Services Ltd.
Darlene Billard-Croucher	Bayshore Home Health
Brenda Hunt	Caring Hands Inc.
Joan Horwood	Horwood's Home & Community Support Services
Todd Horwood	Horwood's Home & Community Support Services
Pauline Cole	Provincial Home Care
Jeanine Drew	CareGivers Inc.
Jenny Jeffries	CareGivers Inc
Bonnie Harvey	CareGivers Inc (student)
Debbie Barney	Labrador South Home Care
Lawney Colbourne	Loving Hands Home Care
Jody Smith	CareGivers Inc.
Irene Sheppard	Maximum Home Support Services
Elaine Rumboldt	Maximum Home Support Services
Sharon Bennett	Maximum Home Support Services
Lorna Clarke	Tender Loving Care
Rowena Hicks	Tender Loving Care
Murray Hayes	Tender Loving Care
Carla Bellows	Tender Loving Care
Sean?	Tender Loving Care

Appendix B

Detailed Comparison of Program Structures for Select Canadian Jurisdictions

Program Element	British Columbia	Alberta	Saskatchewan	Nova Scotia
Program(s)	Home Care / Better at Home / Seniors Action Plan	Continuing Care / Aging in the Right Place / ED2Home Program	Home First / Quick Response Program	Living Well Continuing Care Services
Objectives & Scope of Services	• The objectives of home care in BC are to plan and deliver, either directly or through contracted service providers, a range of programs and services appropriate to the needs of individuals assessed as eligible for home and community care services. • Although the specific mix of programs and series may vary from community to community, it is the objective that health authorities ensure that clients have access in all areas of the province, where practicable	• The objectives of Alberta's home care program are to assist Albertans to achieve and maintain health, well-being and personal independence in the community. • The scope of services is community-based programs, such as home care, personal and technical supports, community rehabilitation, and assisted living.	• The objectives of Saskatchewan's home care system are to help people who need supportive, palliative and acute care to remain independent at home. • They encourage and support assistance provided by the family and / or community. • The services provided by home care are: – Case coordination/ management; – Nursing services; – Homemaking and management services (respite, meal service, personal care); – Home maintenance; and, – Volunteer programs, therapies, and adult day programming.	• Nova Scotia defines continuing care as an array of services to assist Nova Scotians of all ages, who have assessed unmet needs. Its objectives are to: – Help people maintain optimal well-being and independence at home; – Facilitate appropriate use of health and other community-based services and make the best use of resources; and, – Meet client needs and optimize client well-being and independence Nova Scotia's scope of services include: home care and support, self-managed care, supportive care, caregiver benefits and equipment grants.

Program Element	British Columbia	Alberta	Saskatchewan	Nova Scotia
Key Client Segments	• There are no age restrictions on home care and support services; however, all clients are evaluated using the Resident Assessment Instrument – Home Care (RAI-HC). • Key clients are those that score the highest on this tool and require care – the largest age group of individuals receiving home care in BC are currently those aged 76-85 years old.	• Key client groups have not been strictly defined as there is no aggregated, provincial level data on age and diagnosis of individuals receiving home care.	• Home care and support services are provided to individuals based on assessed need. • While there is no provincial policy that addresses limits to service, the regions often determine that when home care service reaches the level of the cost of care of a nursing home, home care clients should be reassessed and options provided.	• Home care helps people of all ages who need assistance to maintain their optimal well-being and independence at home. Home care serves clients with acute, chronic and palliative needs.
Service Levels	• There are no limitations on services outlined in provincial home and community care policies, but health authorities use assessment outcomes and care planning guidelines to determine appropriate service levels.	• There are no limits to service provision.	• Home care services are provided to individuals based on assessed need. • While there is no provincial policy that addresses limits to service, the regions often determine that when home care service reaches the level of the cost of care of a nursing home, home care clients should be reassessed and options provided.	• The maximum home support per 28 day service plan is 100 hours. The maximum number of nursing visits per 28 day service plan is 60. Monthly maximum service limits do not apply under following conditions: – The client meets the palliative home care criteria; and, – The client is on a waitlist for placement in a publicly funded long-term care facility.

Program Element	British Columbia	Alberta	Saskatchewan	Nova Scotia
Clinical Assessment	• Access to publicly-funded home and community care services is through an assessment process, conducted by a health care professional. • All clients receiving home care and support services are assessed using the Minimum Data set for Home Care (MDS-HC), a component of the RAI-HC.	• Alberta Health Services uses the RAI-HC Assessment and is implementing the RAI-Contact Assessment to identify client needs.	• RAI-HC is used across the Province to serve as the standard and automated assessment tool. • This assessment is supported through technology and computer support software purchased by each Regional Health Authority from an interRAI approved vendor. • Most regions also use the MDC-HC.	• The RAI-HC assessment is used to identify client needs. • The RAI-HC assessment is imbedded in the customized assessment software called SEAscape installed on laptops used by care coordinators. • A complete copy of the assessment is provided to the home care provider organization who shares it with the nursing and home support staff assigned to the client, as appropriate.
Eligibility Criteria	• The individual must be a citizen of Canada or have applied for permanent resident status. • The individual must have been a citizen of BC for at least 90 days. • The individual must have chronic health conditions that impair their ability to function independently; that require care following discharge from hospital or require care at home rather than hospitalization; or require end-of-life care.	• Anyone living in Alberta with a valid health care card can receive home care services as long as their needs can be safely met in the home, with the following exceptions: – Require services that are the responsibility of another agency/department; and, – Require services that are the legal responsibility of the owner or operator of the individual's place of resident.	• Applicants must meet one of the following criteria: – Hold a valid Saskatchewan Health Services card (or be in the process of establishing permanent residence in and have applied for a Health Services card); and, – Be a resident of Manitoba or Alberta in a border community where contractual arrangements have been approved by the Ministry.	• Residents of Nova Scotia with unmet needs who have been assessed as requiring home care due to an illness or disability that can be cared for safely and effectively at home, and have or are in the process of applying for a Nova Scotia health card; and, • Services required by the applicant should not generally exceed the cost of the equivalent level of services in a Department licensed nursing home.

Program Element	British Columbia	Alberta	Saskatchewan	Nova Scotia
Service Delivery Model	• British Columbia uses a mixture of public and private sector for service delivery, but there is no option for self-managed care. • Professional services such as home care nursing and community rehabilitation are delivered by RHA employees. • Home support services and personal care services are provided both through the health authority employees and through contracted agency organizations.	• Non-clinical home care and support services are delivered on an agency basis. • Self-Managed Care (SMC) is a program also available in which eligible home care clients, and/or their legal representative enter into a legal agreement with Alberta Health Services (AHS). This agreement provides a Home Care client resources to directly pay for and managed their care and support services.	• All home care services are provided directly by the RHA home care programs. Every RHA must offer the primary home care services. • Individualized funding gives clients increased choice and flexibility in home care. Clients or their guardians receive funding to arrange and manage non-professional support services.	• Home care services are provided through both the public sector and through agency contracts with the private sector organizations (e.g., VON, Bayshore Health). • Self-managed care and family caregiver options are also available. • The Red Cross, in addition to being one of the home support providers, is also contracted to provide a bed loan and special equipment service.
Funding Model	• Base global funding is allocated to the RHA on a population needs based funding model. • A client who receives home support services must pay a daily charge calculated as the client's remaining annual income multiplied by 0.00138889. • A client is not required to pay more than $300 for services in a month if the client, or the client's spouse, receives earned income.	• Alberta's Ministry of Health provides global funding to Alberta Health Services (AHS) which allocates funding to the programs that it delivers and contracts, including home care. • Home care services are publicly funded and provided through AHS.	• The RHAs are responsible for billing home care clients for non-professional services (exclusions for palliative and post-acute discharge apply). • Individual client fees or charges are based on the client's income and the number of services delivered to the client. • Clients have the opportunity to apply for an income-tested subsidy.	• Home care services are funded and provided through the publicly funded health care system and services can also be purchased directly by individuals. • Net income and family size are used in the determination of home support client fees (maximum monthly fee caps apply). • Income information for home care clients is verified by line 236 of the Federal Income Tax Return.

Program Element	British Columbia	Alberta	Saskatchewan	Nova Scotia
Qualification requirements for home support workers	Community health workers must be registered; one prerequisite is a training program of 6-8 months duration (or equivalent).	In order to become certified, employees must complete a 37 module curriculum. Certification does not appear to be a requirement to practice.	Staff must complete a standard training program within two years of initial employment.	To practice as a Continuing Care Assistant (CCA) individuals must be a graduate of a CCA program (or equivalent) and pass CCA provincial exam.
Supplemental services funded through home and community care	• Choice in Supports for Independent Living (self-managed funding) • Adult Day Services • Respite Services • Nursing Services	• Personal Care • Respite Services • Nurse Practitioner • Volunteer Programs	• Nursing Services • Personal Care • Respite Services • Meal Service • Home Maintenance • Volunteer Programs	• Nursing Services (RN and RPN) • Respite Services • Meal Services • Therapies (PT & OT)
Programs and services provided outside of health care and directed to seniors, adults with disabilities and children with disabilities	**Seniors** • Independent Living BC (BC housing) • Senior's Supplement (Social Development and Innovation) **Adults & Children with Disabilities** • Assistance Program for Students with Permanent Disabilities (StudentAidBC) • Special Transportation Subsidy (Social Development and Innovation)	**Seniors** • Alberta Seniors Benefit Program (Seniors and Housing) • Special Needs Assistance for Seniors (Seniors and Housing) **Adults & Children with Disabilities** • Residential Access Modification Program (Human Services) • Alberta Brain Injury Initiative (Human Services) • Family Support for Children with Disabilities (Human Services)	**Seniors** • Seniors Housing Program (SK Housing Corporation) • Seniors Income Plan (Family and Social Support) **Adults & Children with Disabilities** • Adaptation for Independence Program (Housing and Renting) • Cognitive Disability Strategy (Family and Social Support)	**Seniors** • Senior Citizen Assistance Program (Housing NS) **Adults & Children with Disabilities** • Access-A-Home Program (Housing NS) • Disabled Residential Rehabilitation Assistance Program for Homeowners (Housing NS) • PSDS Equipment & Services Program (Labour and Advanced Education)
Determination of Client Rates	Client rate is based off of net household income (line 236), universal childcare benefit, registered disability savings plan, basic living expenses, as found on Federal Income Tax Return.	No consistent provincial process is in place.	Clients pay $7.96 for first ten units of service, after which they pay rate based off of annual income (line 236), deductions, exemptions and declarations on Federal Income Tax Return.	Client rates are determined using net household income (line 236), and family size as found on Federal Income Tax Return.

Leading Models of Community Based Care

Jurisdiction	Client Segment(s)	Program Description	Outcomes	Recognized By
Models including Integrated Teams and Multi-Sector Partnerships				
ON	**Seniors** **Children**	**Integrated Care for Complex Populations (ICCP)** • The aim of this new program was to determine how better to support older adults with complex needs at home and in their community using existing (not additional) resources. • ICCP is a new model of care that involves integrating partners across sectors to create one integrated care team around each client. • Each team is quarterbacked by a care coordinator, who works with primary care to develop a coordinated care plan based on the priorities of clients and their caregivers.	• Increase in the number of clients with high and very high priority levels being cared for in the community. • Reduction of ALC beds by 50%. • Reduction of hospital-to-long-term care facility demand by 20%. • Increased client and caregiver satisfaction.	Accreditation Canada
NS	**Seniors**	**Palliative and Therapeutic Harmonization (PATH)** • PATH meets the needs of frail elderly patients with multiple medical issues through comprehensive assessment, clear communication to patients and family, and careful medical decision-making using a validated and standardized methodology. • PATH trains health care providers to capture a comprehensive understanding of each patient's health determinants and trajectory. Care providers then collaborate with families to achieve a collective understanding of the realities of care options and develop evidence-informed care plans.	• PATH patients and caregivers decline 76% of planned medical and surgical intervention procedures. • PATH patients are more likely to choose home care options, leading to a 10% decline in hospitalizations. • 100% of PATH patients and caregivers find the overall experience to be very helpful for care planning and personal decision making.	Accreditation Canada

Jurisdiction	Client Segment(s)	Program Description	Outcomes	Recognized By
BC	**Seniors**	**Home Is Best™** • This initiative describes structured partnership between home and community care services, acute care, and primary care to provide a bundle of system enablers, such as proactive discharge planning, expanded community support services, increased access to home care services, and telephone outreach. • The goal of the initiative is to help seniors stay healthy in their homes for longer, return home after a hospital stay as soon as possible, and prevent or delay admission to hospital or residential care until necessary.	• Reductions in the time it takes to admit a client to community services. • Decrease in the number of patients designated as 'alternate level of care'. • Shorter hospital length of stay. • Reduced emergency room visits. • Health care clinicians are more satisfied and effective, as they are encouraged to practice their full scope of practice.	Canadian Home Care Association
PEI	**Seniors**	**West Prince Telehospice** • This pilot project is intended to provide support to a dying person at home 24 hours per day. • Using a telephone line and fully interactive audio visual equipment, nurses and other health professionals can monitor and assess the health/vital signs of clients and provide education to clients living at home. • Key features of the program include 24-hour access to multidisciplinary provider teams, integration across the continuum of health, access to all home care services including full coverage for drugs, supplies, and equipment.	• 76% decrease in days that dying clients were hospitalized. • 20% reduction in emergency room use. • 15% reduction in physician office visits.	Accreditation Canada
ON	**Seniors** **Children**	**Paperless Operations in Community Health Care** • The Champlain Community Care Access Centre's (CCAC) 'paperless project' has delivered a fully electronic community health record and referral capability. • The Champlain CCAC is the only CCAC with an Intake Referral Portal, and is piloting two additional electronic referral capabilities within Ontario.	• Increased client safety • Enhanced coordination of services and activities across the many parties involved in the community health care sector. • Ability to access all relevant client and health information on demand by both internal CCAC staff and external partner staff. • Reduced administrative and related overhead costs.	Accreditation Canada

Jurisdiction	Client Segment(s)	Program Description	Outcomes	Recognized By
QC	Seniors	**SyMO** • SyMO is a computerized planning and monitoring tool for home care services. This tool simplifies communication among the professionals involved and supports better planning of procedures with clients. • The tool allows care providers to consult and modify a client's clinical profile, needs, upcoming procedures (clinical roadmap), medication profile, history of prior visits, observation notes, forecast of medical supplies required, therapeutic nursing plan, as well as access to standard care plans that can be used to create detailed plans for clients.	• Improves the efficiency, quality, accessibility and continuity of services delivered in the home. • By facilitating the organization of work, the tool results in more work time spent with the client in the home.	Accreditation Canada
QC	Seniors	**Optimization of In-Home Occupational Therapy Services** • In order to respond to long wait times for occupational therapy and personal care services, a revised service delivery model was implemented that involves transfer of expertise and duties from the occupational therapists to the aides/auxiliaries. • The occupational therapy aide, under the supervision of occupational therapists, is able to deliver personal care services, including client education, without the direct on-site involvement of the occupational therapist.	• In 2010, the wait time for personal care services was two to six months compared to a current wait time of two weeks before receiving a visit. • In winter of 2013, provided services to 30% more clients and provided 61% more interventions, while the waitlist decreased by 41%.	Accreditation Canada
ON	Seniors Children	**eShift** • This new service delivery model enables effective care for clients and families requiring "around the clock" monitoring by placing PSWs at the bedside who are linked to a delegating nurse in a different location using real time technology. • Specially trained PSWs observe and report signs and symptoms using a Smartphone application connected to a secure portal monitored by the nurse. • The nurse then monitors and delegates appropriate interventions in real time.	• 92.3% of clients did not have an ER visit in the last weeks of life compared to 44% of EOL clients cited in research. • 15.4% of required hospital admission related to poorly managed symptoms compared to 32% found in Quality of Death study. • 92.3% caregivers claimed to not experience caregiver burnout with eShift in place.	Accreditation Canada

Appendix C

Program Intake and Referral Improvement Opportunities

ID	Opportunity	Objective(s) Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
1	Improve promotion of the Program across all care settings to support the appropriate referral of clients to the Program.	• Increase the percentage of eligible populations accessing the Program and avoiding institutional placement. • Decrease ALC length of stays in acute care. • Delay and decrease LTC admissions.	Program Eligibility	Effectiveness	• Policy changes will need to be finalized before promotional/educational efforts. • Additional demand would result in additional need for resources (financial and human) for the PHSP, but would result in savings from other areas (e.g., ALC).
2	Establish consistent online resources to aid client navigation and self-referral.	• Increase the percentage of eligible populations accessing the Program and avoiding institutional placement. • Increase client/family satisfaction.	Business Processes	Effectiveness	• Structure of the page: – One single page with sub-pages for regional contacts or four separate pages with standard structure. • Management of changes to the sites given the operation across four RHAs.
3	Establish a centralized provincial intake and application process to improve Program consistency and efficiency.	• Reduce time for clients to be assessed and receive supports.	Policy Standardization	Efficiency	• A communication method would be required between the intake coordinator and the RHA to initiate service. • The referral and intake process is for the broader community supports program and recommends a variety of programs.
4	Enhance inter-discipline practitioner collaboration to improve the timely referral of clients.	• Decrease ALC length of stays in acute care. • Delay and decrease LTC admissions.	Business Processes	Efficiency	• Any required policy changes need to be made before developing collaborative plans with nurse practitioners.

Assessment Planning and Coordination Improvement Opportunities

ID	Opportunity	Objective Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
5	Enhance clinical assessment tools and implement hours based service limits (as opposed to financial ceilings) to more accurately define and communicate client care needs.	• Increase the percentage of eligible populations accessing the Program and avoiding institutional placement. • Decrease ALC length of stays in acute care. • Delay and decrease LTC admissions.	Program Eligibility	Effectiveness	• Technology and training requirements to enhance or replace the RAI-HC tool (through addition/removal of select questions) and interpret results. • Quantify level of over-servicing with current assessment tools to develop a more detailed business case.
6	Perform risk-based reassessment of client needs to improve CHN/SW productivity and service capacity.	• Reduce the time for clients to be assessed and receive supports. • Increase client/family satisfaction.	Business Processes	Efficiency	• Client monitoring and surveillance requirements. • Risk assessment framework and methodology.
7	Delegate reassessments to supervised RHA paraprofessionals to improve CHN/SW productivity and service capacity.	• Reduce time for clients to be assessed and receive supports.	Staffing Model	Efficiency	• Monitoring and audit requirements. • Training requirements. • CHN/SW oversight requirements.
8	Streamline financial assessment processes to improve FAO productivity and service capacity.	• Reduce time for clients to be assessed and receive supports.	Business Processes	Efficiency	• Determine how to access CRA information electronically. • Determine how the income & needs based tests may be simplified.
9	Optimize financial eligibility criteria and client co-payment to improve resource allocation and enhance Program sustainability.	• Other	Program Eligibility	Effectiveness	• Governing social policy. • Monitoring and audit requirements.

ID	Opportunity	Objective Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
10	Improve the hand-off of service plans to agency and SMC providers to improve the continuity of care and eliminate redundant assessments.	• Increase the percentage of eligible populations accessing the Program and avoiding institutional placement. • Reduce time for clients to be assessed and receive supports.	Business Processes	Efficiency/ Effectiveness	• Determining what information the agency requires in order to provide a seamless transition and high quality care. • Determining how information will be transferred to agencies (i.e., electronic forms, email).
11	Allow flexibility through expanded individualized funding models to improve client choice and the flexibility in how hours and subsidies are utilized.	• Increase or maintain client and family satisfaction. • Increase the percentage of eligible populations accessing the Program and avoiding institutional placement.	Funding Model	Effectiveness	• Accountability and approvals framework. • Client monitoring and surveillance requirements.
12	Expand day programs and residential operations to promote the sharing of services and supports.	• Increase or maintain client and family satisfaction. • Increase the percentage of eligible populations accessing the Program and avoiding institutional placement.	Service Delivery Model	Effectiveness	• Understanding the distribution of clients across regions to define a business case. • Accountability and approvals framework. • Client monitoring and surveillance requirements.

ID	Opportunity	Objective Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
13	Develop integrated care plans to improve the continuity of care across CSS program and services, and to minimize living arrangement disruptions.	• Increase the percentage of eligible populations accessing the Program and avoiding institutional placement. • Increase the number of individualized community inclusion plans for clients. • Increase or maintain client and family satisfaction. • Decrease ALC length of stays in acute care. • Delay and decrease LTC admissions.	Business Processes	Effectiveness	• Training requirements. • Collaboration across programs and disciplines. • Implementation of integrated care plans. • Client monitoring and surveillance requirements.

Home Supports Delivery Improvement Opportunities

ID	Opportunity	Objective Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
14	Establish agency agreements with service levels to improve accountability and oversight.	• Increase client / family satisfaction	Service Delivery Model	Effectiveness	• Breadth and detail of service levels. • Alignment to Program philosophy, guiding principles and client quality indicators. • Scope of consequences for agency non-performance.
15	Consolidate the number of agencies to improve agency sustainability through economies of scale and support monitoring of service levels.	• Reduce time for clients to be assessed and receive supports.	Service Delivery Model	Efficiency	• Right-sizing the number of agencies based on regional service delivery requirements. • Stakeholder engagement and local economic participation.

ID	Opportunity	Objective Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
16	Explore outcomes based funding arrangements to improve agency commitment and accountability.	• Increase the percentage of eligible populations accessing the Program and avoiding institutional placement.	Funding Model	Effectiveness	• Scope of consequences for agency non-performance. • Alignment to Program philosophy, guiding principles and client quality indicators.
17	Implement policies, processes and technology enablers that improve client monitoring and care team collaboration.	• Decrease living arrangement disruptions of clients. • Increase family and caregiver participation in client's service plan. • Decrease ALC length of stays in acute care. • Delay and decrease LTC admissions.	Service Delivery Model	Effectiveness	• Client privacy. • Scope of client monitoring and surveillance. • Utilization of accessible and effective technology platform.
18	Define HSW qualification and education requirements and strengthen monitoring practices to improve the quality of care delivered.	• Increase or maintain client and family satisfaction. • Decrease living arrangement disruptions of clients.	Staffing Model	Effectiveness	• Qualification standards. • Scope of education program. • Monitoring protocols and practices.
19	Segment HSW levels to create a sustainable career path and improve the quality care provided to clients with complex needs.	• Increase or maintain client and family satisfaction. • Decrease living arrangement disruptions of clients.	Staffing Model	Effectiveness	• Basis of segmentation (e.g., complexity of care, level of support, client segment). • Job evaluation. • Change management and union relations.
20	Expand provincial policies on the delegation of clinical duties to improve the productivity and service capacity of CCS resources.	• Increase or maintain client and family satisfaction.	Staffing Model	Efficiency	• Scope of clinical task delegation. • Training and supervisory requirements. • Change management and union relations.

ID	Opportunity	Objective Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
21	Streamline the administration of SMC arrangements to improve accessibility, client choice and RHA monitoring of funding agreements.	• Increase the percentage of eligible populations accessing the Program and avoiding institutional placement.	Service Delivery Model	Effectiveness	• Service delivery model for self-managed care administration (e.g., CRA business registration, payroll etc.). • Scope of services for outsource service providers and selection criteria.

Policy & Monitoring Improvement Opportunities

ID	Opportunity	Objective Impacted	Primary Deliverable Area	Improvement Type	Key Considerations
22	Implement a performance management framework to improve the ability of HCS and the RHAs to monitor and evaluate Program outcomes.	• Increase the percent of populations accessing home support.	Monitoring & Evaluation Indicators	Effectiveness/ Efficiency	• Integration with provincial LTC and Community Support Services Strategy. • Determine what exiting resources can be targeted to support design, implementation and maintenance by both HCS and RHAs.
23	Enhance Program governance to support the delivery of a standardized Program that has clearly defined HCS and RHA accountabilities.	• Other	Policy Standardization	Effectiveness/ Efficiency	• Appropriate policy guidelines and operations standards changes. • Change management.
24	Enhance the consistent utilization of CRMS to enable the monitoring and evaluation of Program and client outcomes.	• Other	Monitoring & Evaluation Indicators	Effectiveness/ Efficiency	• Establish CRMS reporting and audit requirements. • Understand how CRMS reporting functionality can be leveraged to make evidence informed policy and service decisions.
25	Modernize Program policies to reflect revised vision, improvement opportunities and the delivery of a standardized Program.	• Other	Policy Standardization	Effectiveness/ Efficiency	• Change management. • Consider role of Program among broader community supports services. • Determine the role that external stakeholders should play in modernizing the Program.

Appendix D

There are five characteristics of a strong health assessment tool:

1. The assessment is comprehensive. It provides a level of detail sufficient to plan care, and every item captured should have a purpose for care planning.
2. Cognitive assessment is featured.
3. Other drivers of dependency should be reliably described, including accounts of mobility, function and the social setting.
4. The source of the information is clearly identified.
5. Information can be easily shared. The assessment should present findings in a way that facilitates communication and makes it easy to share the information gathered.
6. The cost of performing the assessment should provide value for money. Cost includes the purchase of the assessment tool, as well as maintenance fees, payment for managers/trainers, support for the human resources needed to complete the assessment (e.g., time needed) and any costs associated with resource recommendations that are not optimized (i.e., recommending services above what is necessary for a particular client).

Appendix E

Future Demand Scenario Assumptions

Low Scenario

- **Prevalence:** Assumes no prevalence growth from current levels.
- **Expenditure and Hours:** Assumes no growth in hours or expenditures.

Medium Scenario

- **Prevalence:**
  - Assumes 36-month growth rate unless determined not to be representative;
  - Eastern Seniors have assumed 24 month growth rate for 65-69;
  - Central Seniors have assumed 24 month growth rate;
  - Labrador Seniors have assumed 10-month rate for 75-79, 14-month rate for 80-84, 30-month rate for 85-89, 14-month rate for 90+;
  - Eastern SCWAs have assumed 26-month rate;
  - Western SCWAs have assumed 10-month rate; and,
  - LG SCWAs have assumed 24-month rate.
- **Expenditure and Hours:** Assumes 2% growth of hours and expenditure for seniors.

High Scenario

- **Prevalence:** Based on assumptions made in medium scenario, but with maximizing the sensitivity bars to 50% rates.
- **Expenditure and Hours:**
  - Seniors – assumes 3% growth of hours and expenditure for seniors (historically shown average across segments of 1.94% in expenditure and 1.92% in hours);
  - AWD – assumes historic expenditure growth for specific RHA + 1%;
  - Assumes historic growth of hours for entire province + 1%; and,
  - SCWA – assumes historic expenditure and hours growth for entire province + 1%.

Appendix F

Monitoring & Evaluation Indicators

Goal 1: To support people of all ages to live in their home and community.			
Indicator Type	**Indicator**	**Data Source(s)**	**Reporting Frequency**
Specific	Reduce the time for clients to be assessed and receive supports.	CRMS	Weekly
	Increase or maintain client and family satisfaction.	Client Survey	Quarterly
	Increase the percentage of eligible populations accessing the Program and avoiding institutional placement.	CRMS	Monthly
Adjacent	Decrease LTC admissions.	CRMS/Meditech	Monthly
	Decrease ALC length of stays in acute care.	Meditech	Monthly
	Decrease living arrangement disruptions of clients.	CRMS	Monthly
Goal 2: To support individuals to actively engage in the community.			
Indicator Type	**Indicator**	**Data Source(s)**	**Reporting Frequency**
Specific	Increase the number of individualized community inclusion plans for clients.	CRMS	Quarterly
	Increase or maintain client and family satisfaction.	Client Survey	Quarterly
Goal 3: To support and empower families and caregivers in their role.			
Indicator Type	**Indicator**	**Data Source(s)**	**Reporting Frequency**
Specific	Increase utilization of family caregiver option under the Program.	CRMS/CRMS-Client Pay	Monthly
	Increase family and caregiver participation in client's service plan.	CRMS	Quarterly
	Increase utilization of respite hours under the Program.	CRMS/CRMS-Client Pay	Weekly
	Increase or maintain family and caregiver satisfaction.	Client Survey	Quarterly
Adjacent	Decrease living arrangement disruptions of clients.	CRMS	Monthly

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