CAPITAL REGIONAL DISTRICT

STAFF REPORT TO THE HEALTH FACILITIES PLANNING COMMITTEE MEETING OF WEDNESDAY, JULY 20, 2005

TITLE:

Home and Community Care in the Capital Regional District.

SUBJECT:

Staff's commentary on responses from the Vancouver Island Health Authority to questions posed by the District in May 2005.

BACKGROUND:

At Committee meetings on May 4th and May 18th, senior executives from the Vancouver Island Health Authority (VIHA) responded to questions put forward by the District (see Appendix 1). These questions were asked to gain a better understanding of the context for VIHA's decision to renovate existing residential care facilities ahead of creating new residential care beds.

The schedule for these meetings did not allow staff to comment on VIHA's responses. Staff has subsequently provided a response to VIHA and a copy is available for Committee members. This report covers the first four of VIHA's responses to the Committee's questions.

1. Decline in the over 75 population

VIHA references the decline in the over 75 population and the upper Island's lower residential care resources as reasons why the South Island (Capital Region) will not receive any new residential care beds. Potential increasing demand for residential care in the Capital Region will be met by assisted living, expanded community services and the renovation of existing residential care facilities.

Use of the over 75 population to define the Capital Region's elderly population as declining is misleading because it conceals different rates of growth and rates of use amongst cohorts which make up the over 75 population.

While the over 75 population declines between by 872 (3%) to 2010, the over 85 population increases by 1,285 (13%). Current rates of use of assisted living and residential care for the 75 to 84 population is 4% while the over 85 population is 15% - almost four times higher.

If VIHA is using an aggregated over 75 population measure to forecast and plan future service levels instead of more detailed population breakdown, it is significant because it risks underestimating the number of spaces needed by as much as 9% or 200 spaces.

VIHA's internal analysis of population, health needs and service delivery changes (on which this decision to not increase residential care beds was made) was not shared.

Forecasting residential care is reasonably complex and we recognize that projection of constant rates of use to future populations is flawed. However, we know of other projection methods in other provinces which could be considered. As recommended in the 2004 Assisted Living Review, a more detailed planning model needs to be developed.

2. Proposed upgrading to four intermediate care facilities

VIHA states that the four subject intermediate care facilities proposed for upgrading have the potential for taking complex care clients following renovations. If these renovations do not proceed there would be a loss of appropriate access to 260 beds.

This is misleading. These four facilities have been taking more complex care clients[1] since 2002, increasing from 51% to 82% of residents in 2005. The un-renovated facilities have not stopped VIHA from placing complex care referrals or expecting the facilities retain them (instead of referring extended care residents to extended care facilities as was done in the past).

3. The premium for housing non-acute people in hospital instead of residential care

VIHA refer to the District's estimates being laden with assumptions, that acute care is generally more expensive than residential but not always (e.g. at the end of a patients stay when they no longer require intensive therapies) and that the District's estimates were based on gross figures which should not be used for decision making purposes.

VIHA's response provides no alternative assumptions or refinement of cost figures which makes their position on the issue difficult to understand.

Acute care is always more expensive than residential care even for those assessed and awaiting placement (at the end of the patient stay with no intensive therapies).

The acute care cost referred to in our calculations is $435/day which is the rate for alternate level of care, not the $1,200/day full acute care rate acknowledged by VIHA's CEO in an earlier meeting with the District Board. The $125/day rate for long term care is the provincial rate and includes capital debt service which is excluded in acute care rates.[2]

It is unacceptable to dismiss the concept of an "avoidable" premium by stating that the *"focus of health care is on the appropriateness of the care setting for the individual needs for which we argue you cannot calculate a premium."* Not only is there a premium for staying in acute care versus residential care, acute care is an **inappropriate** environment for non-acute patients, placing them at risk of acquiring secondary infections, exposing them to medical accidents and de-conditioning, saying nothing of delaying access to acute care services by patients genuinely needing acute care.

During April and May when these issues were being discussed it turns out that VIHA had additional information in the form of its 2005 Performance Report. This report gives a "red light[3]" to Alternate Level of Care as a measure of inappropriate use of acute care. Alternate Level of

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[1] *Intermediate Care Level 3 and Extended Care Level clients*
[2] *For comparison, debt service costs for the Phase 1 Royal Jubilee redevelopment deferred over 430 beds would amount to $51.00 per day alone*
[3] *Performance significantly outside acceptable range, warranting further action and monitoring*

Care (ALC) is a designation applied to people in hospital beds waiting to return home, to residential care or to other short stay hospital units. ALC is measured as the % of ALC patient days to total inpatient days.

The 2004/05 rate is 15% (against a target of 11.7%) with the last two years at 13.5% and 14.5%. Again, this is not exclusively related to residential care placement. Wait list analysis[4] shows an average 123 day wait period (2004/2005) for people in hospital waiting residential care placements or the equivalent of 20,000 days of non acute patient stays. If the average wait time is reduced to 30 days, this would constitute a saving of 15,000 inpatient days or approximately 30% of the ALC days.

4. Number of people in hospital waiting residential care

VIHA indicates that over the past several months the number of people in hospital waiting residential care has fallen significantly. With assessed and waiting placement patients having declined to 40 over the past six weeks compared to over 100 in October 2004.

The 2004/05 AAP[5] monthly report has not been made available but previous year's reports suggests it significantly underestimates the number of people in hospital waiting residential care (in 2003/2004 the AAP report showed a monthly average of 39 people versus 117 people in the NBA Wait List analysis report).

The monthly NBA Wait List Analysis shows a large unexpected increase in the number of admissions to residential care in the first three months of 2005 which did reduce the number of people waiting in hospital.

VIHA explains the drop in assessed and waiting placements as a consequence of recent initiatives, most of them involving converting existing acute or residential care beds to special purpose units allowing earlier discharge and increased time to convalesce prior to a next relocation.

In most cases these new units do not represent a net increase in capacity but involve either a change in function or a net loss in another function (which may in itself compound system shortages). VIHA concurs later that convalescent and sub-acute care have a small impact on residential care placements.

The major factor in the increasing number of monthly placements is likely the addition of 75 ***interim*** residential care beds. Another possible factor is the changing profile of residential care clients and the restricted admission requirements.

People qualifying for complex care are likely to be frailer and have less time to live. An increasing rate of turnover in residential care could lead to situations (or may have reached the stage) where the rate of discharge exceeds the rate of new entrants such that the existing facility capacity is able to cope with population demand. As in the 2004 Assisted Living Review, there is no evidence that the process of postponing residential care access until such a late stage is compensated by good quality home support and assisted living.

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[4] *NBA Wait List Analysis Report*
[5] *Assessed and Awaiting Placement*

Clearly residential care capacity in 2004 was not sufficient, leading to the 75 interim beds and an increase in VIHA's residential care targets from 86 spaces to 90 to 95 spaces per 1,000 populations over 75.

Again, this area is complex but improved analysis and modeling would lead to more accurate projections.

The three month trend of much higher residential care placement rates also needs more time to prove permanent (reports for April and May were unavailable when this report was written).

VIHA's Performance Report (2005) also reports a red light for residential care placement times with only 73% of placements occurring within the target 90 days. Previous annual rates were not mentioned but the waitlist statistics show 94% in 2002/03 and 80% in 2003/04 indicating a worsening trend.

The 2004/05 rate appears to exclude the last three months of 2004/05 which as mentioned previously, saw a much higher rate of admissions to residential care and a decline in the numbers of people overstaying in hospital.

Clarification of other VIHA responses is contained in the full report to VIHA.

The review of these four questions is sufficient for the purposes of this report and the conclusions which follow.

CONCLUSION:

- The responses which VIHA provided to the Committee in May were in lieu of receiving their 2005 - 2008 Home and Community Care Plan (Draft) approved by the VIHA Board in March 2005.
- VIHA's answers appear to be insubstantial and inaccurate. In some cases they do not refer to other VIHA reports, particularly the March 2005 Performance Report. This report, which was presented at the in-camera portion of the March 2005 VIHA Board meeting and appears to be the only general description of VIHA's performance, is not available publicly.
- Without adequate substantiation of their analysis and the opportunity to confirm their planning assumptions, we content this could lead to inadequate services provision, potentially negatively impacting the lives of elderly and non-elderly alike and the economics of the larger health system.
- We believe that the current state, with its apparent adverse human and financial consequences, is capable of being improved.
- A concerted effort to improve the home and community care (chronic care) system is needed; without this, future demand from a growing elderly population would be expected to cause increased avoidable human and financial costs.

- A concerted effort to improve Home and Community Care requires the participation of a wide range of vested interests including VIHA's affiliated service providers, community agencies, seniors groups, funders and local government. VIHA's disinclination to communicate and collaborate deprives the system of its ability to share knowledge and ideas, to explore new arrangements and generally make the system work better.

- There are two "starting" recommendations contained in this report, both of which were included in the Assisted Living Report (see Appendix 2). Both recommendations are stated in basic terms and would need more detailing through the participation of others (e.g. through the establishment of an advisory group). They are:

    1. Increase agency and public participation in Home and Community Care program planning and policy development.

    2. Increase public reporting and accountability in Home and Community Care.

RECOMMENDATION:

1. That this report be accepted as information.

Jeremy Tate, Director
Health Facilities Planning

Comments of the Director of Finance:

N/A

Comments of the Acting Chief Administrative Officer:

VANCOUVER ISLAND health authority

Response to CRD Health Facilities Planning Committee Questions

1. Current Shortage of Residential Care Beds

Q Does VIHA agree that there is a current shortage of residential care beds?

A In forecasting the future need for services to the year 2010, we have analyzed the population demographics, health need and how it is anticipated that the delivery of services will change. VIHA recognizes the need to enhance a range of services to best meet the needs of the aging population. The range will include: residential care, assisted living, increased home and community support, and increased rehabilitation and convalescent programs.

The population in VIHA aged 75 and over is forecast to increase by about 8% by 2010, however this is not evenly distributed across the health authority. In the South, the population aged 75 and over is actually forecast to decrease by 1% (about 440 people), compared to an increase of 19% in the Central area (about 3,900 people) and a 21% increase in the North (about 1300 people).

There is forecasted need to increase community services throughout VIHA. However, the growth in new residential care beds will be focused in the Central and North areas where population is forecast to significantly increase. In the Victoria (CRD) area, however, there is a need to replace old buildings with new ones.

Q If there is a need for more residential care beds, why is VIHA proposing to fund the renovation of existing residential care, which will involve more residential care bed losses, in preference to funding new residential care beds?

A The proposed renovations are at four Intermediate Care sites that have the potential for taking complex care clients following renovations. They were originally built for low and intermediate care residents who were ambulatory with lower care needs. Not all the present buildings need to be replaced; they could meet the needs of the complex care residents by doing some renovations. Should the renovations not proceed the loss of beds would not only be 16, but also loss of appropriate access to 262 beds. The loss of 16 with the renovations makes the other 246 beds accessible for high needs residents. In order to offset the 16-bed loss, the present 36 transition beds opened at the GRH would be increased to 50 beds, resulting in a total loss of 2 beds.

2. Financial Impact of Apparent Shortage of Residential Care

Q What does VIHA estimate is the annual financial premium for having approximately 130 people assessed and eligible for residential care waiting over 30 days in hospital?

A Any estimate of this kind is laden with assumptions about care needs, where the capacity exists in the system, the services within the specific hospital and the costing methodologies; all of which are debatable. In health care the focus is on the appropriateness of the care setting for the individual's needs, for which we argue you cannot calculate a premium.

In general, acute care is more expensive than residential care, but this is not always the case depending on the individuals needs and where the capacity exists within the system. In fact, costs at the end of the patient's stay, such as during the assessed and awaiting residential care period, can be quite low because the patient no longer requires intensive therapies.

The "premium" estimates Mr. Tate provided at the last meeting were based on very gross figures that should not be used for decision-making purposes.

The number of people in hospital waiting residential care has fallen significantly over the past several months. During the last six weeks, the assessed and waiting placement patients have averaged a total of 40 in the three South Island Acute care hospitals. This is down from over 100 in October 2004. This has been due to a number of recent initiatives to identify more appropriate alternatives for these clients and ensure acute care beds are available for those who need acute care. These initiatives have added approximately 85 beds since late 2004 into the system. The initiatives include:

- Opened an eight bed Emergency Room Short Stay unit at Royal Jubilee Hospital for patients requiring up to 72 hours of care;
- Reopened a 10 bed Palliative Care Unit at Saanich Peninsula Hospital following renovations;
- Converted a 25 bed Medical Unit to 21 sub-acute beds at Victoria General Hospital to improve staffing efficiency and appropriateness of care;
- Opened 46 psycho-geriatric beds at Sandringham in Victoria;
- Converted a 20 bed Sub-Acute Unit and a 25 bed Transitional Care Unit at Eric Martin Pavilion (EMP) to a 45 bed Alternate Level of Care Unit to accept direction admissions from emergency departments for patients needing respite care, and for those who do not need acute care, but are failing to thrive at home;
- Opened a 22 bed Convalescent Unit at Oak Bay Lodge to focus on reactivation and readiness to return home;
- Purchased 75 interim beds at various long-term care facilities throughout VIHA to reduce waits for people in hospital requiring long term care; and
- Purchased an electronic tool (Pathways) to provide real time patient flow and capacity information, which will facilitate timely transitioning of patients to residential care.

3. Future Residential Care and Assisted Living levels

Q How does VIHA intend to monitor the situation to confirm that this reduction of three new residential beds and 294 Assisted Living units will work?

VIHA currently monitors both on a monthly and annual basis the mix and volume of services. The system measures we use include:

- The number of people who no longer require acute care, but who cannot be discharged for a variety of reasons including those awaiting:
  - residential care placement
  - home and community care services
  - housing
  - other community supports
- Wait times for:
  - Residential care placement either from hospital or community
  - Placement to an inpatient bed once admitted by the Emergency Room physicians
- Admissions via the Emergency (equates to an unplanned admission)

Client and resident satisfaction surveys are conducted periodically. A survey for home care and assisted living will also be developed provincially, for system wide application.

Q In last years Integration Plan, it was described that VIHA's Home and Community Care plan would achieve a rate of 86 spaces per 1000 population over 75 years, just shy of the Ministry of Health's target. What is VIHA's current target?

A We are in the process of updating out strategic plan to the year 2010. This plan incorporates service capacity projections of 90 to 95 spaces/1000 over age 75 years by 2010. The projections are based on the future demographics, the health needs (living arrangements of seniors) and anticipated changes in how services are delivered.

4. Assisted Living as a Substitute for Residential Care

Q Do you have any early signs of its effectiveness in substituting for residential care?

A Assisted living is not a substitute for residential care. Previously, the elderly in need of assistance received community supports in their own homes until they reached a maximum resource level and then they were placed in a residential care facility, whether they needed or wanted that service. The need to develop alternatives to meet other needs in a better way was clear. Presently, only those with complex care needs are placed in residential care. Assisted living is now an option for those who cannot stay in their own home, do not have high complex care needs, but require additional supports.

Q What are some of the early positive signs?

A Two qualitative evaluations have been completed at two Assisted Living sites by an internal reviewer. The evaluations were positive with those living in Assisted Living places stating "feeling better", feeling "safer", having privacy maintained, etc. The families noted the relief of having the burden of care reduced; health conditions becoming more stable as the client received better nutrition, was less isolated and had more social interactions.

At the start of the program, Assisted Living clients moved from residential care units. Now a percentage of clients are moved into Assisted Living directly from the hospital. These clients cannot go home because they cannot manage the environment (e.g. stairs) or their support system is no longer present. These people do not require complex care and can direct their own care. In Assisted Living they can have an increase in home support since the services for all clients are "bundled".

Q Are there any concerns about assisted living?

A There are opportunities for improvement in all services; Assisted Living is no different. A small percentage of clients can be stressed by the move or their care requirements increase upon admission. These issues also occur for some people when they are admitted into residential facilities. One of the criteria for admission to assisted living is that clients can "direct their own care." Of concern is the definition of "directing their own care" for clients who have some degree of dementia. Each of these clients has unique needs and it is difficult to predict when they will need residential care. Refining tools and processes to ensure the right service is available to the right client is an ongoing issue for all services, including Assisted Living.

Q When will an independent evaluation of assisted living be undertaken?

A An independent evaluation for assisted living is in the planning stage at a provincial level. VIHA has a representative sitting on the MOHS Assisted Living planning committee discussing a provincial evaluation. As well, the Assisted Living program staff has a quality assurance plan to address concerns.

5. **Overly Rigid Residential Care and Home Support eligibility and use of Emergency Departments.**

Q Has VIHA observed an increase in the use of hospital emergency service by the elderly over the past two to three years?

A The eligibility criteria for home support has tightened since the mid 1990s in order to address those most in need of care, home support that would enable them to remain in their homes. Before that time, the home support resources were sometimes going to support gardening, animal care, and weekly housekeeping.

Our best information does not indicate an increase in Emergency Department use by the elderly, however, demographic trend data for Emergency Room use is limited provincially, not allowing tracking by age cohort. VIHA recently implemented an Emergency Room Triage and Tracking Information System in South Island hospitals. This system will assist in better understanding utilization of emergency department resources in the future.

Q If the rate of use of emergency service has gone too high, what are some of the ways to reduce it?

A Emergency Room visits over the past five years have been fairly stable as evidenced by the average visits per day.

Average ER Visits Per Day for Select VIHA Sites

	2000/01	2001/02	2002/03	2003/04	2004/05
RJH	109.1	99.9	99.2	103.0	105.1
VGH	114.8	104.9	106.4	101.9	106
Total	223.9	204.8	205.6	204.9	211.1

Across the country, national levels of acuity and use of acute beds and emergency departments are not dissimilar from the experience in VIHA and BC.

We continue to look at ways to reduce the community's reliance on Emergency Rooms when services can be provided elsewhere. For example, the development of Primary Care Clinics for those who do not have a general practitioner is something VIHA has implemented and is considering expanding. Other examples include increasing staffing to redirect people home with supports when hospital admission is not required.

6. <u>Use of the District owned Carey Road site in Saanich and the Gorge Road intended care facility.</u>

Q Although there is a month before we expect an answer, is there anything you can say about it right now?

A VIHA is very pleased to have Carey Road site as an option but will not be making decisions on sites until the Integration Plan 2010 has been approved by the VIHA Board.

Q How many additional people beyond the 112 James Bay Lodge residents are in the GRH extended care facility and are their plans to increase the numbers at the facility?

A Presently there are 36 temporary beds in place for those in hospital assessed waiting placement to a residential facility. Opening a further 14 temporary beds will help mitigate the loss of 16 beds with the four site renovations.

Over the next few years, the GRH site may be used as other facilities need a decanting site. The safety of the buildings and environment will be continually monitored as it has been over the last years.

2 <u>Feedback on the Districts Assisted Living Review.</u>

The VIHA does not dispute the numbers in this report, however, the situation has changed since September 2004 and more recent data indicates a significant improvement in patient flow between services. Please see attached trends in Residential Care. Residential Care admissions over the past year show a steady increase; the ratio of people added to the residential care wait list versus removed (either placed in residential care or for other reasons) has gone from .98 in 2003/04 to .77 in 2004/05. This is a trend in the right direction.

Reaction to the changes taking place in seniors' care tends to be focused on beds, assuming that the most important intervention for seniors is a residential care bed. What we, and most other health jurisdictions are proposing, is providing a continuum of services that meet needs of people with a variety of health requirements. We know that most seniors want to remain living in the community, and can do so if they are well supported. Assisted Living, improved community supports such as respite, adult day programs and community bathing programs are being increased and can provide this support.

The CRD appears to want the province and the Health Authority to develop new plans. VIHA is currently conducting sophisticated and detailed analysis, based on forecasted projection and up to date data, to confirm both the direction and the required capacity the health authority is aiming toward.

The report claims that too many beds were closed too fast. This assessment can only be made based on a point in time, and that time has passed. VIHA has taken significant steps during the past six months to open beds on a short-term basis to manage the period of time when inadequate facilities must be updated and the complementary services to Residential Care are developed.

Mr. Tate recently requested a response from VIHA staff explaining the recent improvements in admission and wait list figures.

> "The NBA Wait List Analysis shows average monthly placements to residential care... in the final three months of the year almost double the rate of the previous nine months (99 versus 52). This probably is occurring for a number of reasons.
>
> First is recent increase in residential care (and assisted living) capacity. Second is higher turn-over in residential care facilities likely related to delayed admissions, incoming residents in poorer health and shorter average lengths of stay before death. This is probably the most important factor. Third is the convalescent and sub-acute units which accommodate post acute patients , giving them more time to stabilize before determining their next step with a greater likelihood of non-residential care options.
>
> For January, February and March 2005 the number of residential care admissions (and removals) exceeded the number of new people listed by 59. In 2003/04 the monthly average was 11 more admissions and removals than new persons added and in 2002/03 it was 2."

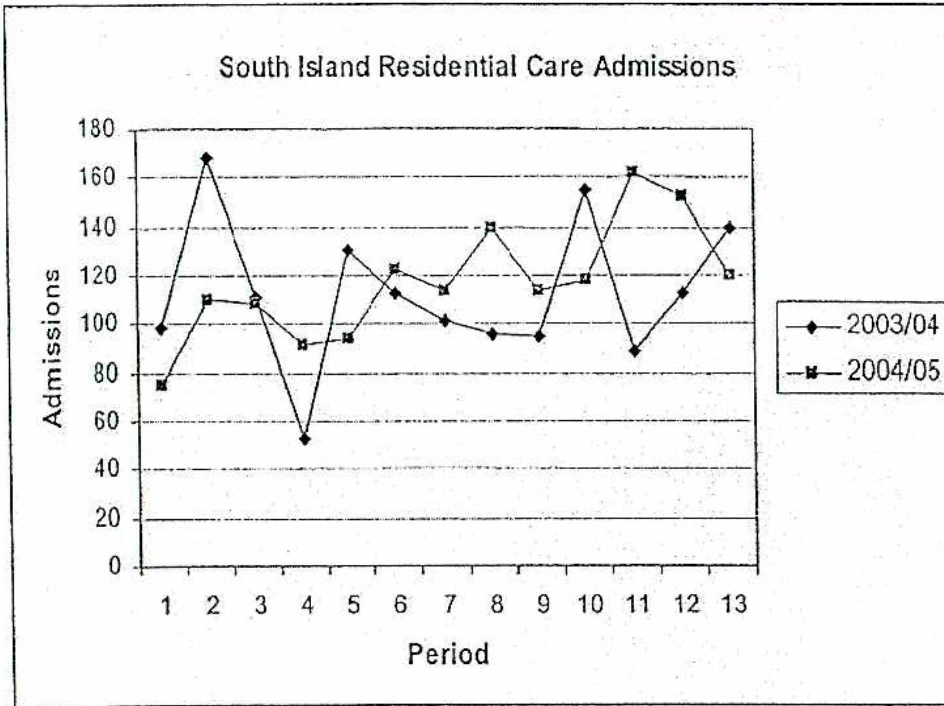
As noted above, VIHA's key performance measures indicate improvement. We do not, however, share the above assessment of the reasons.

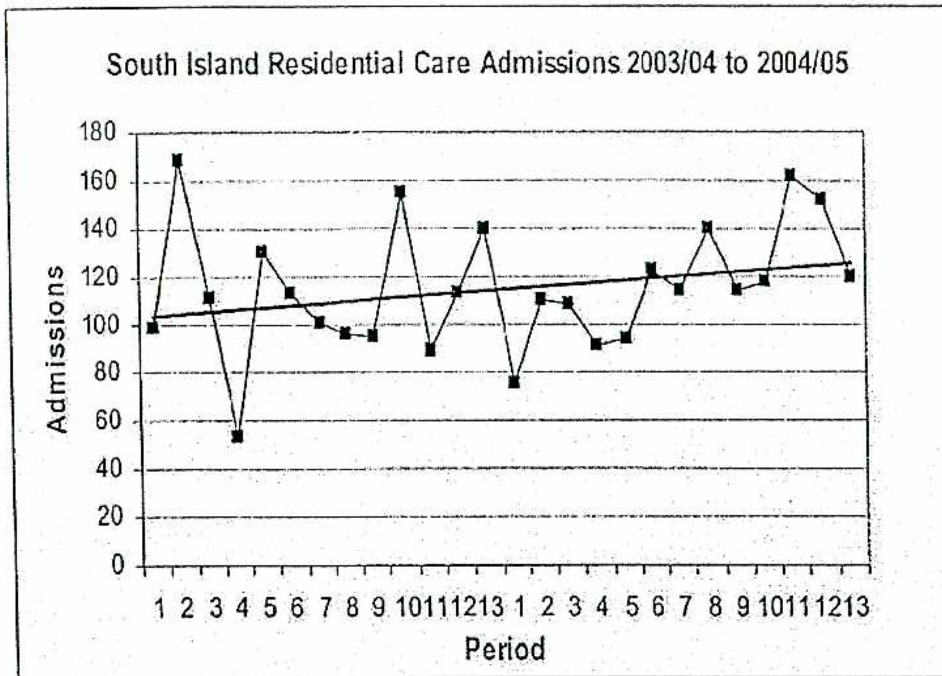
While there is significantly higher turnover in residential care facilities, we see this as a result of deaths, not delayed admissions as stated. Clients are frailer on admission, than they have been in the past due to changes in provincial admission policy. Only those persons with complex care needs are admitted to facility. For this reason alone, we would expect to see a shorter length of stay.

The impact of convalescent and sub-acute care will not be evident in the residential care statistics. These services are for people who require additional time to recover from an acute illness before they return home. The only link that might be made to the wait list is if these people did not receive the rehabilitative supports available on the convalescent unit, their health needs may have increased to the point of requiring residential care.

Please note: data on those waiting for Assisted Living is not sufficiently reliable to report due to the developmental nature of the service (i.e. Lists can reflect people who awaiting new units to be developed, but may not "need" all the services at the time they put their name forward). Also the list requires "clean-up" to ensure those who have deceased, moved etc are no longer on the list.

Residential Care Admission Trend

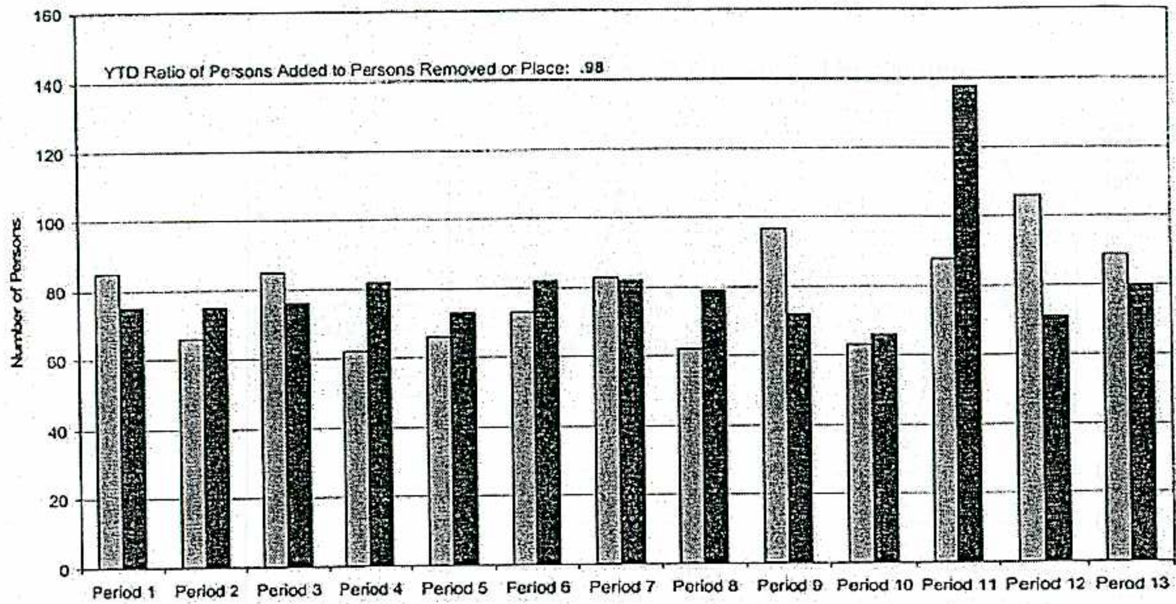




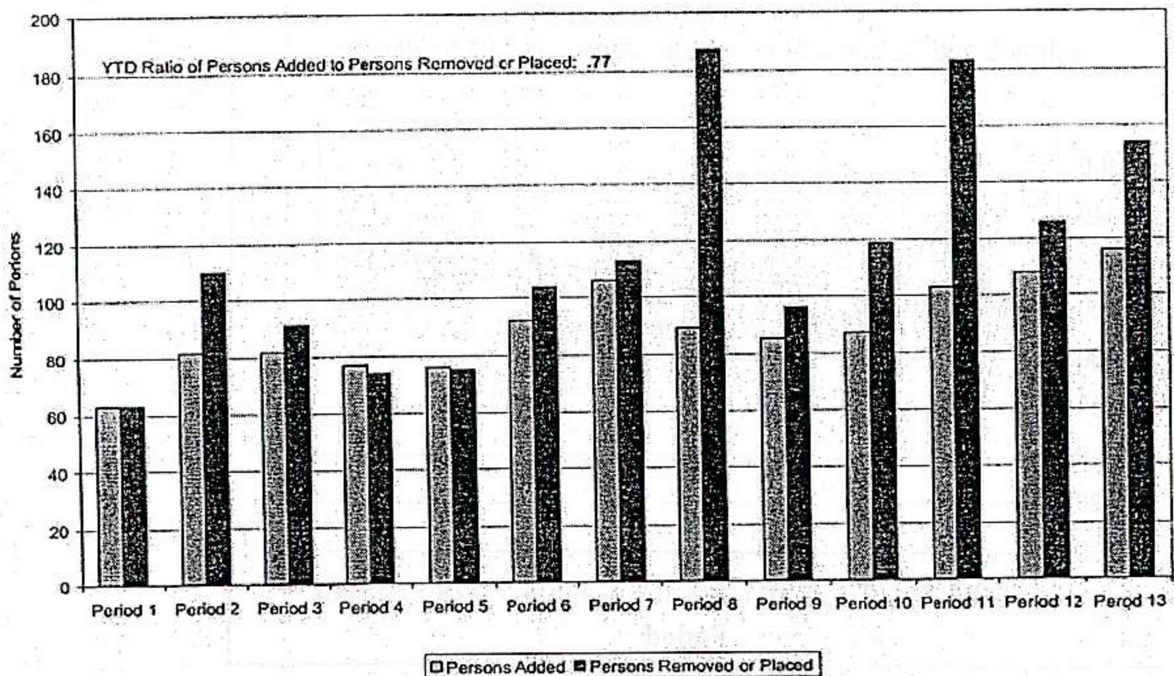
Data Source: VIHA Statistical Trend Report

Trend of Persons Added, Removed and Placed by Period

Fiscal Year 2003/04



Fiscal Year 2004/05



Data Source: Needs based Assessment Database

Prepared by: Performance Monitoring and Improvement
Date: May 12, 2005

APPENDIX 2
2004 ASSISTED LIVING REVIEW – "The Capital Region Experience"

RECOMMENDATIONS

The recommendations are largely directed to the Vancouver Island Health Authority and its funder and overseer, the Ministry of Health Services and Planning.

I. RECOMMENDATIONS

1. Approve 250-300 new residential care beds and cap publicly funded assisted living at 631 units.

The evidence of a shortage of residential care is clear. Large numbers of people are waiting too long in hospital for residential care placement and admitted emergency patients are backing up emergency departments. Most residential care placements from the community are emergencies with a 30-day maximum wait period contrasted to current average wait times of 78 days. Too many high level residential care beds have been withdrawn too quickly, their substitutes have so far been insufficient to offset them and their future potential is uncertain. The private pay sector has not stepped in and is unlikely to do so. The 250-300 beds in question are high level extended care/intermediate care units with high monthly cost for which public subsidy is normally required. The provincial planning model on which VIHA's implementation was based was suspect. If VIHA's original plan to close 920 beds had been carried out the consequences would have been much worse.

2. Redo the provincial residential care and assisted living plan.

VIHA's implementation of the Home and Community Care renewal was influenced by the provincial Residential Care and Assisted Living Planning Model. Provincial encouragement of the highest reduction of residential care in a context of inadequate funding and organizational capacity to create alternatives was unrealistic. Implementation appears to have been driven more by a desire to save money than a rationale attempt to find the right amount and distribution of services. The Residential Care and Assisted Living Planning Model needs to be redone. Considering the undue influence of financial objectives, the next plan needs a more independent and comprehensive approach. The Plan should be commissioned by the Ministry of Health Services but undertaken by an experienced third party, not by provincial staff. We note that that the Manitoba Centre for Health Policy did a review of the residential care bed requirements in 2002 for that province and suggest that the government consider similar action.

3. Undertake a major review and strategic plan of the Home and Community Care system.

Our findings for the Capital Region suggest a Home and Community Care system in significant difficulty. From media accounts this may be a province wide phenomenon.

Deficiencies in the Home and Community Care sector not only affect access (timeliness) and quality of care for chronically disabled people but also adversely affect hospitals by reducing their capacity to treat acute patients and admit from emergency departments. They also affect families and caregivers.

The last major review of Home and Community Care, or Continuing Care as it was then known, was completed in 1999. The Community for Life report has fallen short if today's conditions are a testament to its implementation framework. The Community for Life report unfortunately did not deal with costs, how much an optimal continuing care system would cost and how it would be financed.

Evidence of insufficient financial and human resources abound today in the Home and Community Care system. The sub-par Home and Community Care system is therefore in part, possibly a large part, a function of shortages of funding to supply sufficient services and manage the system. A major strategic review of Home and Community Care should be undertaken at the provincial level. Again, primary consideration should be given to estimating the cost of an optimal system, and proposing how it would be paid to be affordable to the individual user and government. Knowing that an under-funded Home and Community Care system also costs other parts of the health system and society, it would be important to estimate savings associated with additional Home and Community Care capacity.

There are probably three financing options:

- the status quo, which is actually the product of an unofficial long term trend of reduced government funding (inflation adjusted),
- an official position by government to cap funding and to acknowledge increased private pay provision,
- a fully covered public system with a combination of higher user charges or increased tax based funding.

While this system review is primarily a provincial matter, regional reviews and plans, produced in collaboration with the participating agencies and community organizations, would be of value. The local Home and Community Care system has been largely closed to participation by affected parties and needs to be opened up. Regional Plans would also provide an easier opportunity to design an optimal system, cost it and inform the provincial review.

4. Review benefits and costs of high levels of home support services and recent eligibility restrictions.

Southern Vancouver Island apparently has the highest per capita rate of use and highest service levels for home support clients in the province. This probably puts the Health Authority under some pressure to conform to benchmark rates elsewhere, unless there are benefits, such as reduced rates of other more costly services.

VIHA mentions high home support levels contribute to lower hospital use by the elderly. Although the initial evidence is lacking, it may also contribute to lower residential care rates. The removal of coverage for lower care level people and the withdrawal of allowable tasks such as meal preparation, house cleaning and laundry seems counter-intuitive. While the excluded tasks may be provided less expensively through private companies and reduced coverage necessary to accommodate increased demands of former residential care clients, the community agency survey suggests an increasing number of people have not been able to find alternatives. The agencies believe that more frail elderly people are living without or with too little support and have to deteriorate before they get help. This has lead to more emergencies and people being in poor condition (deconditioned) when entering residential care.

If the community agency perception is right, there will have been an increase in emergency department visits amongst the over 75 population and possibly higher rates of increase for those

cut off from or not receiving publicly funded home support services. Other service may also have increased; doctors or treatment clinic visits for example.

If these things and others are occurring, they should be factored into an evaluation of the effects of reductions of home support. This might prove difficult to research with a host of factors involved. However with the various linked data bases allowing analysis of individual use of major health services, it should be possible to discern any differences in overall rates of use (around the use of home support) which may exist.

The concept of preventing health deterioration in itself and for the purpose of reducing or delaying medical treatment is assumed to be one of home support's main attributes. The community respondents felt strongly that reductions in home support had caused more problems than they were worth and made reinstating coverage and tasks their highest priority. Evidence and opinion from the Health Authority on the benefits and costs of their home support policy and practices is needed.

5. Review other elements of community agency feedback.

In addition to suggestions to restore home support eligibility and reinstate meal preparation, housecleaning and laundry, feedback from the community agency survey included the following priority areas: improving transportation, creating more affordable supportive housing and assisted living and increasing the number of case managers (enabling earlier intervention to avoid people in crises). Improving communication of publicly funded services and how to get them was also an important concern. Are these concerns shared by VIHA and what should be done?

6. Assess the capacity of community agencies and work more closely with them.

The main concern for the sector is the increased workload that followed the contraction of publicly funded home support (and residential care) services on an already under-funded, understaffed, volunteer dependent sector.

They advise that they cannot accept more work unless the Health Authority addresses their funding and staffing problems. Some people terminated or made ineligible for home support managed to afford private arrangements or secure family, friend or neighbour help. Those who didn't have the money or the family sought help from community agencies and faith communities. The agencies and churches either helped them find it or provided the support themselves. If there are limits to expanding voluntarism and community agencies aren't able to keep up with further government reductions, what will happen? VIHA should have a close look at the capacity of this sector and what it needs to keep up with the seeming growing demands placed on it.

Furthermore, the community agencies want the Health Authority to work together with them. This collaboration would involve the agencies in aspects of planning and policy development and addressing what they need to play their part in supporting frail elderly people.

7. Conduct an independent external evaluation of assisted living.

This review has concentrated on describing the first phase or introduction of assisted living and its impact on the health system, the assisted living-seniors housing sector and the community, voluntary sector. In addition to its system impacts (and their costs), it should be determined how much less costly assisted living is compared to residential care. It would be important to know

the frequency of emergency visits, the number of hospital days, medication rates, physician and treatment centre usage, resident satisfaction and length of stay, to name some of the elements.

It would also help if VIHA reported on the number and type of people waiting for assisted living, their wait times, where they are "discharged" to and how long the wait.

8. Increase public reporting and accountability.

Home and Community Care is a large part of the health system and affects many lives. With an increasingly ageing population, Home and Community Care will grow. The general public should be informed of the performance of the local system in comparison with other regions, its level and type of resources compared to others and what direction and changes are expected. Openness and transparency makes people more aware of the nature of problems from which they can assess their individual actions and solutions in dealing with the system.

9. Simplify, standardize and maintain definitions and terminology.

The public is confused with the names and definitions used in the Home and Community Care system. The Independent Living B.C. Initiative started out as Supportive Living and the legislation speaks of assisted living residences. Home and Community Care, with its apparent exclusion of residential care, was formerly Continuing Care. Complex care residences or residential care facilities used to be multi-level care facilities which in turn were previously separate intermediate care and extended care facilities. The general public doesn't generally understand the difference between residential care and assisted living. The private pay industry has its own definitions to define its product. Government should adopt a clear terminology and stick to it.

10. Improve information systems.

The data and information obtained for this report could have been better. It was sometimes difficult to get, had its shares of errors and inconsistencies and current year data was often unavailable. That basic information is unavailable or not of good quality suggests problems are likely to occur in planning and managing the system.

11. Improve research and evaluation in Home and Community Care.

There are a number of important research and evaluation areas identified in the report including; home support reduction impacts, assisted living evaluation, community agency capacity in Home and Community Care and residential care average lengths of stay. All that can be recommended here is that they be done. All that can be requested is that VIHA and the provincial government confirm their current research and evaluation activities (related to Home and Community Care) and what is planned over the next twelve months.

12. Increase agency and public participation.

From the survey we heard comments of VIHA not actively collaborating with its affiliated agencies, the community sector or the private sector. Communication of its programs and explanation of Home, Community and Residential Care issues are very limited. It was also not uncommon in this review for agencies contracted to VIHA to ask that their comments not be identifiable. There seemed to be a sense of potential unwelcome consequences of providing comments unfavourable to VIHA.

One example of the need to inform and engage is the private pay residential care and assisted living sector. Government planning and supply decisions affect the private pay sector. Private investors need to know what's going on and to be regularly updated. Apart from high level overviews of program activities in its Redesign Plans, VIHA has not produced any meaningful public report on its planning or processes behind the Assisted Living Initiative.

The job of providing support to the frail elderly and the non–elderly is much too big for a central health bureaucracy to do on its own. The benefits from a more active collaboration with the many agencies and sectors it relies on to carry out the work should be considerable.

13. Clarify the 90-day maximum wait time for residential care placements.

A maximum ninety (90) day wait time for residential care is a key measure of the health system performance. This seems an excessive wait for people waiting in hospital where the average wait is 108 days. Also, a majority of community placements are classified as emergency placements with a maximum 30-day wait. The current 90-day standard is a questionable measure and should be reconsidered.