Future of Home Care Services in Manitoba

The Government of Manitoba
Minister of Health, Seniors and Active Living

Reg Toews, Project Consultant

CONSULTANT REPORT

EXECUTIVE SUMMARY

The Review was commissioned to develop a comprehensive home care plan for the future that will ensure that Manitoba has a home care service that is safe, reliable, responsive, equitable and sustainable and that will strengthen Manitoba's universal and publicly funded home care services, and provide a follow-up to the Office of the Auditor General report recommendations. A specific impetus for this project was the growing demand for services from the baby boomer generation of seniors.

The review process involved broad consultation with the different levels of home care personnel, clients, family and informal caregivers and stakeholders, including an online opportunity for public input, demographic/clinical data analysis, and a review of the professional literature and internal documents. A twelve member Leadership Team was established to provide input and guidance to the Consultant. A four member Support Unit, composed of home care services staff, supported and enriched the review process.

Home Care services were established in 1974. Its primary purpose was to allow people to remain at home for as long as possible. In 1997, the newly established Regional Health Authorities (RHA) took over responsibility for the operation of home care services. For the past number of years home care has annually served approximately 39,000 clients with approximately 15,000 admissions and 15,000 discharges annually.

Key demographic and clinical changes include:
As part of the process for developing a comprehensive plan for the future a thorough demographic and clinical analysis was completed. This process identified the following.

- The Manitoba Bureau of Statistics projects that Manitobans age 65 and older will nearly double by the year 2038. The greatest increase in numbers will be found among the 75 to 84 age cohort.
- The prevalence of chronic conditions has increased and co-occurring conditions are experienced at higher rates in seniors.
- Based on a 5-year average of admissions, utilization is greatest from age 75+ with over half of the provincial home care admissions coming from this age group. Seventy-two percent of home care admissions were 65+ years of age.
- Among the changes in Winnipeg Regional Health Authority (WRHA) home care clients is an increase in the prevalence of cognitive impairment and the presence of multi-morbidity – the co-occurrence of two or more chronic medical conditions.
- All of the regions in Manitoba are projected to experience an increase in home care admissions over the next 20 years (till 2037). Based on a year-over-year percentage change calculation this increase would be between 2%-3% per year, or a yearly increase equivalent to 3.5%
- The prevalence of cognitive impairment will increase as will Activities of Daily Living (ADL) impairment where hands on assistance is required. The proportion of clients with complex care needs is estimated to increase at the same rate as the increase in the number of clients.
- If projections hold true, home care services in Manitoba will essentially have to double their efforts within 20 years to provide the required service needs of clients.

Key findings from the review include:

- Family and informal caregivers are an essential component of home care but may be a diminishing resource in the future.
- Home care is not standardized across the province to the degree it should be.
- Home care is under continuing pressure to facilitate the discharge of patients from the hospital. This has the effect of pushing home care in the direction of a health/medical service model.
- Self and Family Managed Care (SFMC) program is growing and seniors, in addition to younger adults with physical disabilities, are making increased use of it.
- The complexity and acuity of client need is continuing to increase.
- Nurses are delegating more tasks to Home Care Attendants (HCAs).
- The lack of continuity in the assignment of HCAs and insufficient time allocated to complete the assigned task remains an issue.
- Information Communication Technology (ICT) programs currently available in home care are generally inadequate – frequently what does exist is old.
- The Continuing Care Branch (CCB) is unable to fulfill its assigned role due to insufficient resources.
- Recruitment and retention of home care personnel is a constant challenge – at any one time there is a vacancy rate of 8-10%.

Key implementation recommendations from the review include:

- Endorse the foundational components of the future home care services as outlined in the Report: purpose, objectives and service delivery structure, basket of core services, and ongoing role of family and informal caregivers.
- Develop a single standardized list of core services.
- Develop a caregiver care plan separate from the client care plan at the time of the needs assessments.
- Outline a partnership relationship between the client/caregiver and home care, and put less emphasis on the word "supplemental" which has become too limiting a term.
- As the needs of clients increase ensure training and education opportunities are available to the caregiver with funding attached to allow for implementation.
- Continue SFMC as a valid option available to clients.
- Ensure home care and acute care work together to develop deliberate and effective discharge plans and sufficient personnel are in place so that home care does not increasingly become a health care/medical program only.
- Set a timeline to complete the amalgamation of home care services in each of the rural/northern RHAs.
- Continue to expand, as appropriate and resources allow, the use of the delegated task process.
- Provide the CCB with the appropriate resources for it to fulfill its defined leadership role.
- Develop a comprehensive central policy manual that reinforces consistent province-wide home care services.
- Post provincial performance/clinical data on-line once available.

- Develop a detailed financial projection for the next 3-5 years.
- Efforts should continue undiminished to ensure that all HCAs in home care are certified.
- Develop a system-wide Human Resource (HR) strategy for home care that would include, but not be limited to, strategies that are designed to attract and retain millenials and immigrant workers in the workforce.
- Develop a standard provincial curriculum to be followed by all provincial institutions – public and private – when educating HCAs.
- RHAs provide mandatory education/training for all Direct Service Workers (DSWs) on dementia, managing challenging behaviour, mental health and other emerging health issues.
- Develop a comprehensive province-wide ICT strategic plan for home care.
- In the short term, explore making appropriate mobile technology available to DSWs, Direct Service Nurses (DSNs), Case Coordinators (CCs) and Resource Coordinators (RCs).

Sustainability

There are two areas that have primary impact on the future sustainability of home care – financial and HR/Workforce – and to a lesser extent ICT and other costs. While it is solely a government responsibility to determine the amount of resources to be allocated to home care the following illustrative scenarios can be of assistance in arriving at such a decision. Approximately 5.5%-6% of total health expenditures are annually spent on home care.

- Scenario 1 – The Manitoba Bureau of Statistics completed a study entitled *Health Care Spending in Manitoba 2012 to 2037* in which it projects that health care expenditures will double in that period. Applying this to home care would result in expenditures increasing from $324m in 2014/15 to $648m in 2037.
- Scenario 2 – The second scenario is based on the assumption that the future will look very similar to the past. For a 15 year period (1999/2000-2014/15) home care funding increased by a total of 116% or a yearly increase equivalent to 7.7%. Based on that experience a future 22 year period (2015-2037) would represent an increase in funding of 170 percent or an increase of approximately $550m for a total home care funding by 2037 of $874 million.
- Scenario 3 – This scenario is based on future fixed cost increases and volume growth. Volume growth is projected for the next 22 years at a yearly increase equivalent to 3.5%. Extrapolating from information provided by the Provincial Health Labour Relations on cumulative compensation increases for the past 19 years compensation costs going forward might increase at a yearly rate of 4-4.5% plus any increases in benefits/pension. Fixed costs are primarily determined through the collective agreement negotiating process – so fixed costs may be higher or lower than in previous years. Combining volume increase and fixed cost over a 22 year period the total increase would be approximately 177% or $573m for total home care funding of $897m by 2037.

The above scenarios do not provide for increased spending on ICT and other related costs. What can be said with some certainty is that home care funding will need to increase in the future.

Due to a projected yearly growth in units of service (unit equals one hour) equivalent to 3.6% or 80% over the next 22 years approximately an additional 2000 HCA/Home Support Worker (DSW) EFTs will be required – approximately 90-100 new EFTs each year. During that same period an

additional 310 DSN EFTs will be required. In addition to the above front line workers there will also be a need for more Scheduling Clerks (SCs), CCs, RCs and administrative staff. It goes without saying that recruiting all of these additional personnel will represent an extreme challenge, particularly since at any one time home care has a vacancy rate of 8-10%.

Office of Auditor General and Inquest Recommendations
The CCB and the RHAs continue to plan and implement their responses to the above recommendations.

The Way Forward
While this review has looked primarily at the long term demands on home care the implementation process for select major recommendations cannot be delayed – the way forward begins now. These major recommendations include: developing an effective province-wide ICT system for home care; providing the CCB with adequate resources so that it can provide strong provincial leadership, and addressing pressing HR issues.

There are also a number of items requiring future work. These items include: studying the whole area of home-based technology and its application, completing a study on the broad area of HR in home care, carrying out a study on housing with health services models to determine which models are most beneficial for home care and the client, and researching different funding models for home care services.

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TERMS OF REFERENCE AND PROJECT CHARTER

In August 2015 it was announced that a Home Care Leadership Team led by Reg Toews was to be appointed to develop a comprehensive plan to guide home care services in the future and to guide the province's response to a recent report by the Office of the Auditor General (OAG). The Home Care leadership Team will use the OAG recommendations, the Brian Sinclair and Frank Alexander inquest recommendations, and the valuable insights of home care staff, clients and families, and stakeholders to shape a plan to ensure Manitoba continues to be a leader in providing home care services into the future.

The Project Charter intent is to provide the opportunity to develop a comprehensive home care plan for the future where Manitoba has a home care service that is safe, reliable, responsive, equitable and sustainable and will strengthen Manitoba's universal and publicly funded home care services. Recommendations were to address:
- Manitoba has the capacity and resources to deliver the home care services and respond to the growing demands for the services;
- Alignment with other sectors of the health system;
- Public accountability;
- Financial and operational sustainability.
- Identify long term health human resource planning strategies needed to maintain these important services for Manitobans into the future

The full scope of this project includes the following additional items:
- Provide recommendations on the most appropriate and efficient structure for the delivery of home care in Manitoba;
- Develop a plan to address the health human resource requirements for the future of home care in Manitoba;
- Develop a strategy to standardize and clarify baseline services offered through home care across Manitoba;
- Place home care services for Manitoba in the national context, by examining leading practices from other jurisdictions nationally and internationally;
- Ensure that plans to address the recommendations resulting from the OAG report and inquests are developed;
- Engage stakeholder groups, families and caregivers to provide their insights into the future of home care in Manitoba;
- Articulate implementation considerations.

A few clarifying comments on the scope of the project are in order. A specific impetus for this project is the growing demand for services from the baby boomer generation of seniors. The size and expectation of this population cohort will put extreme pressure on all health services, including home care. The primary purpose of this project is to provide guidance to Manitoba Health, Seniors and Active Living (MHSAL – more usually referred to as "the Department") on the future of home care services and what steps will need to be taken to address the growing demand

for home care services. Secondly, the scope of this project does not include an in depth examination of the current home care services but does include an overall understanding of the various services and any issues and concerns confronting home care. This understanding of the current services, and any issues and concerns, is important when making projections on the future of home care.

METHODOLOGY

The methodology involved a four-part process: consultation, demographic/clinical data analysis, literature review and review of internal documents.

Creation of a Leadership Team

A project requirement was the establishment of a Leadership Team (LT) with the Consultant as chair. The LT worked with and provided input and guidance to the Consultant in completing the project. The LT also reviewed all the report recommendations while they were still in draft form. The twelve member Leadership Team (see Appendix A for a list of the members) was composed of representatives from home care staff, Regional Health Authorities (RHA), the Continuing Care Branch (CCB), clients, family/ informal caregivers and stakeholders. The home care staff consisted of home care attendants (HCA), case coordinators (CC), resource coordinators (RC), direct service nurses (DSN), and leadership staff. The membership included three staff members from the Winnipeg Regional Health Authority (WRHA), four members from the rural RHAs, and four members representing clients/caregivers /stakeholders. The LT met monthly (10 meetings) over the length of the project. The LT also developed a stakeholder/client/caregiver engagement process that complemented the work of the LT by drawing in additional individuals from within the home care sector.

Consultation Process

The consultation process formed a very important component of the methodology. This process involved interactive conversations with all levels of home care personnel, clients/caregivers and stakeholders as well an online opportunity for public input.

The Consultant's interviews/meetings with service providers, clients/caregivers and stakeholders were completed over a 5-6 month period. This process involved over 90 meetings with a few hundred individuals meeting either as individuals or in groups. These meetings took place in all five RHAs and were structured as separate meetings with home care leadership, CCs, RCs, DSNs, and HCAs. The Consultant also interviewed Department personnel. Additionally, in each RHA meetings were held with a small group of clients/caregivers/stakeholders. Some client/caregiver phone interviews were also completed. Separate meetings/interviews were held with stakeholder, agency, and various advisory council representatives drawn from the different sectors of home care.

Finally, as part of the consultation process Manitobans were invited to share online their perspectives and concerns regarding the current home care services and their suggestions for the future of home care. Over 300 responses were received which were subsequently analyzed for themes.

Demographic/ Clinical and Data Analysis

A home care program researcher seconded part-time to the Support Unit (SU – the Support Unit will be described in detail at the end of this section) from the WRHA, was primarily responsible for demographic and clinical trend analysis as it related to both current and future home care services. The Consultant and other SU members also contributed to this process.

Literature Review

The Consultant and the Support Unit members were all involved in a review of both national and international literature. While numerous sources were accessed the Internet was a valuable resource for articles, reports and literature on the various aspects of home care. The appendix contains a list of the major articles read as part of this review.

Review of Internal Documents

The major source for internal documents on home care services was the Continuing Care Branch. These documents were supplemented with information from other sources, e.g. other divisions/programs within the Department, RHAs, other government departments (specifically Department of Families) etc.

Establishment of a Support Unit

A four member Support Unit (SU), composed of home care services staff, supported and enriched the work of the Consultant (see Appendix B for a list of the members). The SU members brought to their assignment many years of experience in home care, other health care programs, and related non-governmental experience. The members were seconded from their regular duties with the WRHA, a rural RHA and the CCB. Besides one full time secondment all the other secondments were part-time. Typically, the Consultant and the SU met on a monthly basis. The SU members also participated in the monthly LT meetings. Individual members of the SU prepared presentations for the LT meetings on eight major home care review topics (see Appendix C for a list of the presentations and the names of the presenters).

INTRODUCTION

Historical

The Manitoba Home Care Program (MHCP) was established in 1974. Its primary purpose was to allow people to remain at home as long as possible living as independently as possible. The Department of Health and Social Development in its1974 Annual Report describes in some detail the responsibilities of the Office of Continuing Care which was created to co-ordinate the existing home care services delivered through hospitals, private agencies, and departmental offices into one community-based, province-wide program; to develop needed home care resources; and to

integrate the assessment for placement in personal care homes with the assessment for Home Care to assure the most appropriate utilization of care services and care facilities.

In addition to the program being community-based and province-wide it was to be government-funded (no cost to the client), centrally managed with decentralized delivery of service, based on an assessment of need and utilizing professional and non-professional personnel as well as volunteers. Services were to be provided to individuals that required them to function adequately at home by reason of aging, physical health disability, personal crisis or illness, or the disability of the parent usually able to provide care to a child, and who, without services, would likely be unable to remain at home. Additionally, the program was intended to relieve some of the inappropriate pressure on acute and personal care home beds resulting from the absence of comprehensive alternative care in the home.

The program was to provide a range of services including nursing services, social services, rehabilitation services, health promotion services, and support services as required to maintain a person in their own home. Also included in these services were household maintenance, personal care and hygiene, health treatment and maintenance, counselling services, and home care equipment and specialized services.

From its inception the program met an immediate need, particularly in rural areas. It grew quickly from 5,000 persons served in April 1974 to 6500 in November 1974. As well approximately 300 persons were assessed and panelled for placement in December 1974. Over the intervening decades the program continued to grow and evolve while remaining true to its original purpose and objectives. It increasingly became an essential component in the provincial health care system.

Provincial Overview

Between 1974 and 1997 when the RHAs assumed responsibility for the administration and operation of home care services, with the Department providing policy direction and oversight, there have been significant changes. Self and Family Managed Care, Palliative Care and more specialized services have been added. The complexity and acuity of cases has increased, as have the incidence of cognitive impairment, mental illness and the prevalence of two or more chronic medical conditions among home care clients. The delegation of tasks by the direct service nurse to the HCAs was introduced and these numbers continue to grow. The pressure from the hospitals to discharge patients to their own home continues to increase the expectation on home care to provide the necessary services in a timely manner. A regularized workforce of equivalent full time (EFT) personnel has replaced the former "casual" workforce of HCAs and Home Support Workers (HSWs). New housing models, such as Supportive Housing and Assisted Living, have been introduced requiring home care to provide the personal care to these tenants. What remains unchanged is the purpose of home care - to help people stay in their own home for as long as possible - and for home care to assess all clients for placement in Personal Care Homes (PCH) and Supportive Housing (SH).

According to the recently completed RHA regional scan, the RHAs provided the following core services: personal care, nursing, therapy services (occupational therapy [OT] and physiotherapy [PT]), household maintenance, meal preparation, laundry, respite and off-site services. In addition, the RHAs also provided a variety of specialized services as well as equipment and supplies.

In 2015 the five RHAs employed the equivalent of approximately 3,500 full time personnel plus additional casual staff to provide the home care services. The annual funding provided by the Department has been stable for the past five or six years. According to the information provided by the Continuing Care Branch in 2014/15 the RHAs received $324m in funding from the Department. In the past 15 years (1999/2000 to 2014/15) the funding from the Department has more than doubled.

Since 2006/07 home care has annually served approximately 39,000 clients. In the past 15 years the number of clients served has increased by approximately 9%. In 2012/13, according to the most recent information available, there were approximately 15,500 admissions and approximately 15,700 discharges. These numbers have remained stable for the past five years.

I. DEMOGRAPHIC AND CLINICAL CHANGES

Part I of this report reviews several topics fundamentally important to understanding the current state of home care in Manitoba and the future of the service. Section A reviews population aging in Canada in general and in Manitoba specifically, and how the changing demographics impact home care. Section B examines the current profile of home care clients in Manitoba and recent trends leading up to the current client status. The final section provides a glimpse into the future of home care through projections of various home care indicators.

A. Change in Demographics

Canada's population is aging – there is an increasing share of older persons in the population. Statistics Canada reported that in 2015 there were more Canadians aged 65 years and older than children ages 0 to 14 (Statistics Canada, 2015a). That year the growth rate of seniors in Canada was approximately four times the growth rate of the total population. This phenomenon is expected to intensify over the next few decades as the aging of Canada's baby boomers takes place. Statistics Canada estimates in the next 20 years, the proportion of older Canadians should continue to grow and increase the gap with the proportion of Canadians age 14 and younger (Figure I.1).

Figure I.1: Population aged 0 to 14 years and 65 years and older, 1995 to 2035, Canada
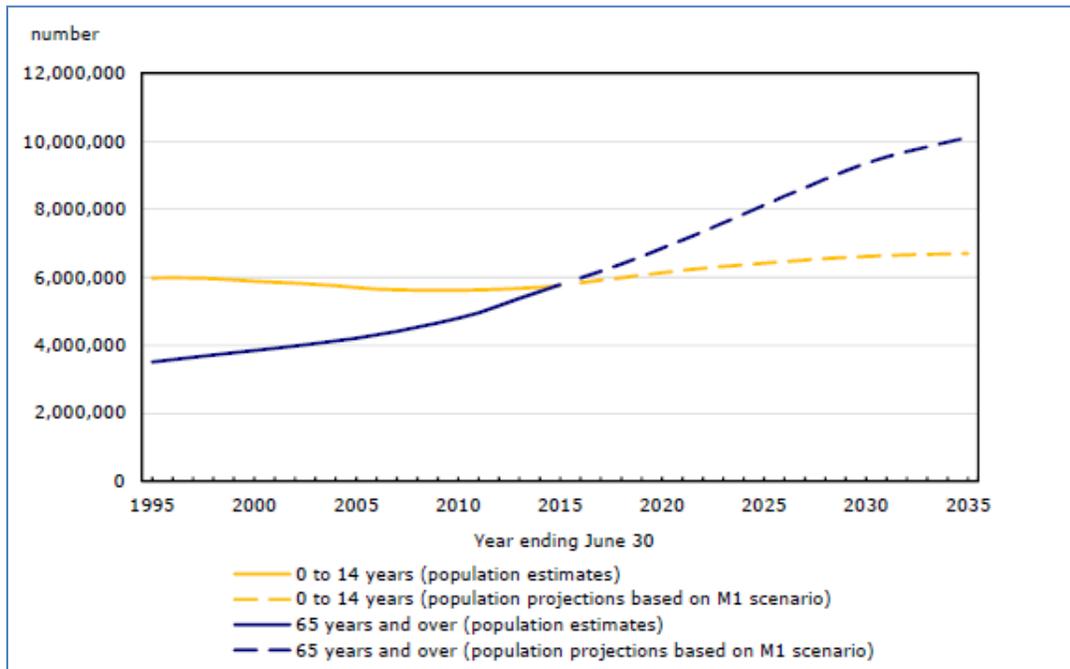
Source: Statistics Canada, 2015a; p. 51

Statistics Canada (2015b) estimates the greatest aging of the country will occur between 2026 and 2045 as the baby boom cohort ages into age 65 and older categories. Based on different scenarios reflective of Canada's historical trends in fertility, life expectancy, and migration rates, Statistics Canada's estimates of the distribution of Canada's projected population, by age group, is provided in Figure I.2.

Figure I.2: Distribution of the total population by age group, observed (1921 to 2013) and projected (2014 to 2063) according to low-growth (L), medium-growth (M1) and high-growth (H) scenarios, Canada
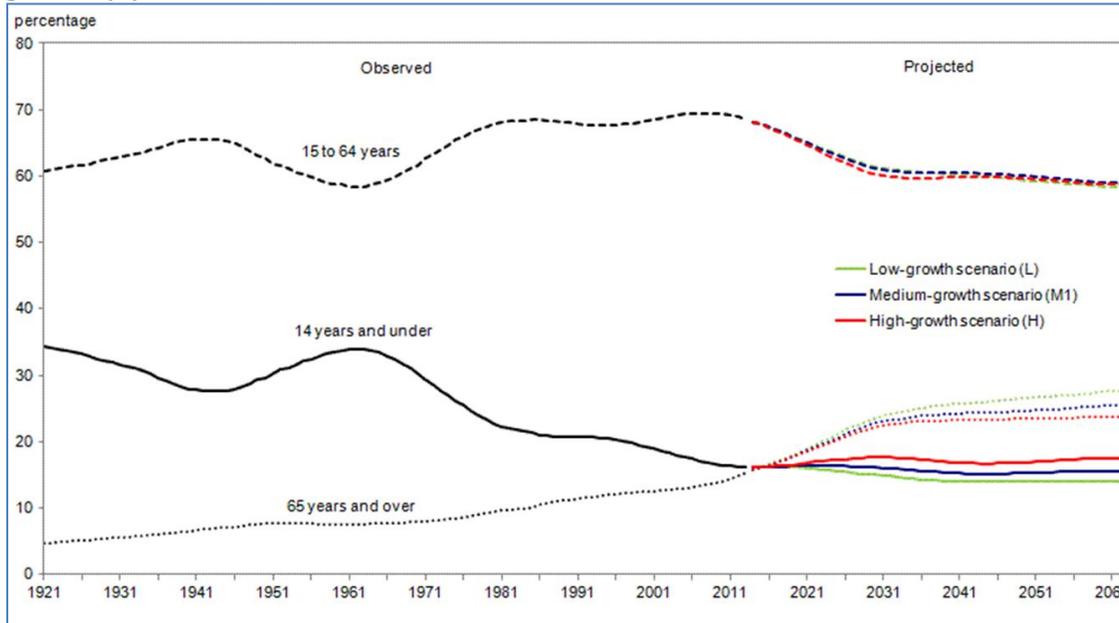
Source: Statistics Canada, 2015b; p. 13

The province of Manitoba is experiencing similar population aging, although not quite at the same rate as the overall Canadian population. Manitoba is on average a younger province than Canada as a whole, but still aging nonetheless. Two recent Manitoba publications highlight this change through examination of population change from decades past to projections of Manitoba's population growth and demographic changes in decades to come. The Manitoba Bureau of Statistics' 2015 report '*Impacts of Demographic Change on Manitoba*' and the 2014 report from Yan and colleagues at the George and Fay Yee Centre for Healthcare Innovation, '*Manitoba Population Projections: 2013-2042*', both reviewed historical trends in Manitoba's fertility, life expectancy, and migration rates to project future demographic scenarios for the province. The projections from both reports point to a future with a significant increase in the number of seniors in the Manitoba population. The examination from the Manitoba Bureau of Statistics (MBS, 2015) projects that Manitobans age 65 and older will nearly double by the year 2038. The greatest increase in numbers will be found among the 75 to 84 age cohort (Figure I.3).

Figure I.3: Population Aged 65 and Over: Select Age Groups
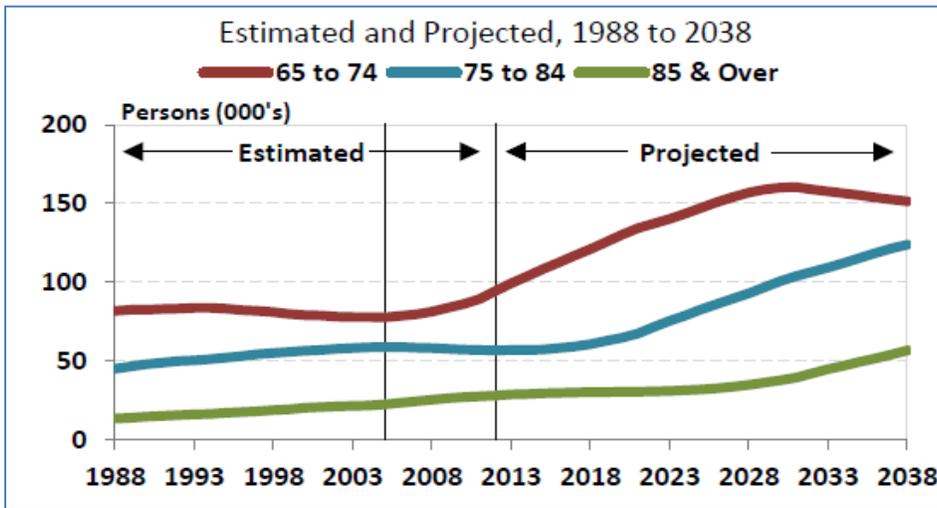
Source: MBS (2015); p. 4

Similar projections were reported by Yan and colleagues (2014). The authors project that the number of seniors will more than double the size found in 2013 by the year 2042, regardless of the scenario investigated.[1]   The overall number of seniors, and the proportion of the population they comprise, will grow substantially and is less influenced by different scenarios (Figure I.4). There seems to be greater certainty about the growth in the number of seniors in Manitoba. Within the next 25 years the older cohort of Manitobans may be equal to or greater than the number in the 0 to 19 age cohort.

Population Aging and Home Care
The projected changes in Manitoba's demographics have implications for Manitoba's healthcare system generally, and home care services in particular. We know that use of health care services increases with age. With age a person's health status declines. The prevalence of chronic conditions increases and co-occurring chronic conditions are experienced at higher rates in seniors. Activity restrictions increase, physical disability increases, and cognitive impairment increases. The primarily chronic conditions experienced with older age are often not curable and instead require long-term support and care. As such, demands for home care related services increase with age (Chappell, 2011).

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[1] The authors projected population changes based on low (L), medium (M), or high (H) assumptions about fertility, life expectancy, and migration rates.

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Figure I.4: Observed (1990-2012) and Projected (2013-2042) Population of Manitoba by Age Group for Three Projection Scenarios
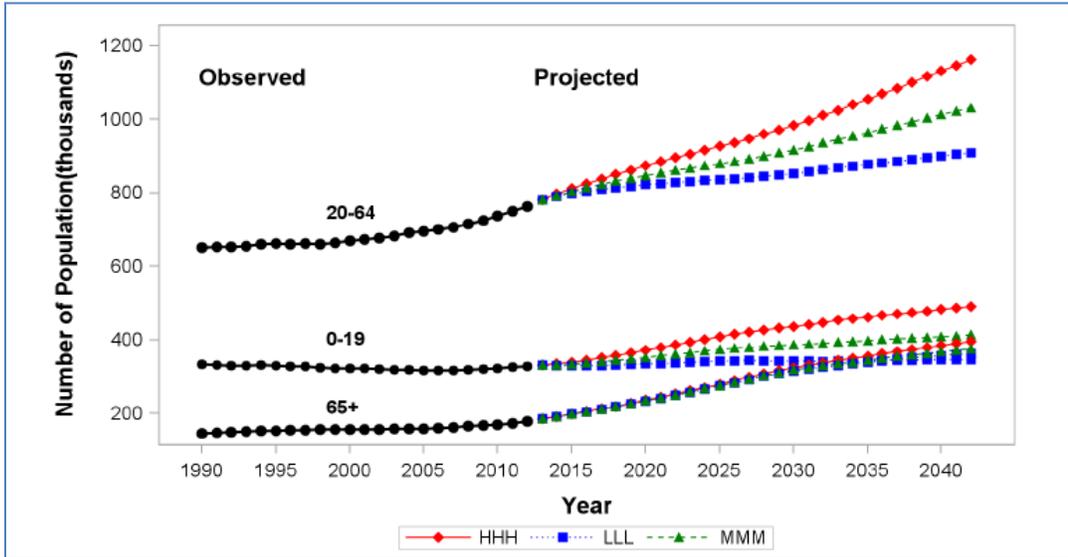
Source: Yan et al., 2014; p.19

Manitoba's senior population's reliance on home care is evident in Tables I.1 and I.2. Home care admission statistics provided by the Department demonstrate that the population aged 65 and older represents the vast majority of clients admitted to the service in Manitoba between 2008/09 and 2012/13 (Table I.1). Based on a 5-year average of admissions, utilization is greatest from age 75 onwards with over half of home care admissions in the province being comprised of that age group. Each Regional Health Authority in the province has the largest proportion of home care admissions coming from the seniors in their region.

The age-related admission patterns translate into seniors being the largest users of home care service throughout the year. The Winnipeg Regional Health Authority (WRHA) home care program reviewed intake, community assessment, and community service data for 2015 and found over 20,000 different individuals accessed the service. Over three-quarters of these clients were age 65 or older (76%), with a full 61% of the clients being age 75 or older (Table I.2). Given seniors' utilization of home care services, the changing demographics and aging of the population that Manitoba will face in the next few decades does indicate there will be an increased need for formal home care support. The utilization of the service may be heightened further by other factors, such as potential less availability of family caregivers due to lower fertility rates or seniors' increasing demand for care options in the community so they can age in place. Some of these factors are placing current and possible future pressure on home care and are explored in other sections in this report.

Table I.1: Manitoba Regional Statistical Home Care Admissions Summary: 5-Year Average (2008/09 – 2012/13)

Region	# Clients Age ≤ 18 (% of total)	# Clients Age 19-44 (% of total)	# Clients Age 45-64 (% of total)	# Clients Age 65-74 (% of total)	# Clients Age 75+ (% of total)	Total Average # Admissions
Interlake-Eastern RHA (IERHA)	25 (2%)	105 (7%)	321 (22%)	300 (21%)	709 (49%)	1,461
Northern RHA (NRHA)	11 (3%)	55 (15%)	116 (31%)	85 (22%)	111 (29%)	378
Prairie Mountain Health (PMH)	28 (1%)	142 (5%)	440 (16%)	449 (16%)	1,769 (63%)	2,828
Southern Health (SHSS)	34 (3%)	78 (7%)	206 (17%)	218 (18%)	642 (54%)	1,179
Winnipeg RHA (WRHA)	38 (0.4%)	649 (7%)	1,978 (21%)	1,702 (18%)	5,103 (54%)	9,470
Manitoba	137 (1%)	1,028 (7%)	3,062 (20%)	2,754 (18%)	8,335 (54%)	15,316

Source: Provincial Home Care Regional Statistical Admissions Summary

Table I.2: WRHA Home Care Clients by Age Category, 2015

Age Category	Female	Male	Total # Clients	% of Total Clients
0-19	127	117	244	1%
20-44	653	735	1,388	7%
45-64	1,585	1,667	3,252	16%
65-74	1,702	1,332	3,034	15%
75+	8,083	4,328	12,411	61%
Total	12,150	8,179	20,329	

Source: WRHA Home Care

B. Clinical Developments in Home Care

Just as Manitoba's demographic make-up has been changing, so has the profile and clinical status of the province's home care clients, likely in part to the aging of the population. A good example of client change comes from the WRHA where client status and the changing composition have been tracked by home care for over a decade. Clients in WRHA home care account for over 60% of home care clients in Manitoba and therefore strongly influence the status of home care in the province. For example, as seen in the previous section in Table I.1, the WRHA accounted for 62% of admissions to home care in Manitoba over the five year period examined.

WRHA clinical assessment data collected on all long-stay home care clients were examined for changes in client indicators. All WRHA Home Care clients who are anticipated to need service for greater than 60 days are assessed with the interRAI assessment tool for home care, the RAI-HC (Morris et al., 2002). The tool is a reliable assessment that informs Home Care Case Coordinators about client need and guides care and service planning. Table I.3 identifies the number of long-stay home care clients in Winnipeg assessed with the RAI-HC from 2002 to 2015. These clients represent those individuals who require sustained, long-term care, often due to chronic issues. Their ages range from approximately 16 and upwards, so they are considered an 'adult' long-stay client population.

Table I.3: Number of WRHA Long-Stay Home Care Clients Assessed with RAI-HC, 2002-2015

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Male	2742	3024	3263	3317	3453	3590	3543	3489	3575	3510	3531	3579	3546	3916
Female	6441	6979	7523	7500	7773	7820	7780	7419	7527	7390	7276	7136	6961	7295
Total	9183	10003	10786	10817	11226	11410	11323	10908	11102	10900	10807	10715	10507	11211

The following graphs highlight the changing profile of the adult long-stay home care client population in Winnipeg, based on their RAI-HC data. Figure I.5 reveals that just as the population of Manitoba has been aging over time, so has the population of long-stay home care clients. The average age of clients was 76 years old in 2002 and rose to 79 years old by 2015. Alongside that demographic change is a slight change in the gender composition of home care clients, with the proportion of clients being female dropping over time to a current proportion of 65%.

Figure I.5: Average Age and Percent Female, Long-Stay HC Clients in WRHA, 2002-2015
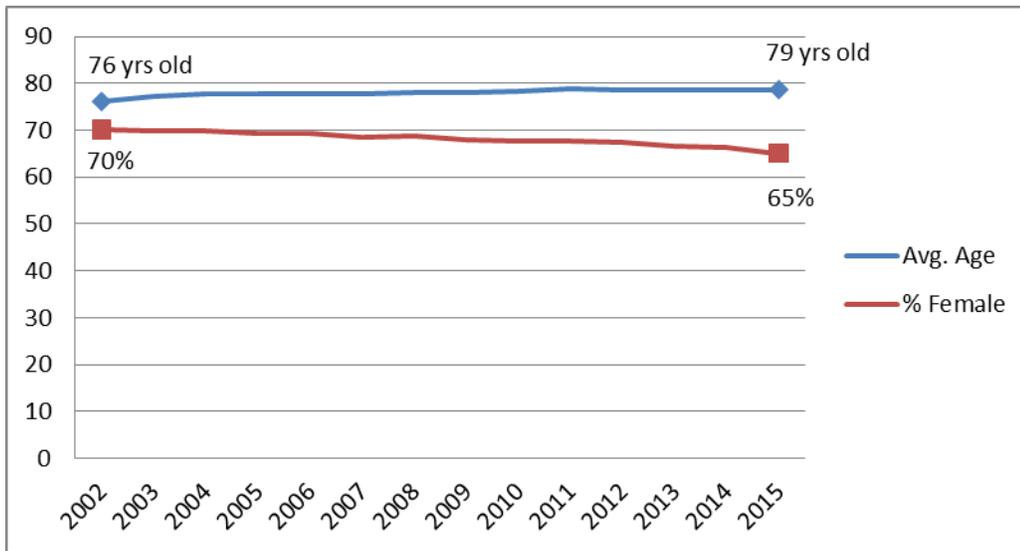
One of the most striking changes in WRHA home care clients is the prevalence of cognitive impairment[2]. Figure I.6 clearly shows a significant increase in cognitive impairment among clients, rising from 26% in 2002 to 42% of long-stay clients having cognitive impairment by 2015. This dramatic increase in cognitive impairment is not driven exclusively by an increase in the prevalence of dementia. Dementia among clients has not risen at the same rate as cognitive impairment in this time period, growing from a prevalence of 16% in 2002 to 20% in 2015 (Figure I.6). It may be that a certain proportion of the current rate of cognitive impairment is due to undiagnosed dementias, but the WRHA Home Care Program does indicate that increases in the prevalence of other neurological conditions and mental health conditions are contributing to that increased rate of cognitive impairment seen today as well.

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[2] Cognitive impairment levels measured on the RAI-HC during clinical assessment; Figure I.6 depicts the prevalence of cognitive impairment that ranges from mild to very severe.

Figure I.6: Prevalence of Cognitive Impairment and Dementia, Long-Stay HC Clients in WRHA, 2002-2015
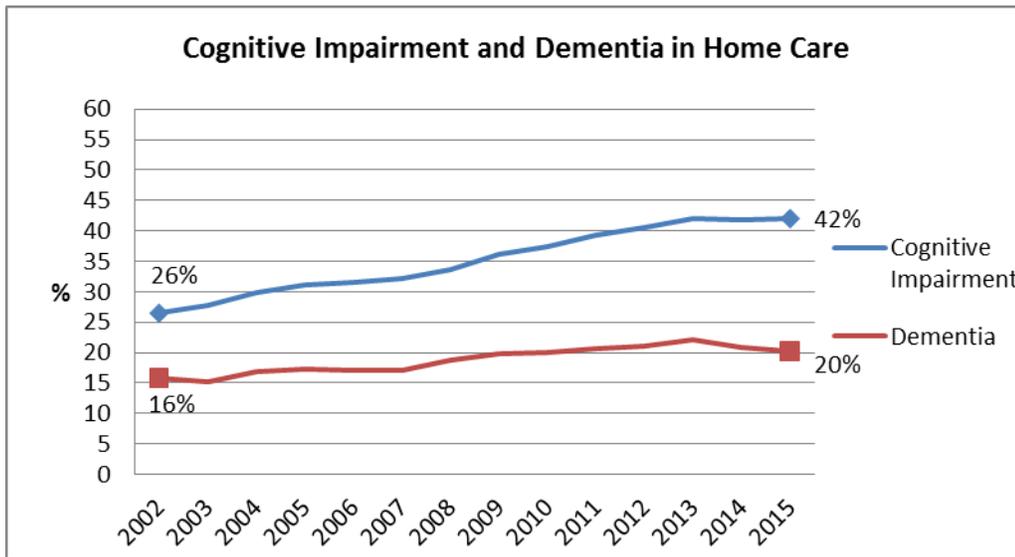
The increase over time in the prevalence of psychiatric diagnoses among long-stay clients is presented in Figure I.7. The rate has nearly doubled in 14 years, growing from 12% in 2002 to 22% by 2015. Depression is not the condition contributing to this trend since its prevalence among WRHA Home Care clients has remained relatively unchanged at 9% in this period (Figure I.7).

Figure I.7: Prevalence of Psychiatric Diagnosis, Long-Stay HC Clients in WRHA, 2002-2015
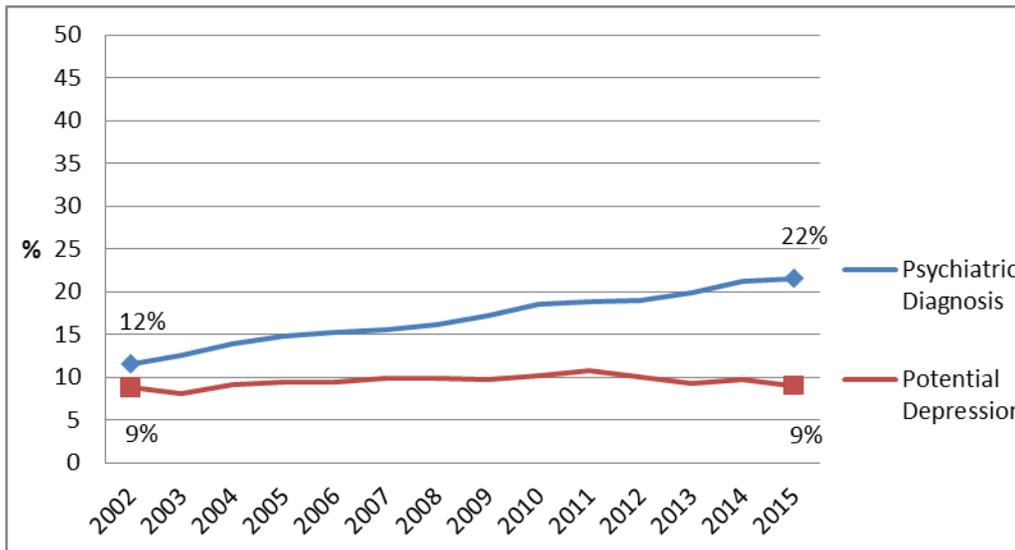
Similar to depression, some other chronic diseases were found to be quite stable in their prevalence over time. For example, stroke, congestive heart failure (CHF), coronary artery disease (CAD), and chronic obstructive pulmonary disease (COPD) are depicted in Figure I.8. All four diagnoses ranged between a prevalence of 15% to 17% in 2002; the range changed to 13% to 19%

by 2015. The rate of COPD had the greatest change, increasing from 15% to 19% over time. CAD also increased, but seems to be declining and is currently at 16% (up from 15% in 2002). CHF has declined as well, decreasing from 15% in 2002 to 13% in 2015. Prevalence of stroke however remains fairly stable around 17% throughout.

Figure I.8: Prevalence of Certain Diagnoses, Long-Stay HC Clients in WRHA, 2002-2015
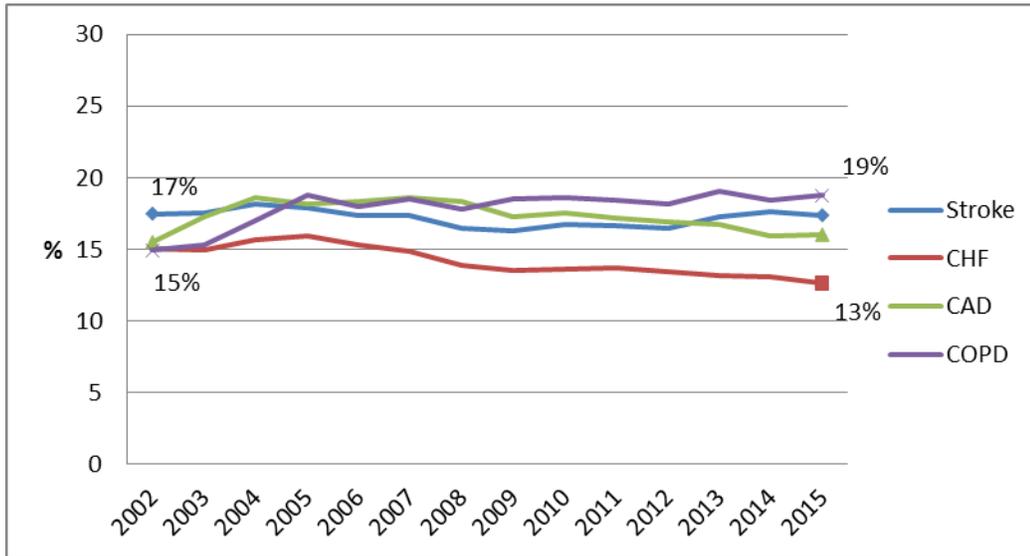
Even though certain chronic diseases did not change considerably in their prevalence over time, the presence of multi-morbidity – the co-occurrence of two or more chronic medical conditions in a client – is now prevalent at a higher rate among clients. Based on the number of diseases assessed as present with clients in their clinical RAI-HC assessments, a count of disorders per client can be obtained. Nearly all long-stay clients have the co-occurrence of two chronic conditions, but as Figure I.9 reveals, the prevalence of multiple conditions among clients is rising. The proportion of long-stay home care clients in the WRHA with five or more disease diagnoses rose from 49% in 2002 to 57% in 2015. Home care clients are dealing with multiple disease conditions at once, increasingly so, and this has implications on clients' functioning and care needs.

Not surprisingly the proportion of clients requiring assistance with their Activities of Daily Living (ADLs; e.g., dressing, bathing, eating, toileting) has risen over time, and at a rate that is very similar to the pattern seen for the prevalence of 5+ diseases (Figure I.9). The proportion of long-stay home care clients in the WRHA who require hands on assistance with their ADLs rose from 20% in 2002 to 26% by 2015. A client's increased need for support with these daily self-care activities can increase the demands on both the informal and formal care network.

Figure I.9: Prevalence of 5+ Disease Diagnoses and ADL Impairment, Long-Stay HC Clients in WRHA, 2002-2015
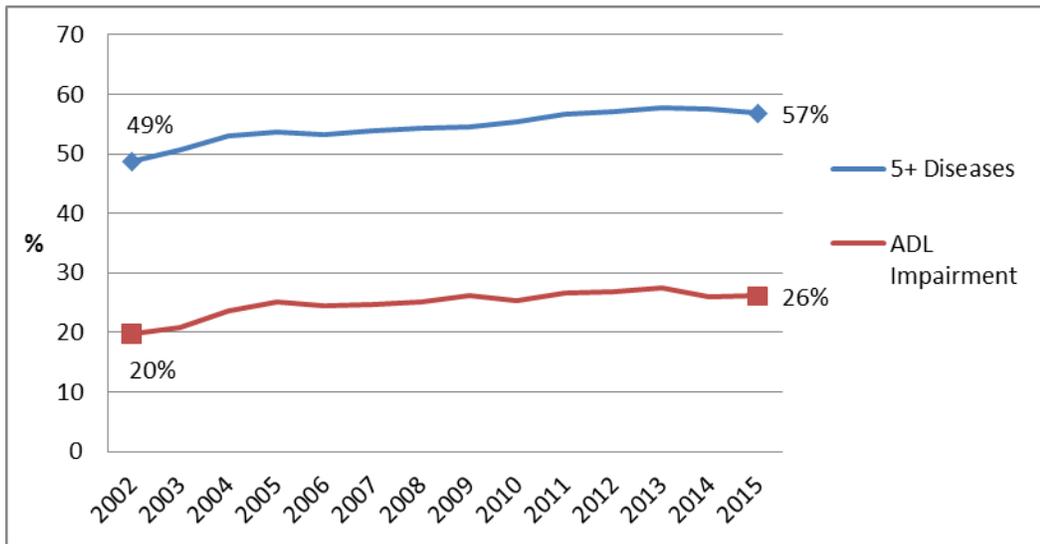
The changes over time in the WRHA's Home Care clients' clinical profile have resulted in a significant increase in overall client complexity and care needs.   Figure I.10 provides a view of this change in clients based on two key indicators:

1) Clients who are screened as high or very high (scores of 4 & 5) on the MAPLe algorithm (Method for Assigning Priority Levels (Hirdes et al., 2008)); a client's MAPLe score can be used to prioritize clients needing community- or facility-based services and to help plan allocation of resources. Clients who are screened as high or very high on the MAPLe algorithm are at the greater priority levels and are at higher risk for adverse outcomes. These clients are more likely to be admitted to a long-term care facility and their caregivers are at greater risk for stress;

2) Clients' at risk for institutionalization in a long-term care facility, identified from the risk indicators identified in RAI-HC assessments.

Over the past 14 years, the proportion of long-stay home care clients in the WRHA who are high/very high in priority for care based on the MAPLe score has steadily and significantly increased, rising from 27% of clients in 2002 to 36% of clients in 2015. A nearly identical prevalence and increase in the proportion of home care clients who are at risk to be placed in long-term care was found over the same time period (Figure I.10). Currently over one-third of clients have greater and more complex care needs that place them at greatest need for community care and even at risk for needing to be cared for in a residential setting.

Figure I.10: Prevalence of High/Very High MAPLe Scores and Risk for Institutionalization, Long-Stay HC Clients in WRHA, 2002-2015
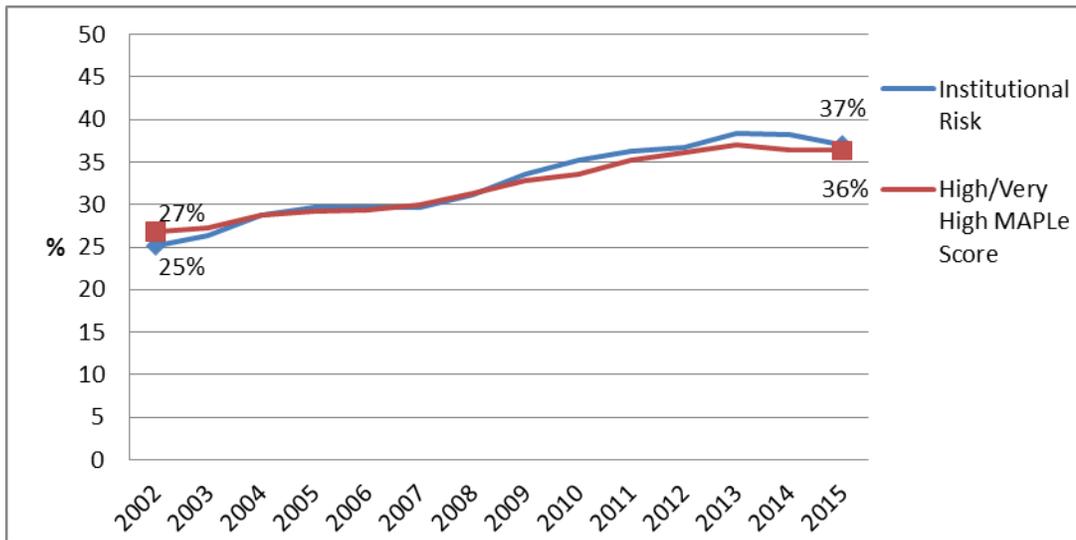
With the change over time in the clinical make-up of home care clients, not surprisingly there is a change in the informal caregivers as well. The prevalence of caregiver distress has increased, most notably among caregivers who live with the clients. Shown in Figure I.11, the rate of distress for caregivers who live with the client rose from 22% in 2002 to 26% in 2015.

Figure I.11: Prevalence of Caregiver (CG) Distress, by Live-In Status with Client, WRHA 2002-2015
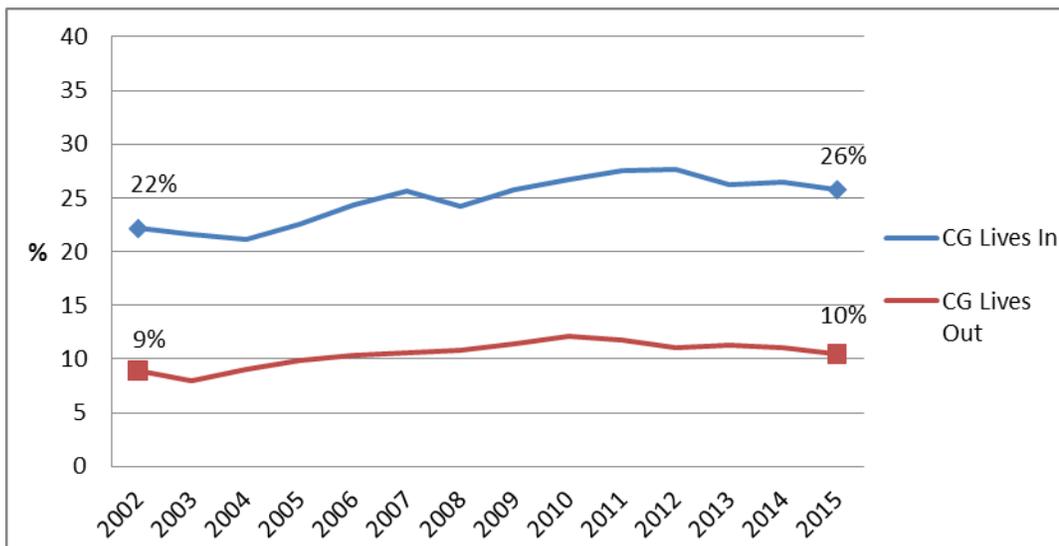
The review of the clinical profile of home care clients in Manitoba's largest health region identifies that clients in Winnipeg have changed significantly in a 14-year period in several key areas. It is likely that similar client change is being experienced in the other Manitoba regions as well. The overall result is that clients in home care today present with higher rates of cognitive impairment,

physical impairment, mental health issues, multimorbidities and care needs, which subsequently puts them at greater risk for institutional placement and their caregivers at greater risk for distress.

These clinical developments increase the pressure on home care, and point to areas where increased resources and support for staff may be needed, such as education to better manage and care for clients with cognitive and mental health needs, or education to clients and caregivers for management of chronic disease and increased caregiver support. The clinical changes experienced by home care clients also have implications for home care in the future. The next section of the report examines some of those potential scenarios as Manitoba's population continues to age.

C. Home Care Projections

The previous sections of the report identified that Manitoba's demographic composition has changed, and that home care clients have changed as well. Considering the population projections displayed for Manitoba, what may the future of home care service provision look like? To examine this question, this section of the report combines home care data with population projections to make projections specific to home care and to examine what home care demand may be like in the coming decades. It is vitally important to appreciate what the future may hold for home care in Manitoba so that appropriate policies and programs can be developed.

The following home care projections serve to offer insight into future home care scenarios; they are in no way meant to accurately predict the future of home care but instead provide illustration of a possible future with the service based on what is currently known in the province. As such, the projections reported here should be considered as indicators of likely future home care demands and expenditures if home care policies are unchanged and the drivers of demand remain unchanged, i.e., if current status quo in home care is maintained. In this manner, such projections can provide understanding into how to prepare for possibilities, as well as what may need to be done to shift towards a more preferable future for home care.

Projection Methods

Various forms of home care prevalence data were combined with the Manitoba population projections produced by Yan and colleagues (2014). Specifically, to project the various home care indicators, age- and sex-specific rates in the home care data were multiplied by the age- and sex-specific population projections produced for Manitoba. Sensitivity analysis was conducted by varying the population projections available (low-growth scenarios, medium-growth scenarios, and high-growth scenarios) with home care data. The projections provided in this report are based on medium-growth population projections only since the low-growth and high-growth scenarios did not yield drastically different results due to similar projections for older adults (the primary consumers of home care services) regardless of the scenario (see Figure I.4). Moreover, the Manitoba Bureau of Statistics (2015) also assumed in their report that a medium-growth scenario was most likely to occur for Manitoba.

The most recent year of home care data available for the various indicators were used to form the prevalence cohort and to identify the home care rates to project into the future. Given the projections are for illustrative purposes only, no other home care scenarios were tested for the projections. Projections are provided up until 2037, two decades from now, which is a realistic time period to be observing and planning for. As well, the entire baby boom cohort will be in their seventies at that point, which is when need for and demands on home care generally increase.

Projected Home Care Admissions and Number of Clients

Table I.1 previously shown provided the average number of home care admissions, by age group, in Manitoba from 2008/09 to 2012/13. Using those age-specific figures and projecting forward with the Manitoba population projections, a future picture of home care admissions in the province is provided in Figure I.12. The average number of home care admissions per year for all ages in Manitoba between 2008/09 to 2012/13 was 15,572 admissions. If age-specific admission rates remain unchanged, by 2037 the projected number of home care admissions per year is 28,778, due to the large increase in seniors expected in the Manitoba population in 20 years. Nearly double the number of admissions to home care is projected if the current admission practice is maintained in the future. All of the regions in Manitoba are projected to increase in the number of home care admissions over the next 20 years. Based on a year-over-year percent change calculation, the projected Manitoba increases range from 2%-3% per year, with an average increase over the years of 2.6%. This is higher than the projected annual population growth rate of 1.2% for Manitoba reported by Yan and colleagues (2014), since home care's growth is mainly due to population aging. Based on a linear calculation (the total percentage growth for the period divided by the number of years – 84.8 % divided by 24 years), the projected Manitoba yearly increase is equivalent to 3.5 percent. In the two approaches to the calculation the final result is the same.

Figure I.12: Number of Home Care Admissions in Manitoba and Regions, Projected for 2016-2037
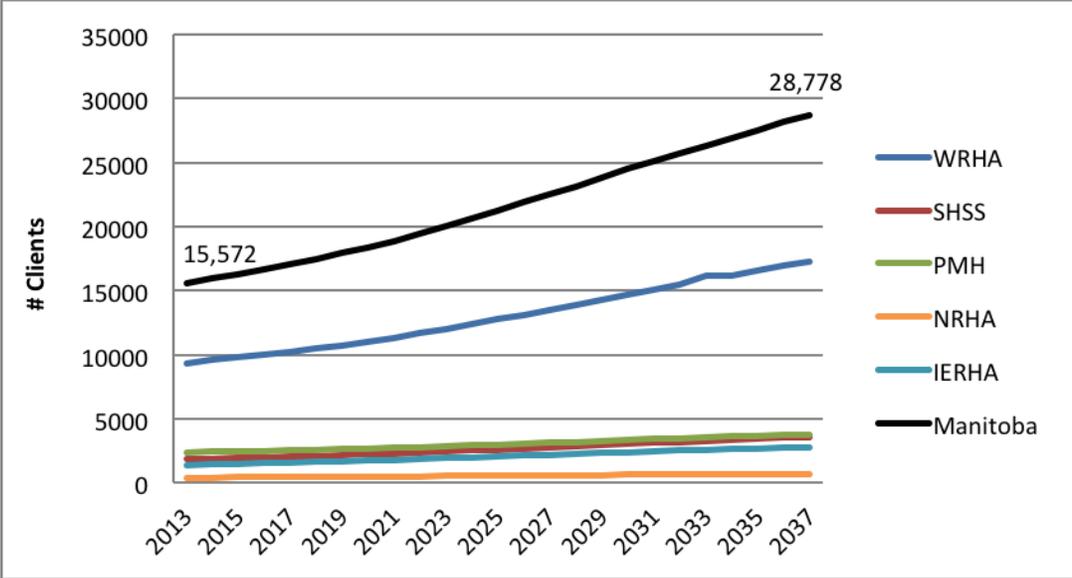
Along with projected increases in admissions, the total number of clients receiving home care service per year is projected to increase significantly as a result as well. An example is provided by data from the Health Regions, where age- and sex-specific client counts are available. Based on intake, assessment, and home care service data for 2015, the total number of home care clients for all ages was 38,246. With that baseline number and projecting the sex and age groupings forward with the population projections, Manitoba is projected to have 68,465 clients by 2037 (Figure I.13), a similar near doubling result as was found for admissions in Manitoba.

Figure I.13: Number of Home Care Clients in Manitoba and Regions, Projected for 2016-2037
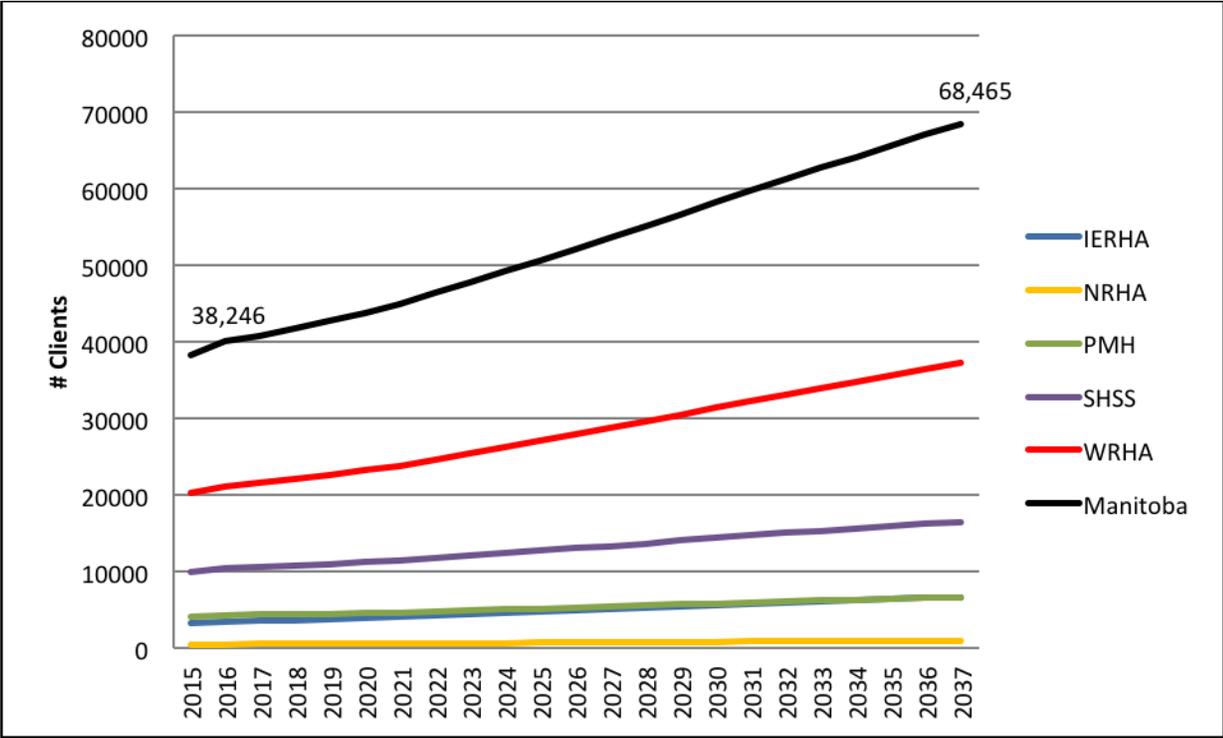
Projected Home Care Client Characteristics

With the significant projected increase in home care client admissions and total number of clients requiring service, what will be the impact on the clinical characteristics of clients in 20 years? The WRHA clinical assessment data in Winnipeg for clients collected with the RAI-HC tool provided the best source of information for such projections. The WRHA RAI-HC long-stay client characteristics presented in the Section IB, *Clinical Developments in Home Care,* were combined with WRHA's population projections. RAI-HC client clinical data from the 2015 year were utilized, and since the assessment data is sparser for younger age groups, the projections focused on a long-stay adult population age 20 and older. For illustrative purposes, three key client characteristic indicators are projected in this section.

Projections for the number of WRHA long-stay adult home care clients with cognitive impairment are displayed in Figure I.14. In 2015 there were 4707 clients, age 20 and older, who had cognitive

impairment. Projections estimate that 9,265 adult long-stay clients will have cognitive impairment by 2037, a 97% increase from 2015.

Figure I.14: Number of WRHA Clients with Cognitive Impairment, Age 20+, Projected for 2016-2037
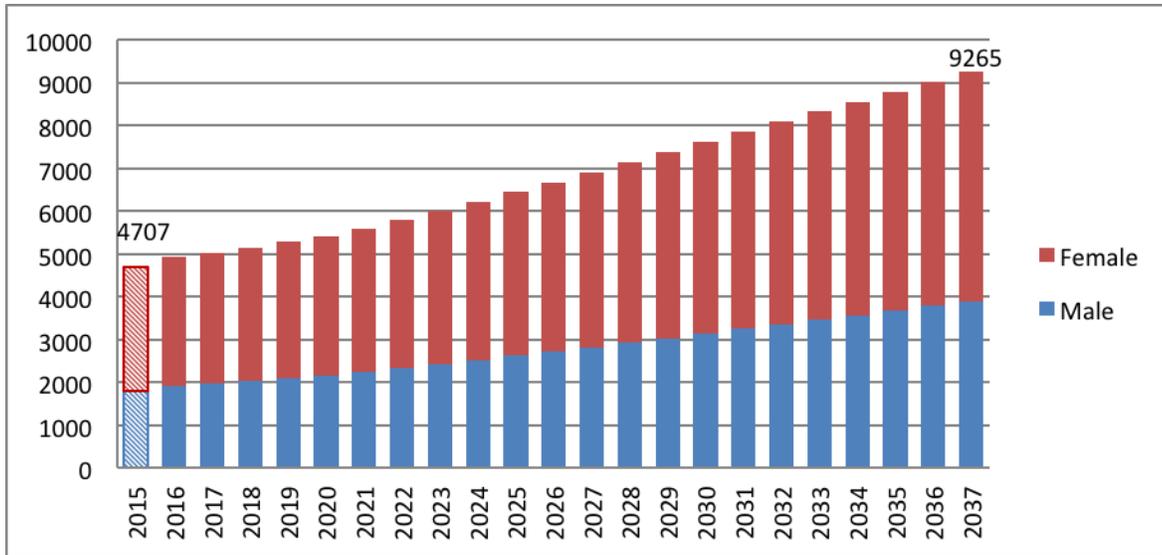
A slightly lower increase is projected when it comes to clients with ADL impairment who require hands on assistance with those activities. In 2015 2,292 adult long-stay clients in Winnipeg were assessed as needing ADL assistance. This could increase to 5,568 clients by 2037, a 91% increase (Figure I.15).

A similar increase is projected for WRHA adult long-stay home care clients who are high/very high in priority for care (RAI-HC MAPLe scores = 4 or 5). In 2015, 4,071 adult clients were assessed at these higher priorities for care and at greater risk for adverse outcomes, such as institutionalization. Projections place the number of clients at 7,932 by 2037, a 95% increase (Figure I.16).

Figure I.15: Number of WRHA Clients with ADL Impairment, Age 20+, Projected for 2016-2037
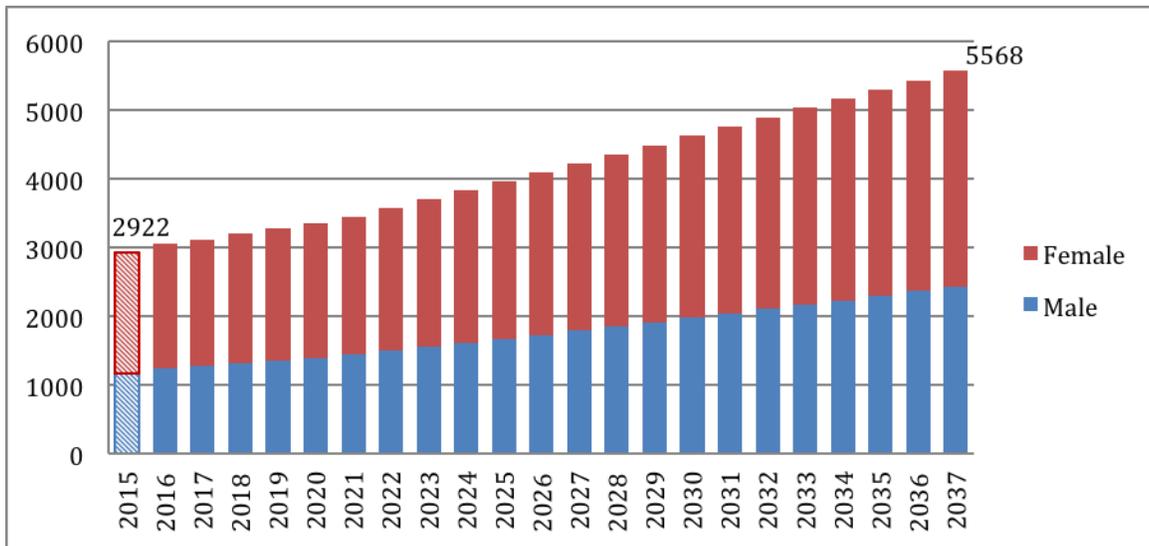
Figure I.16: Number of WRHA Clients in High/Very High Care Priorities, Age 20+, Projected for 2016-2037
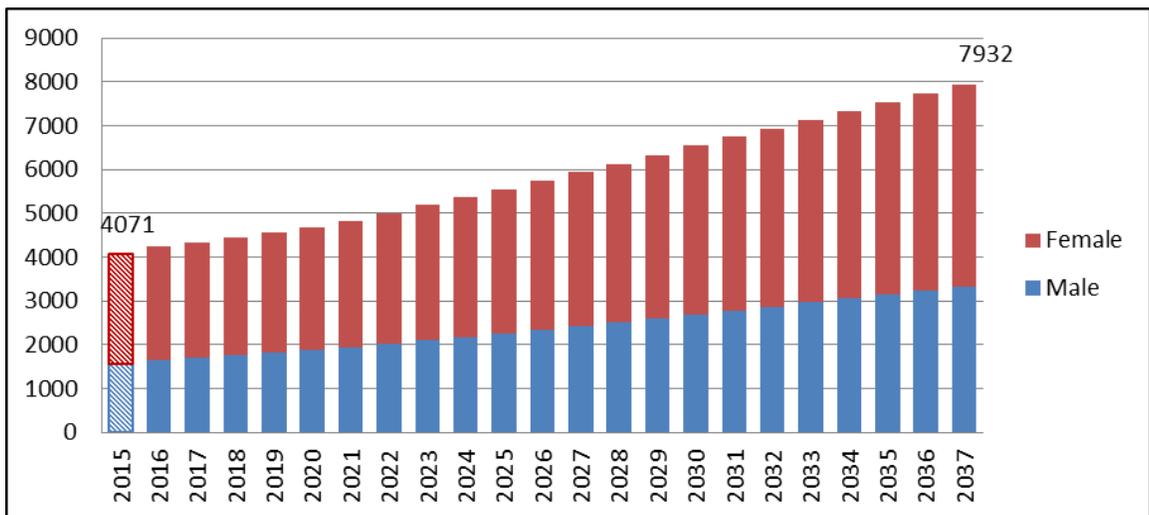
As the number of clients is projected to increase over time, the proportion of clients with complex care needs is estimated to increase at a similar rate. The projected characteristics of adult long-stay home care clients in Winnipeg display the potential magnitude of client care needs in the future, if current client characteristics continue similarly into the coming decades.

Projected Home Care Service Hours

As would be expected, home care service provision in the future will be affected similarly by population aging as have the other home care indicators. To examine this aspect of home care, provincial data on home support type services was reviewed. In Manitoba, all Health Regions use an electronic scheduling system for Health Care Aides/Home Care Attendants (HCAs) and Home

Support Workers (HSWs) providing service to home care clients. The majority of home care service hours are supportive services provided by HCAs/HSWs (e.g., for assistance with Activities of Daily Living or Instrumental Activities of Daily Living). For this report, the HCA/HSW scheduled service hours in Manitoba were reviewed for the 2015 calendar year. In 2015, Manitoba Home Care Programs' scheduled services amounted to 4,720,467 hours.

For projections, Manitoba's home support service hours for 2015 were categorized into age- and sex-specific rates and were carried forward into the year 2037 based on the Manitoba population projections (Yan et al., 2014). The projected total home care hours in Manitoba by 2037 are illustrated in Figure I.17. Based on anticipated population changes, an 80% increase in overall home care service hours is projected for the province, with hours increasing from 4,720,467 hours in 2015 to a projected 8,502,774 hours by 2037. The figure clearly identifies that projected increase in hours is mainly due to projected population increases in the 75 years and older age group in the province.

Figure I.17: Home Care HCA/HSW Service Hours in Manitoba, Projected for 2016-2037
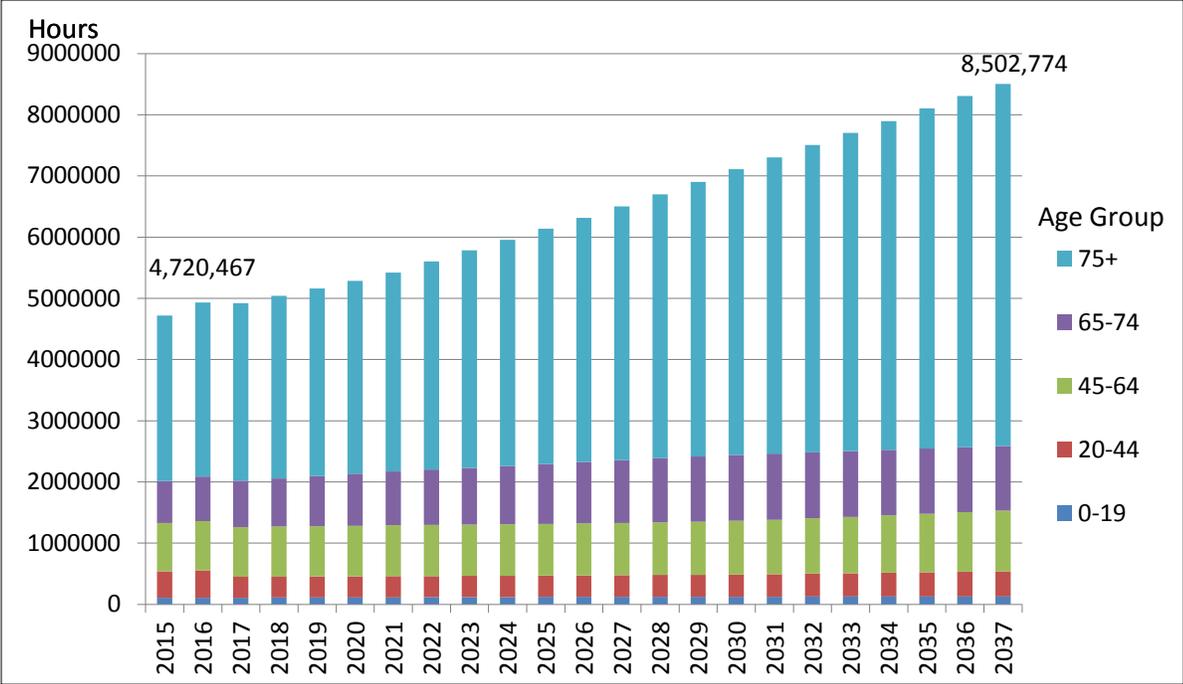
The other main category of service provision in home care is nursing. Province-wide data on scheduled nursing services were not available, but such data were available in the WRHA. Table I.4 provides an overview of the scheduled home care service hours in the WRHA for 2015. The vast majority of hours (86%) were for supportive services provided by HCAs/HSWs, followed by nursing services. The potential impact of the WRHA population projections on nursing services is displayed in Figure I.18. Nursing service is projected to increase in the WRHA from 492,209 hours in 2015 to 848,068 hours in 2037, a 72% increase.

Table I.4: WRHA Home Care Service Hours, 2015[3]

Service	Hours
HCA/HSW	3,046,847
Nursing	492,209
Respiratory Therapists	2023
Stroke Care Services	15,768
Total Hours	3,556,847 (for 19,539 clients)

Figure I.18: Home Care Nursing Hours in WRHA, by Age Group, Projected for 2016-2037

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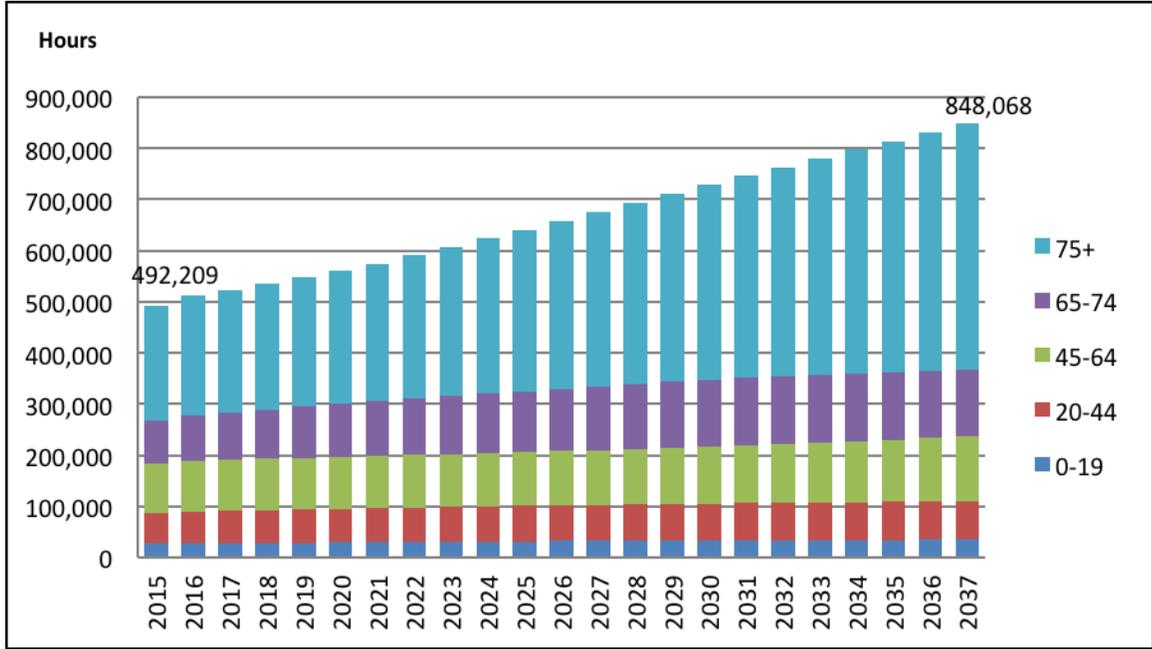
[3] Not included in the service hours are the clients and the amount of scheduled time for clients in the Self/Family-Managed Care Program and clients in Specialty Programs.

D. Summary

Manitoba's population is aging and is expected to continue to age for the next few decades. This phenomenon has considerable implications for home care. Already home care populations are themselves aging, and becoming more frail and complex as was demonstrated within the WRHA Home Care Program. The demographic composition in coming decades indicates potential changes and challenges for home care that must be faced. If projections hold true, home care services in Manitoba will essentially have to double their efforts within 20 years to service the increased number of admissions and clients cared for throughout the year, case manage the clients' complexity, and provide the required service needs of the clients. Consideration needs to be given to what is required to meet those demands, or conversely, to prevent such future scenarios.

Moreover, the projections produced for this report were based only on the most recent snapshot of client data available in Manitoba and the WRHA. Potential future increases in rates of client complexity, care needs, and service needs based on recent trends observed in the province were not considered for the projections; therefore any further increases in the rates of any of the home care indicators presented beyond current rates will result in higher projections for home care in the future and increased demand on the service.

Regardless of other factors that may have an impact on home care service needs in the future, it is evident the number of seniors who will need such formal support will increase in the coming 20 to 25 years. This phenomenon dictates a need to examine multiple aspects of home care service, which are discussed in the other sections of this report, and to consider the planning and policy implications of such potential change.

II. CONSULATION AND DATA FINDINGS

Before proceeding to the next section on Programs and Service Delivery it is important to have a clear picture of what was learned from the intensive consultation process and from the examination of the available statistics and data. This approach combines both the insights gained from experience and the analysis provided by the statistics and the data. One without the other is incomplete. The statistics and data in this section do not duplicate the information/data provided in the previous section on Demographic and Clinical Changes. This section provides provincial statistics and data while the previous section generally provides WRHA specific information. Combining the information in the two sections provides a more complete picture of the provincial home care services and the characteristics of the home care clientele.

A. What was Learned from the Consultation Process

As already mentioned in the methodology section, the consultation process involved interactive conversations with all levels of home care personnel, clients/caregivers and stakeholders as well as an online opportunity for public input. The consultation process was very important in defining the current state, identifying current issues and challenges and obtaining input on the future of the home care.

A relevant observation at this point is how similar the responses were even though they came from different perspectives or vantage points. It can be safely stated there was considerable agreement on the strengths and benefits of the current service, on the issues and challenges faced by home care and on what home care will/should look like in the future. In the interests of managing the length of this report comments/observations will not be entered more than once unless they add something specific to the viewpoint of a particular group.

Consultation with Home Care Personnel

The meetings with staff were typically lively meetings with many, if not most, staff participating in the discussion. The Consultant found this input very helpful in understanding the current program and in shaping his thinking on the future of the program. These discussions were framed around the following three broad questions: What is working well in home care? What are the current challenges/issues in home care? What will/should home care services look like in the future? Frequently the discussion centered on more than one question at a time. The following summary combines the comments received from the different levels of staff in their separate meetings (see Methodology). What follows is a summary of the responses to each of the questions.

What is working well in home care?
- Home care allows clients to remain at home, promotes independence, facilitates client choice and decision-making, improves quality of life and makes for happier individuals;
- Takes pressure off the hospitals and personal care homes by facilitating earlier discharge from hospital and delaying entry to PCHs/Support Housing;

- Home care, by its presence, provides support to family members and friends and increases peace of mind;
- Self and Family Managed Care great for client/family and provides more flexibility and maximizes client/family decision-making;
- Worker is able to build relationship with client – human touch
- Task delegation supports the providing of better care and increases the range of tasks that can be performed by the HCAs;
- Clients have a voice in determining what they need and are full participants in developing the care plan;
- Home care offers strong support for young adults with a physical disability;
- Availability of a culturally diverse workforce able to serve a growing number of culturally diverse clients;
- Home care is able to respond to a wide range of client needs;
- Home care is publicly funded;
- A strong and capable workforce that, in general, enjoy their work.

What are the current challenges/issues in home care?
- Client and family expectations of the program continue to increase;
- Lack of understanding that the program is supplemental;
- Frequent lack of family and informal caregiver resources;
- Lack of understanding of what is included in light housekeeping services;
- Insufficient human resources (HR);
- Managed care not being offered to clients;
- Continued increase in the complexity and acuity of cases including an increase in cases of dementia and clients with mental health issues;
- Not enough training for direct service staff in mental health issues and dementia;
- Home care becoming more health/medical focussed and moving away from client care to more time spent on paperwork;
- Difficulty in providing services in remote areas;
- Lack of consistency in how the home care is being applied;
- Lack of sufficient ICT resources;
- Difficulty in getting in contact with staff after hours;
- Process for delegating tasks from the Direct Service Nurse to HCA very complex and time consuming;
- Early hospital discharge of clients without proper care plans in place;
- Increasing cultural and language issues;
- Continuing EFT related issues – program increasingly task driven, insufficient time allocated to complete the scheduled task, scheduling doesn't allow for travel time and lack of continuity in the provision of the service – too many workers providing care.

What will/should home care look like in the future?
- Complexity and acuity of cases will continue to increase;
- Continued increase in number of clients with mental health issues, dementia and chronic illnesses;

- Baby boomers will have higher expectations of the service and greater access to personal information;
- Continued risk home care services will continue in a "medical direction";
- More use of technology e.g. tablets replacing paper work;
- Increase in the use of delegated tasks;
- Families and informal caregivers less available to provide care;
- More respite required for family/informal caregivers;
- More client cultural diversity with accompanying impact on the home care direct service providers;
- More younger clients where parents can no longer provide care;
- Medical therapies will help people to live longer but not cure them – increase in fragility and co-morbidity;
- Increase in the range of housing options for seniors with continued expectation of home care to provide care services;
- More use of clinics and mobile units to provide care to more clients;
- HCAs will continue to provide most of the care and will be certified;
- Hospitals will keep pushing for shorter hospital stays with accompanying expectation of home care to facilitate discharge;
- Access to PCH beds will become more difficult with the expectation that home care will pick up the slack;
- More skill training will be required for front line staff e.g. in regard to dementia, mental health issues etc.;
- Continued increase in the number of palliative care clients;
- Aging workforce will require more succession planning;

Consultation with Clients/Caregivers

In each of the four rural regions the Consultant met with small groups of caregivers and clients. In Winnipeg there was a meeting with the WRHA Home Care Advisory Council, which includes in its membership clients, family members and concerned citizens.

While the same three questions were introduced the discussion tended to centre on the specific home care experience of the client and/or caregiver. Most of the participants indicated they had had a positive experience with home care. Included were such statements as: "had excellent workers looking after our loved ones," "my caregiver has a quality of life that he wouldn't otherwise have without the program," respite services provided were "really appreciated." Others stated Self and Family Managed Care operates successfully to keep clients in the home instead of a facility, without home care, clients would not have quality of life, allows aging in place, and many other similar comments.

There were also comments on what was not working in home care. These comments included: lack of staff, newly hired staff are not trained well enough, inconsistent care – different staff coming into the home, lack of communication of clients concerns from workers to RCs, scheduling staff not considering time required to travel from one appointment to another, "somewhere along

the line the humanity has gone out of home care," not enough time assigned to the tasks, "we didn't realize there was housekeeping/laundry service that we could access."

There were also observations made about the future of home care. Comments included: household maintenance should be provided across the province, caregivers should receive more services/resources, home care will need to be a guaranteed service, all HCAs should be certified, better communication between clients, DSWs and CC/RC, standardized services across the province, better training opportunities for all staff.

Consultation with Stakeholders

More than twenty meetings/interviews were held with stakeholder groups, agencies or committees. This included a broad representation of different entities representing varied perspectives: physically disabled community, cognitively impaired, intellectually disabled, unions, housing, palliative care, advisory bodies, long term care and others.

Typically these meetings centered on the specific interests of the various groups. Their comments and perspectives will be woven into different parts of the report. Where the comments were more general they expressed thoughts that had come up in meetings with staff and clients/caregivers.

Public Consultation

Over a period of a few months approximately 300 responses were submitted to the Department online survey established to invite public feedback on the home care services including any suggestions the respondents might have for the future of the service. Comments were received from clients, families and informal caregivers, stakeholders, home care personnel and the general public. The comments and observations received through this online process were very similar to the comments heard by the Consultant in the meetings/interviews and group interactions. Clients and family members expressed concerns about the following areas most frequently: workforce and human resource issues, including insufficient home care personnel, communication issues between the client/family and home care services staff, lack of flexibility in carrying out the task consequently unable to attend to other care issues, wait times too long before they receive services, insufficient caregiver supports - more are required, and the need for additional training opportunities for clients/caregivers. The online comments received from home care staff were very similar to the comments received during the interview process.

The input received in this online consultation process should be of ongoing value to the Department in addressing current issues and making home care services as responsive to client/caregiver need as possible.

B. What Statistics and Data tell us about Home Care

The Continuing Care Branch provided the statistics presented in this section. The last year the Department received this information from the RHAs and compiled it in reports was for the fiscal year 2012/13. The Department decided, at that point, to discontinue the former collection system

with the anticipation this information would be systematically available through the new computerized Procura scheduling system. To date this has not happened. The Consultant was informed the information provided might not always be entirely accurate since the RHAs do not always use the same definitions or submit it to the Department in a timely manner. However, it can be considered sufficiently reliable for the limited purpose of this review. The data should be treated with caution when used for any other purpose.

Since 2006/07 home care has served annually approximately 39,000 individuals. In 2012/13, there were approximately 15,500 admissions and approximately 15,700 discharges. The number of admissions and discharges has remained essentially stable for at least the last five years. In 2013/14 an average of 27,246 clients received home care services each month.

In regard to age at admission in 2012/13 the breakdown is as follows:
- 53% = 75+ years of age and
- 20% = 65-74 years of age (total of 73% = 65 years of age or older))
- 19% = 45-64 years of age
- 7% = 19-44 years of age
- 1%<18 years of age.

Of the total number of admissions in 2012/13 59% percent were female and 41 % were male. These numbers have remained essentially the same over the five-year period. Of the total number of clients assessed approximately 10% were deemed ineligible for services. In approximately one-third of the cases, ineligibility was the result of care not being required.

In regard to the source of referrals on a province-wide basis, 55% were hospital referrals, 13% were referrals from family or friends, 10% were referrals by a doctor, 5% were self-referrals and 17% were referred from other sources. Again these percentages have remained essentially the same over the five-year period. It might be noted that between Winnipeg and rural Manitoba there are some fairly significant differences in the source of the referrals. In Winnipeg nearly 64% are referred by the hospital while in the four rural RHAs this varies from 33% to 50%. Similarly, in rural Manitoba 15-20% of the referrals come from family and friends while in Winnipeg only 10% of referrals come from this source. In Winnipeg 8% are referred by a doctor while in rural Manitoba doctor referrals can range from 11% to 16% and in some years even higher.

At the time of home care admission, care level equivalency is assessed for each client.   In the year 2012/13 14% percent of the clients were assessed at PCH level 1, 25% at PCH level 2, 7% at PCH level 3 and 1% at PCH level 4. An additional 8% were assessed acute care level equivalency and 21% were assessed as Hospital Extended Care/Long Term care level equivalency. This reinforces home care's role in maintaining clients with a significantly high level of care in the community.

At the time of home care discharge, the reason for the discharge is recorded. As an example, In 2012/13 approximately 35% of clients were discharged because they had improved/recovered and no longer required home care, 23% were deceased and over 10% had been placed in a PCH. There are differences between the regions. In one region 23% were discharged into a PCH and in another region 40% had improved/recovered.

From 2008/09 to 2011/12 approximately 7.5m (million) units of service were provided annually by professional and non-professional staff including Self and Family Managed Care (one unit = one hour). In 2012/13 this dropped to 6.9m units of service. Home care attendants delivered approximately two-thirds of the service. On a province-wide basis the number of units of service delivered annually to the average client has declined from 390 service units in 2008/09 to 330 service units in 2012/13. The reasons for this decrease are not readily apparent.

III. PROGRAM AND SERVICE DELIVERY

This section will describe the basic areas/elements to be addressed in a future comprehensive plan for home care services. First, the foundational components of the program will be outlined, followed by a description of the different client groups and finally service delivery issues will be addressed.

A. Foundational Components of Future Home Care Services

The three primary components or "building blocks" addressed in this section form the foundation for future home care services. In the case of each of these building blocks there is considerable continuity with the current program. It must be noted in advance there are significant issues that must receive attention if these foundational elements are to be fully compatible with future requirements. Refinements and adaptations will also need to occur on an ongoing basis.

a. Purpose, Objectives and Service Delivery Structure

Following 40 years experience with home care services there is no indication a major change is required in the purpose, objectives and delivery structure of home care. That is not to say, however, there have been no changes or developments in home care since the beginning. As mentioned earlier, these developments include: introduction of Self and Family Managed Care, development of the Palliative Care program, more specialized services, increased respite services, increased emphasis on cognitive impairment and mental health issues, and significant growth in the number of clients, etc.

The following purpose, objectives and service delivery structure should continue as an integral part of the foundation for ongoing service delivery.
* The purpose of home care remains unchanged: to allow people to remain at home for as long as is safely possible and to live as independently as possible;
* The objectives of home care include facilitating hospital discharge and delaying entry into long term care facilities for as long as possible. Home care continues to manage the placement process;
* Home care service is government funded;
* Referrals to home care may come from any source including self referrals;
* Regional case coordinators complete the needs assessment to establish eligibility for service, develop the care plan in cooperation with the client/family and provide ongoing management of cases;
* The care plan outlines the home care services to be received by the client;
* Home care services are provided by professional and non-professional personnel, specifically including home care attendants, home care support workers, direct service nurses and may include therapy services;;
* Resource coordinators frequently supported by scheduling clerks (SC) are responsible for the recruitment, orientation, scheduling, supervision and evaluation of HCAs.

- RHAs have operational responsibility for service delivery including the planning, delivery and ongoing management.

While never explicitly stated, but surely implied, home care services are based on the concept of health equity as it applies to home care services, and not equality. What this simply means is not everyone is entitled to the same, or equal, services. The specific home care services to be provided are based on the level of need as determined by the needs assessment and resulting in the development of a care plan tailored to the specific client. The description of health equity used by the WRHA is "Health equity asserts that all people have the opportunity to reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance. In the future, home care services should make explicit its commitment to the concept of health equity - even though from a client's or family's perspective it is frequently equality they are after – "my neighbour received a particular service and so should I."

This section and the recommendation flowing from it complement/support Recommendations 10, 11 and 15 of the OAG Report. The OAG Report Recommendations focus on the following: review the central intake processes and flag all urgent referrals, ensure that client care plans meet client's assessed needs, state frequency and amount of service, specify reliable back-up plan, and are updated at least annually.

Specific Recommendations

1. Endorse the Foundational Components of the future home care services as outlined in this section: purpose, objectives and service delivery structure, basket of core services, and ongoing role of family and informal caregivers.

b. Core Services

The core basket of services currently being provided by home care is in continuity with those initially established. The current core services as identified by the RHAs in the Regional Scan include: personal care (ADLs), nursing, therapy services, household maintenance, meal preparation, laundry, respite and off-site services. Some of the RHAs indicated while they provided these services, they could not always provide them consistently across the whole region or on weekends. A major reason for this lack of consistency and uniformity was lack of resources – both financial and personnel. It should be noted there is no departmental standardized list of core services. Development of such a list would contribute to the uniformity of services across the province and would allow the Department to more systematically monitor the delivery of these services by the RHAs.

In the consultation process there was considerable discussion regarding the continued provision of light housekeeping as part of the core services. Comments on the inappropriate use of the light housekeeping services were frequently shared in these meetings. Also, concern was expressed home care would not be sustainable in the long term if these services continued to be included. On

occasion, the Consultant felt as if light housekeeping had become a proxy for the discussion of whether or not all homemaker services should continue as an integral part of home care.

There is no reason to believe home care would be more effective in supporting people to remain at home if homemaker services were not available. In fact to the contrary, it is exactly the provision of these kinds of services that frequently allow people to remain in their own home and out of the hospital or personal care home and enjoy a higher quality of life. As an indication of the importance of these services six provinces/territories, but not Manitoba, also provide errands/appoints services as an additional part of homemaking services (Ogilvie, R., et al., 2014), all be it often with a cost to the client.

A further, but related topic of discussion was the difference in the program status of the light housekeeping service between Winnipeg and rural RHAs. In Winnipeg light housekeeping is a formal part of the basket of core services while in rural Manitoba this service is provided on an exception basis. In the North the practice is very similar to Winnipeg. Currently, approximately 60% of provincial clients are receiving this service.

Since two different approaches to the provision of light housekeeping services cannot be beneficial, at least if uniformity of service across the province is an objective, how did this situation develop? The Consultant could not locate any policy statement or correspondence that supported the rural position of only providing this service on an exceptional basis, (although the Department at least accepted, if not formally approved, both approaches to providing these services).The Department policy *207.16 Household Maintenance and Laundry Service* describes household maintenance and laundry services in a way that would typically be seen to include light housekeeping. Household maintenance is defined as "Tasks required to maintain a safe, clean environment in the client's immediate living area, e.g. vacuuming, sweeping/mopping floors, cleaning both sink and toilet, cleaning refrigerator/oven, changing/making up bed, laundry, and disposing of household garbage/recyclables" (p. 1). It would appear the current position is "practice" and not "policy". The rural RHAs indicate if light housekeeping was reinstated as a core service they might be unable to provide the service due to insufficient resources.

Further work is being done at this time on defining core services. The Department, along with the RHAs and the Canadian Home Care Association (CHCA) have developed a Home Care Network HUB (HUB). The HUB is working towards addressing key strategic priority areas for home and community care within Manitoba and is currently working on defining home care services and the extent to which the core services must be available in each RHA. Consultations have been held with each RHA and work on policy and standards development is underway. The Consultant strongly supports this initiative.

This section and the two recommendations flowing from it support Recommendation 2 of the OAG Report which recommends that the Department specify which services the RHAs must make available to home care clients.

Specific Recommendations

2. Continue household maintenance/homemaking services as an integral component of home care.
3. Develop a single standardized list of core services to be provided province-wide.

c. Family and Informal Caregivers

This topic was one of the topics most frequently discussed in the consultation process. While it was generally accepted the role of family and informal caregivers was an essential part of the home care services there was concern expressed that this service provided by family/informal caregivers would not be sustainable in the future.

Over the past decades there have been many family and societal changes. Included in these changes to the family structure are: families are smaller - fewer children, both spouses are employed, both parents and children are more mobile, children no longer live close to the parents, changes in expectation of what role the family should play. In addition to the above changes there is generally greater public expectation of what/how home care services should be provided.

At the same time that these changes are impacting the family there is also the aging of the baby boomers. Baby boomers will move from being primary care providers to aging parents to being the recipients of home care services - while typically having smaller families with less capacity to provide informal care. As stated in a recent medical journal publication "Clearly, the aging of the baby boomers will be a central theme, not just because there will be proportionately older adults, but because the characteristic feature of this generation has been to transform institutions as they move through the life cycle". (Sloane, P., D. et al., 2014, p. 326)

Much of the discussion in the consultation process centered on how home care would adapt to the diminishing resource of family and informal caregivers as the demands for service continue to increase. Replacing the service provided by family and informal caregivers with home care service was quickly set aside with the realization that 80% of home care services are provided by family and informal caregivers (referenced in the LT meeting presentation *Supporting Informal Caregivers*). By and large, there was the strong belief families want to play a meaningful role in caring for parents and other family members. This desire to have the family as a caregiver was strongly reinforced at a stakeholder meeting with the provincial Caregivers Advisory Committee and by the LT. It can, in all likelihood, be assumed that this is also a societal expectation.

In order to have the family and informal caregivers continue as a major resource in the future it will require a review/refinement of the current policy. The current Department policy, *207.1, Role of Family / Informal Support Network*, specifies that home care "is intended to supplement the role of family and/or informal support network in the provision of care in the community, not replace it. Family members/informal supports (caregivers) are expected to provide as much support to the home care client as is reasonable in their individual situation(s)" (p. 1).

It could be argued, the current statement provides all the necessary latitude to deal with the changing circumstances in the role of family/informal caregivers. The policy requires family/informal caregivers provide as much support as is "**reasonable** in their **individual** situation(s)" (Home Care Program Administrative Manual, policy 207.1, Role of Family / Informal Support Network, p. 1). This allows for a tailoring of the response – in other words equity - in each situation and could be increasingly used in the future.

A more comprehensive change should be pursued in at least four areas. First, the term – and concept – supplemental should be replaced with a more "generous" word/concept. In the consultation process the Consultant got the impression the word supplemental was frequently used as a "hierarchical" term. To the family it would be made clear their family member's care needs were their problem and home care would help out – if resources are available. Home care services in the future would be better served with the concept/term "partnership". This would require home care and the client/family working together more as equals. (It should be clarified in practice, much of this is already happening. The word/concept "partnership" would reinforce this practice.) Each partner would do what it could and together, as partners, they would meet the care need. In all likelihood this approach would come closer to meeting the expectations of the baby boomers. It should be noted, while it is important to develop a plan involving the family/informal caregiver, there will be an increasing number of instances where a family or informal caregiver will not be available. This will shift the responsibility to provide the care onto the regular program. This situation will need to be carefully monitored since there could be significant cost implications.

The second area requiring change is the matter of respite services. When discussing the role of the family/informal caregiver in the consultation process it frequently led to a discussion of caregiver respite and relief. While the meeting participants generally agreed with the ongoing role of family/informal caregivers it was reinforced that more attention would need to be given to the whole area of respite and relief. As identified in the LT presentation by a Support Unit member, a major reason for the need for respite is due to caregiver distress - as many as 30-40% of caregivers experience distress. The most frequently cited contributors to caregiver distress are: physical demands of care; cognitive impairment in care recipient; care recipient exhibits behaviour disturbances and care recipient has psychiatric/psychological symptoms.

The current Department policy (207.1) addresses the area of respite as follows: "The MHCP may provide services including respite and relief for family/informal supports to assist them in the provision of care to the home care client" (Home Care Program Administrative Manual, Policy 207.1, Role of Family / Informal Support Network, p. 1). In the future it will be important to change the phrase "may provide" to something closer to "will provide". One way of addressing this could be to have a formal "caregiver plan" completed at the same time the care plan for the client is completed. The caregiver plan would specifically address the issue of respite in order to prevent burnout and ensure a reasonable quality of life for the caregiver.

The third area requiring attention involves training and education opportunities for caregivers. Increasingly family/informal caregivers are caring for family members with more complex needs and performing sensitive procedures at home previously done in the hospital. While nurses and other professional home care staff may be performing the majority of these procedures, the

family/informal caregivers also carry some of this responsibility. There is also an increase in cognitive disorders and mental health problems as clients age. Additional education and training on how to deal with these issues is of real benefit to the caregiver. The Rupert's Land Caregiver Education Modules are a rich resource for caregivers.

And lastly, the support for caregivers is clearly enhanced when other resources are available in addition to what home care provides. The Manitoba government implemented the Primary Caregiver Tax Credit in 2009. However, there are now more applicants applying who do not receive home care services than those who do. The Canadian government also initiated the Canadian Compassionate Care Benefit. If the growing needs of family and informal caregivers are to be met long term, a much broader approach will be required. Government social, family, workplace and taxation legislation, regulations, policies and programs will need to be seen as a complementary resource to the caregiver support services provided by home care.

This section and the four recommendations flowing from it complement/support Recommendations 12 and 16 of the OAG Report. The OAG Recommendations focus on the following: ensure that case coordinators have the skills to assess the support that family members can realistically be expected to provide, ensure that file documentation for client care plans includes supervisory approval when services exceed protocols and a copy of the paper plan.

Specific Recommendations

4. Develop a caregiver care plan separate from the client care plan at the time of the needs assessment (e.g. respite to be provided, responsibility for the backup arrangement, etc).
5. Update the current policy, *207.1 Role of Family / Informal Support Network*, to emphasize/outline a partnership relationship between the client/caregiver and home care, where the parties jointly decide what each party will provide (this partnership is related to the family/informal supports and home care only); and put less emphasis on the word "supplemental" which has become to limiting a term.
6. Update the current respite section of policy *207.1 Role of Family / Informal Support Network* to include a firm commitment to increase respite services available to caregivers.
7. Assess the level of education/training of caregivers and as the needs of clients increase, ensure training and education opportunities are available to the caregiver from RHAs with funding attached to allow for implementation.

B. Client Groups

Seniors, as a client group, have been examined in detail in the earlier section on Demographic and Clinical Changes, as well as in other sections of this report. Seniors represent approximately 75% of the entire home care caseload. The remaining 25% is, to a large extent, composed of the client groups described below. Also included in this 25% would be individuals requiring only short-term home care.

For these additional client groups, home care is typically supplemental to funding/services provided by other departments or programs. In three of the groups, adults with physical disabilities, children with disabilities and adults with intellectual disabilities, home care is typically, though not always, supplemental to the resources available from the Department of Families and/or the clients'/families' own resources. Home care services, however, are not dependent on the individual receiving assistance from the Department of Families. In the group where individuals are receiving palliative care, there is a very close linkage between home care and the stand-alone palliative care program. The palliative care services are available not only in the client's own home but also in the hospital or hospice setting. Home care services for the palliative care clients are provided only in the home.

In all of these client groups the volume of home care cases is low (though frequently these cases are resource intensive). Nor is it anticipated there will be significant growth in the number of cases in the future. Consequently, these cases will have minimal, if any, impact on the overall sustainability of home care services in the future. When discussing these client groups it should be noted that the scope of this review did not include a comprehensive review of the services provided to these clients. The narrower question to be addressed in this review is whether it is important home care services remain available to these individuals in the future. Down the road it may be important to undertake a comprehensive review of whether home care services are meeting the needs of these clients in the most effective and efficient way possible.

a. Seniors

Seniors will continue to represent at least 75%, of the home care cases. At the same time it is evident that the number of seniors who will need the support of the regular home care services will continue to increase in the coming 20-25 years. Along with this, seniors will continue to experience more chronic illness, cognitive impairment, mental health issues and other health related issues. Family and informal caregivers will quite likely be less available. Seniors will want to continue to live at home and avoid placement in PCH for as long as possible.

Given the demands of this age group on home care services and the increasing cost this will represent, it is imperative the data projections for seniors is monitored on a systematic basis.

Specific Recommendations

8. Review in five-year intervals the data projections for seniors regarding number of clients, admissions, and units of service in order to keep projections as current as possible.

b. Adults with Physical Disabilities

This section will deal with adults living with a physical disability but will not include seniors. Physical disability as it applies to those 65+ years of age is covered in other parts of the report. This section will focus particularly on younger adults with a chronic, long-term physical disability. Included in the consultation process were representatives from agencies who serve clients where the physical disability is the result of a neurological disorder or illness.

The Consultant's understanding of the needs of this client group grew as a result of the conversations and meetings held with representatives from the physically disabled community, and most particularly by the conversations with younger adults with chronic, long-term physical disabilities. (One meeting included the majority of the provincial organizations serving adults with a physical disability). Many of these individuals were receiving home care services and in many instances were enrolled in Self and Family Managed Care. Above all these younger adults with chronic, long-term physical disabilities wanted the Consultant to understand that this group of younger adults was in many ways very different from seniors who experience physical limitations due to age and frailty. Many were employed or seeking employment, advancing their education, leading active social lives, building their friendship circles and going through other life transitions. They were focussed on the future and the opportunities it might bring. Home care services were essential for them to be able to live an independent and socially active life.

The Consultant was unable to locate any provincial statistics regarding the number of adults with a physical disability who were receiving home care. Manitoba Bureau of Statistics did publish a report for discussion purposes titled Disability in Manitoba: 2012 to 2036. In 2012, 15.6% of the Manitoba population aged 15 years or older reported having a disability that limited their daily activity. Of Manitobans reporting a disability, 32.8% indicated their disability was Mild and 20.2% specified it was Moderate while 22.2% and 24.8% respectively indicated it was Severe and Very Severe. According to the report the prevalence of disability for Manitobans is projected to increase from 15.6% in 2012 to 17.4 % in 2036(MBS, 2015). While this report from the Manitoba Bureau of Statistic is not directly helpful regarding home care clients it does indicate that the growth in numbers should be modest.

While many of the comments expressed about home care services by this group of younger adults were similar to the comments heard in the larger consultation process there were also differences. Many of the comments reinforced the point already made that this group has very specific needs. One voice, in particular, emphasized that "40 years ago 'community living'" and 'independent living' for people with disabilities were in their infancy. Now the community is much more accessible and people with disabilities are living more 'normal' lifestyles than they were 40 years ago." Given this change the question was raised whether the current home care program is able to meet the needs of these individuals or whether there is a need for the program to undergo substantial change. Comments of a more operational nature included: workforce issues, back-up supports are needed as the older family member supports are not able to physically complete the care required, services are highly fragmented, need for increased and different respite services for parents, etc.

According to comments made by representatives from the physically disabled community they do not anticipate that there will be significant growth in the number of individuals with a physical disability requiring home care services in the future. However, as already mentioned, for many of these clients home care services are absolutely essential for their health and well-being.

Specific Recommendations

9. Take into account when completing an assessment and care plan for younger adults with physical disabilities this group may be at a stage in life where home care services are essential for their health and well-being (e.g. employed or seeking employment, advancing their education, etc).

c. Children with Disabilities

This is a small but very important client group. Typically the children served by home care have complex medical needs. In general it is the families who assume a major responsibility for providing ongoing care for their own child. As a result providing respite care is very important. While the exact number of families utilizing Family Managed Care is not known, it is a very important option. For the past five years approximately 1% of all provincial home care admissions are 18 years of age and under.

There are two primary sources of referral in home care for children with complex medical needs. The first and possibly the primary one is the WRHA Integrated Children's Services (ICS) program which operates in partnership with Department of Families, Children's disAbility Services (CDS) and the second, in rural areas the service provided by the RHAs typically by direct referral from the hospital. The rural number of children being served is small. CDS is a provincial program providing services and support to children with cognitive or life-long physical disabilities, autism spectrum disorder, those at risk of disability and those with complex medical and developmental needs. It serves approximately 5,000 children annually.

ICS is a Winnipeg program only. In order to be eligible for this program the child must have both complex medical and developmental needs. A team of social workers and nurses assess the child's needs. There is a fluid arrangement to obtain services from either program: whichever program can best meet the needs of the client in the most effective and efficient manner. Shared funding is negotiated based on need and what is in the best interest of the child/family. Client numbers have been fairly stable over the past number of years. WRHA provides long-term services to approximately 200 children annually in addition to other children who receive only nursing services.

In the rural regions CDS is not integrated with home care. This may create some unique challenges: case coordinators and direct service nurses may have limited experience with providing care to children, the child's need may be greater than the resources available, the family may relocate to Winnipeg to obtain services causing family disruption and distress. Also the assessed level of service is often greater than what would be determined in Winnipeg due to lack of experience, knowledge, and fear in providing care to the child. The WRHA will provide information and assistance with the assessment of need to rural RHAs.

It should be noted that a Working Group composed of representatives from the Department, Department of Families and the Department of Education and Advanced Learning has prepared a recent report titled *MANITOBA: Home and Community-Based Services and Supports for Children*

with Complex Care Needs. This report examines the role played by each department and among other items identifies challenges and opportunities in serving children with complex care needs.

In the future the number of children receiving service may increase with increased complexity by virtue of medical advancements; along with that these children tend to live longer and continue to require home care and specialized services. In the future it may be advantageous to the rural regions if the development of a provincial Integrated Children's Service model similar to the Winnipeg model was explored and if feasible developed.

Specific Recommendations

10. Study the feasibility to establish integrated services for children province-wide, similar to the WRHA program.
11. Define and formalize the support and expertise currently being provided to the rural RHAs by the WRHA Children's Integrated Services program.

d. Adults with Intellectual Disabilities

The Department's policy is clear that home care services are available to all eligible Manitobans. This includes persons with intellectual disabilities. If the individual is living in the parental home the home care services are available on the basis of a needs assessment and the development of a care plan. Where it becomes more complicated is when other organizations/agencies who also provide supports to these individuals are involved (e.g. Community Living Associations). These associations, which are established to serve individuals with intellectual disabilities, receive their primary funding from the Department of Families. Where the question about providing home care services arises most directly is when the individual is receiving residential services, and to a lesser extent, when the individual is in independent living with the agency still providing support/day services.

There is a lack of uniformity in how the different regions interact with these associations/agencies and which services they provide. As mentioned, this is particularly so for individuals receiving residential services. It is a question of determining what the respective responsibilities of home care and the agencies are. Typically, home care in these instances will not consider providing HCA services but may consider providing nursing services. This is primarily due to the fact that many of these agencies employ their own care attendants to provide the support services to their clients. While the responsibilities of the attendants are much broader than what home care HCAs might provide there could also be some perceived overlap in responsibilities. At least in one region nursing services are being provided on a case-by-case basis. Where the individual with intellectual disabilities is living independently – not in a community living residence – the eligibility assessment for home care services is much more straightforward. In this situation, based on the assessment of need, a larger range of home care services may be made available.

While the above operational issues are present there are much larger issues that need to be addressed. Continuing Care (Home Care and Long Term Care) and Mental Health Services of RHAs are facing increased requests from CLDS, a branch within the Manitoba Department of Families, to

pay for (generally cost share) contracted health/residential services and/or case manage their clients who have complex health/medical issues. In the WRHA, currently there are a total of 79 cost share clients between WRHA (Home Care and Mental Health) and CLDS. WRHA is paying approximately $5.1 million per year for these cost shares.

Consideration within the health system and in collaboration with other stakeholders is being given to establishing a working group to:
- Identify needs and gaps in services for individuals with intellectual disabilities who have complex health/medical needs, including determining if existing provincial policies/direction require review/modification;
- Undertake assessment of current status and future projection of number of individuals with intellectual disabilities who have complex health/medical needs;
- Discuss potential solutions and clarify roles and responsibilities of RHAs, CLDS and others;
- Develop a formal cross departmental service and funding agreement between RHAs, Department of Families, and other organizations (e.g. Justice) that should be applied consistently across the province;
- Review resource requirements and funding needs of RHAs, Department of Families, and others to deliver required services.

The establishment of a working group to address the above issues should be pursued further.

Specific Recommendations

12. Strongly encourage the establishment of a working group to address the issues identified above.

e. Individuals receiving Palliative Care
The Palliative Care Program (PC) has an identity of its own with very close linkage to home care. In the rural regions, the Director of the Home Care Program is typically also the Director of the Palliative Care Program. In the WRHA, Palliative Care is a separate program with its own coordinator, but nevertheless maintains a close working relationship with home care. In all the regions the HCAs and, where available, the HSWs provide the personal support/ homemaker services. Likely 90% or higher of palliative care clients will need HCA care. The home care DSNs may go into the home to provide nursing services, depending on the RHA, and provide consultative services to staff and clients in hospitals and nursing homes. In the WRHA, and some rural regions, trained palliative care nurses provide the direct nursing and consultative services. Home care remains exclusively a community service, where as palliative care is woven into care across the spectrum of services: in-home, in hospital, palliative care units, and in PCHs. Home care also provides in-home equipment for the palliative care program. While there is no single uniform model for the palliative care program across the province there is always an important role for home care.

According to the un-reconciled statistics provided by the Department, in 2014/2015 there were a total of 2,845 new clients across the province, equally divided between female and male. 76% of clients were 65+ years of age and 73% had a diagnosis of cancer. Of the approximately 2,450

removed from the program in that year the location of death was as follows: Home 17%, Acute Care 46%, PCH/LTC 8%, Palliative Care Bed/Unit 26% and Hospice 2%. It should be noted the clients who die in hospital, may have received all their care in the home but were admitted to hospital in the last day or two leading up to their deaths.

As indicated in the meeting with the Provincial Palliative Care Working Group an increase in resources would allow the program to expand and meet the current and future need in a more effective manner - preferably as a 7/24 system to support home deaths. The need for more resources includes more PC resources during the day to deal with issues immediately avoiding Emergency Department presentations, more physician resources, increased availability of technology and others. Recruitment also remains a real challenge. As the program grows the demand for home care services will also continue to increase. It should be noted the working group strongly expressed the view the Palliative Care Program should continue to have its own identity – if you put it back into home care you would need to create an entire new service to deal with palliative care in hospitals and long-term care facilities.

There was also brief conversation regarding the potential impact of the Supreme Court of Canada decision regarding medical assistance in dying. While there was agreement there would be a need for a robust PC program to ensure individuals had other options than assisted death, the view was also expressed that the growth of the PC program should not be linked with physician assisted dying - palliative care needs to be seen as a very safe place. Also, since PC works to support the family around the dying process what will be its role in supporting the grieving process for those families whose loved ones chose the medical assistance in dying process. There are many other questions that will need to be addressed as this new option unfolds.

Specific Recommendations

13. Palliative Care Program remains separate but with a very close linkage to home care services.

C. Delivery of the Services

In this section a number of the major issues that relate to the delivery of the home care services will be addressed.

a. Self and Family Managed Care

The Self Managed Care program began in 1991 as a pilot project to support home care clients in the disability community who required care but in a manner that did not fit the traditional scope of home care service delivery. As a direct result of this pilot project, in 1994 a province wide Self Managed Care program option was approved. Within a year, the RHAs developed a Family Managed Care program to meet the growing needs of families. The two programs were combined to form one Self and Family Managed Care (SFMC) program shortly thereafter.

For the first 15 years the program grew very slowly. However, in the past 5 years the program has grown more rapidly. By 2015 the WRHA served on average 500 cases and the rural regions were approaching an average of 150-200 cases combined. Growth of the program has been particularly strong among seniors and to a lesser extent as a result of recruitment issues in rural Manitoba and problems experienced in the EFT implementation. In regard to SFMC units of service, in 2015 the WRHA provided approximately 80% of the total number of units with the rural regions approaching 20%. In recent years, approximately 2% of all home care clients were enrolled on SFMC. According to the available data, a SFMC client receives more units of service on average than a client receiving regular home care services.

The funding for SFMC is provided as part of the total RHA global funding. In recent years the WRHA has transferred approximately 10% of its total home care budget to SFMC (in 2015 $25.3m). In two rural regions the percentage transferred varied between 7% and 4%.

The policy and principles of SFMC are outlined by the Department in its policy manual titled: Home Care Program Administrative Manual. According to the manual, home care services are available to all Manitobans who meet the eligibility criteria. A one year enrolment on regular home care may be required prior to establishment on SFMC if there are concerns about care or client instability. Two additional criteria must be met: there must be medical stability and the client must be willing to cooperate with a safe care plan.

The amount of the funds to be transferred to the client/family is based on the needs assessment and the amount of home care services the client would be eligible to receive. The client/family are fully responsible for administering the non-professional personnel, services and funds – this includes recruitment, payment of the salaries, compliance with all applicable employment law, etc. The RHA is responsible for reassessment of eligibility on an annual basis in collaboration with the client. Provision of professional services continues to be the responsibility of the RHAs. SFMC does allow for the hiring of a family member when certain criteria are met.

This program was a frequent topic of discussion in the consultation process. Generally clients/families enrolled on SFMC felt very positively about the program. In particular what was appreciated was the kind of flexibility the client had in arranging their own service and the continuity in personnel that could be achieved. Young adults with a physical disability particularly appreciated self-managed care. They stated SFMC was extremely important in helping them live a full life – social activity, education, employment, friends etc. Home care personnel were also generally supportive of the program and believed that it would continue to grow. The concerns that home care staff expressed centered around the following: the ability of clients to carry out their administrative responsibilities – particularly among seniors; what, if any, were the required qualifications for attendants employed in managed care; was there sufficient monitoring of the program; how different could/should managed care be from the regular home care service delivery; the fact SFMC clients receive more services than the average clients receiving regular home care service delivery; what will be the future workforce impact on the regular home care service delivery and others. Additional comments received from agency representatives included the suggestion Self and Family Managed Care be separated into two distinct streams; the former advisory committee for the program be re-established; the need for increased respite for caregivers; the concern individuals who didn't have a backup were not eligible for SMFC; etc.

In addition to the obvious benefits of SFMC for the individual client – choice, continuity of service, flexibility – there are also benefits to the system from this program. Recruitment of staff – both non-professional and professional – remains a significant challenge for the RHAs. The staff vacancy rate typically runs at 8-10%. The WRHA did a comparative analysis between their regular home care program and SFMC for the year 2015/16. This analysis identified two particular system benefits. The analysis determined SFMC was a very cost efficient program with operating costs lower than the regular program and even achieving some savings. Secondly, this analysis identified SFMC clients employed the equivalent of 565 HCA/HSW EFTs. In other words, if there had been no SFMC option the regular program would have had to employ an additional 565 HCA/HSW EFTs to meet this need. Province wide this represented the equivalent of an additional 678 HCA/HSW EFTs. In addition SFMC replaced the need for resource coordinators and scheduling clerks since the client took over these responsibilities. However, there is an increased need for staff to carry out auditing and monitoring functions. Additional benefits of the program include its flexibility, which may allow providing services in areas of the province that are more difficult to resource. SFMC also provides an option where there are challenges with the relationship between home care worker and the client or family.

SFMC should in the future remain a very important component of the overall home care services. Given the strengths and benefits of this option as identified above, both for the client and the system, there is every reason to consider this a valid option when developing the client's care plan. The issues identified, as well as others will result in a growth in the program. An increased need for respite for caregivers, program and financial accountabilities, and increased expectations will need to be addressed but are not in themselves sufficient reasons to limit the program. What is fortunate is the current approved SFMC policy is fully adequate and does not require significant revision to allow for the future orderly growth of the program.

As an indication of the importance of this item the Continuing Care Council established a Self and Family Managed Care Working Group (WG). Currently, the Working Group is reviewing the policies, application form, contract, financial requirements, and provincially reportable indicators. The WG is also updating the components of SFMC that are provincially standardized and amalgamating those that are not. The WG has indicated that after the assigned deliverables have been accomplished they would have an interest in keeping the WG going. The members indicate they benefit from the experience and expertise present in the WG. The Consultant is of the view preservation of the WG would be advantageous for SFMC.

Specific Recommendations

14. Continue Self and Family Managed Care as a valid option available to clients.
15. Ensure SFMC continues to meet the home care needs of younger adults with physical disabilities who may not fit the traditional scope of home care service delivery.
16. Request the Self and Family Managed Care Working Group, in consultation with the Continuing Care Council, review the SFMC related issues raised in the consultation process.
17. Determine the right mix of staff required by the RHAs to manage this rapidly growing program, e.g. financial, monitoring and data analysis skills and experience.

b. Hospital Discharges

Numerous comments were heard in the staff interviews regarding the pressure they felt from hospitals to expedite the discharge of patients. They found it particularly difficult to put care plans in place if sufficient notice was not provided by the hospital. They felt the cases were becoming more complex and with higher acuity levels. This had the effect of shifting home care more in the direction of a health/medical program model. At the same time home care staff understood the pressure hospitals were under to free up beds.

The RHAs had either formal or informal discharge guidelines in place. The WRHA has highly developed policies and procedures in place to affect discharges. In the case of the rural RHAs the case coordinator might go to the hospital to review the case or there might be discharge planning meetings. In general, the working relationship between the home care staff and the hospital staff appeared to be good with each party generally recognizing the pressure and demands the other party was under. While discharge guidelines or procedures are generally in place, there nevertheless continue to be ongoing issues with the discharge process. What makes this issue more complex is that for effective discharge a three or even a four way partnership is involved – the hospital, home care, the client and the family/informal caregiver.

The WRHA home care program has undertaken a series of initiatives to improve service reliability, flexibility, consistency and wait times. Efforts are focused on ensuring a more collaborative and efficient discharge planning process for those patients who require home care services as well as facilitating timely access to home care services for individuals living in the community. To achieve these strategic goals, the WRHA has set a vision for eliminating hospital holds (a hospital hold is defined as a patient held in hospital awaiting home care services after physicians have declared them medically fit to return home). The first initiative entitled "Towards Home Care's Zero Hospital Holds Vision" addressed the need to improve the downstream processes in the community offices and identify major bottlenecks. Key initiatives presently being implemented include:: streamlining the referral process in the community offices and the electronic processing of referrals; the creation of scheduling and supervisory units; and the optimization of EFT positions and block scheduling.

The second initiative "Barriers to Patient Discharge with Home Support" studied upstream discharge processes in two hospitals to identify reasons for delays in the discharge of patients requiring home care services in the community. Issues identified include: a lack of a clear definition of when a patient is ready to go home; communication delays between hospital staff and community case coordinators due to non-standardized consultation processes; patient issues such as complexity or refusal to accept home care services as offered; and information systems challenges. This study recommended to eliminate hospital holds, every discharge needs to be a planned discharge – to achieve this it would require patients requiring home care services to be identified earlier during their hospital stay, a discharge plan would need to be initiated in advance and the hospital case coordinator to communicate this to the community office 24 to 48 hours in advance. Secondly, the report identified a need to consolidate data collection and reporting between acute care and community care. The WRHA home care program is currently working with hospital sites to address the gaps identified in the report.

Provincial statistics are not available on what percentage of the total number of patient discharges from the hospital requires home care. However, the WRHA systematically collects information regarding hospital hold clients. In 2014/15 the average bed day per hospital hold client in the Winnipeg region was 3.63 days. These numbers have not varied that much in the last few years. In 2014/15 there were 1,917 clients identified as hospital hold during the year. As a point of interest, on average 65% of home care admissions in Winnipeg are referred from the hospital. In rural Manitoba the percentage referred from the hospital is significantly lower.

It would only seem appropriate for home care to continue to work closely with the hospitals to return patients home just as soon as possible. That is the desire of both the patient and the hospital. The risk is that the demands of the hospital will delay home care assessment and service provision to those individuals who are in the community, putting them in a potentially vulnerable, unsafe situation. As already mentioned there is a limit to the level of complexity and acuity home care services can effectively handle. This would indicate additional training would be required for both professional and non-professional staff, as well as caregivers. It will remain important patients not be discharged before they are able to safely make the move home with the assistance of home care and family and informal caregivers. The adequacy of both upstream and downstream resources and processes has a major bearing on how quickly and effectively patients may be discharged. It was suggested in the consultation process the total discharge system should undergo a review and for the system to work effectively, it needs to be a seven-day a week service.

In 2013, Brandon home care implemented a Quick Response Service. The service consisted of an extension in the case coordinators' workday to include weekday evenings and availability from 8:30am to 4:30pm on Saturdays and Sundays (i.e., standby). The service also consisted of implementing a four-person HCA quick response team. The goals of the program included meeting critically changing needs for existing clients at home and facilitating the timely discharge of clients from hospital. The evaluation of this initiative resulted in maintaining the four-person HCA team. Due to a lack of referrals the CCs discontinued working evening hours but continued the weekend standby service.

Given the future increase in the senior population, and seniors' greater use of hospital resources, it must be assumed the pressure on home care to facilitate timely hospital discharges will only increase. This makes it very important home care and acute care work together to develop deliberate and effective discharge plans and sufficient personnel resources are in place to affect timely discharge. It is also of benefit to the system when the RHAs share information/findings on initiatives they have undertaken to improve the discharge process.

This section and the two recommendations flowing from it complement/support Recommendation 17 from the OAG Report which recommends more collaborative discharge planning between hospital and home care staff, staffing both case and resource coordinators on evenings and weekends to facilitate service start-ups.

Specific Recommendations

18. Ensure home care and acute care work together to develop deliberate and effective discharge plans and ensure sufficient personnel resources are in place for timely discharge from hospital so that home care does not increasingly become a health care/medical program only.
19. WRHA to continue with implementation of its plans to improve the discharge process and all RHAs to share their information/findings on initiatives they have undertaken to improve the discharge process.

c. Personal Care Home and Supportive Housing Placements

Increasingly PCHs are only accepting individuals requiring level 3 and level 4 care equivalency. This has placed considerable expectation on home care to provide the necessary service so individuals requiring level 1 and level 2 care equivalency may remain at home or in Supportive Housing and assisted living accommodation. In 2012/13 40% of individuals accepted into home care services had a care level equivalency of 1 and 2. A further 8% had a level 3 and 4 care equivalency. 11% of home care clients were placed in PCH.

In the past, PCH was really the only option if the individual was no longer capable of living at home, even with the provision of home care services. As mentioned already SH has become an option for individuals who in the past would have been admitted to a PCH. (See section on Housing with Health Services for more comments on Supportive Housing) Unlike in PCH, home care complements the care provided by the SH operator. A recent report from the Manitoba Centre for Health Policy stated that about one in 10 people who move into a personal care home may be able to live in supportive housing instead. (Doupe, M., et al., 2016) The downside is not everyone has the financial resources to move into a Supportive Housing unit. This puts increased pressure on PCHs to accept these individuals even though SH could meet their need.

On the basis of experience, it is only appropriate home care continue to panel clients for placement in PCHs and Supportive Housing. In addition, home care should continue to provide, if possible, the appropriate services so that individuals can delay PCH placement as long as possible. The risk, and in instances the reality, is that home care is put in the position of having to accept individuals who require care beyond what home care is able to provide. The government commitment to build more PCH beds may help alleviate this situation, as would the provision of more Supportive Housing units. Over the next few decades the expectation home care will be available so PCHs can use their limited resources to admit higher need clients will continue to increase with an accompanying requirement for more resources.

Specific Recommendations

20. Home care should continue to be responsible for the assessment of individuals for placement in PCH's, SH and other housing models where panelling of the client will be required.

d. Housing with Health Services

It is not within the scope of this project to propose new housing options for the future. However, it is important to have some understanding of what future housing models might be since depending on the model there may be the expectation home care will provide some or all of the health services. As an example, it is anticipated there will be more SH units built in the future with the accompanying impact on home care service delivery. Consequently, it may be instructive to look briefly at the original intent of the SH model. The recently completed *Continuing Care Housing with Health Services Review* provides a detailed overview of the Supportive Housing model. SH was originally designed to be more home-like in nature and to focus more on the social aspects, as opposed to the medically based aspects of care. A prominent feature of the program design was to have tenants in SH remain active in their care (i.e. helping to make meals, setting tables, or doing laundry), which was to assist in helping maintain independence. In addition, SH tenant companion positions were created to intentionally act as the primary service provider on the unit, and be trained to serve in multiple roles (recreation, housekeeping, cooking and assistance with light care needs). According to the review, despite the presence of tenant companions, home care is routinely adding services in SH for some tenants to help them maintain safety or for other related reasons.

Assisted living units, now becoming more prevalent, are very similar to Supportive Housing with the exception that the individual need not be panelled to move into an assisted living facility and companion care positions are not provided. In both models home care provides some or all of the health services. Again it is anticipated more assisted living facilities will be built in the future. The WRHA, in a pilot project, is enhancing the delivery of home care services to residents living in assisted living facilities by relocating the RCs from the regional office to the assisted living facility and in so doing improving the collaboration between the facility and home care. In Winnipeg more assisted living facilities are offering additional health services, such as on-site nurses and recreational therapists. As a result there can be overlap between services offered by home care and the facilities themselves. More of this experimentation is likely to occur in the future.

From a home care perspective, home care services can be much more efficiently provided in congregate assisted living, supportive housing or similar housing models where many individuals live at one location rather than in separate homes. As the WRHA enhanced pilot project demonstrates, additional services can also be provided that cannot be provided to individuals in their own homes. However, as different housing models are developed and current housing options expand a clear definition of the role and responsibilities of home care services in current and future models of housing with health services must be developed. Additionally, further research on housing with health services models should be initiated to determine which models are more effective, efficient and client friendly from a home care perspective. Home care should be an active participant in developing this two-pronged approach to future housing models. It should also be noted that *Advancing Continuing Care: A Blueprint to Support System Change,* a study prepared in 2013 for the Department includes a section focussed on improving options for community based housing as an alternative to PCHs. Suggested actions are: developing and completing a housing framework, partnering with Manitoba Housing and Community Development to explore options, demonstrating alternate housing models in rural areas, etc.

Specific Recommendations

21. Review and define the role and responsibility of home care services in current and future models of housing with health services.

e. Specialized Services

The number of speciality programs has increased over the years – both within the rural regions and Winnipeg. All the regions deliver the following speciality programs: Home Oxygen, Specialized Supports/Special Contracts, and Adult Day Programs. Three rural regions and Winnipeg deliver Home Intravenous (IV) services. Three speciality programs are delivered rurally in partnership with the WRHA home care program. These are: Ostomy - managed and delivered by WRHA on behalf of all RHAs; Hemodialysis - provided in the home under the direction of the WRHA Manitoba Renal Program (MRP); Home Nutrition - managed and administered for all RHAs by the WRHA. Two additional speciality programs delivered by the RHAs, and examined in other sections of this report, are Children's Special Services and Palliative Care. The WRHA also delivers the following additional speciality programs: Hospital Home Team, Respiratory Program, Health Coordination and Community Stroke Care Services.

The speciality programs are an important addition to the regular program. Clearly these specialized services allow clients to remain in their own homes and enjoy a higher quality of life. They also allow more complex cases to be managed in the home and make earlier discharge from the hospital a reality.

The above programs should continue in the future and, as resources allow and expertise is available, more speciality programs should be developed. The partnership between the WRHA and the rural RHAs would appear to be working well and could form a basis for the expansion of additional speciality programs to rural Manitoba. At the very least the feasibility of expanding specialized services should be explored. As cases continue to become more complex and acuity levels increase it is inevitable that with the future population growth specialized services will become even more important.

Specific Recommendations

22. Request rural RHAs explore the feasibility of providing specialized services in their area in collaboration with the WRHA.

f. Community Services and Clinics

As the demand for home care services continues to grow, additional avenues for efficiency will need to be developed. From a home care perspective it is more efficient and cost effective to utilize available community services and clinics, e.g. wound care clinics, and establish these services where appropriate and resources are available. In the future every effort will need to be made to control/reduce the demands on the home care workforce.

In regard to community services, they can be developed and/or funded by the RHA or established by other community organizations. To be effective this will require a high degree of coordination. As an example, the Support Services to Seniors (SSS) program is funded by the RHAs within their global fund allotment and operated by a non-profit board. This program provides many personal support/homemaker services that allow seniors to remain in their own homes. These services may include: transportation for medical appointments, light housekeeping, snow clearing, etc. These services typically require the client to pay a minimal fee. It would be advantageous to expand the SSS program in the future. It reduces the need for home care to directly deliver these services while at the same time having these services available. Clubs, churches and non-profit organizations offer other community services.

The WRHA depends on hundreds of community organizations for support. As an example, the region needs the support from outside agencies and organizations to deliver care to clients requiring more complex care. The community partners also include community organizations such as Occupational Rehab Group of Canada (ORG) that operates more than a dozen group homes in Winnipeg and provides their residents with a range of supportive services. According to the WRHA without agencies like ORG it would not be able to provide services to all of the 15,000 people in Winnipeg who require home care. While there are many more examples of community services and partners both in Winnipeg and rural Manitoba it is clear that home care could not achieve its mandate without the involvement of the community partners and the services they provide. As already mentioned these community services will become even more important in the future.

The WRHA, and to a lesser extent the rural regions, are already providing more services from a clinic location rather than just in the home. An example is the numerous wound care clinics established in Winnipeg and beginning to be established in some of the rural regions. One rural region delivers IV therapy and other ambulatory care procedures in addition to wound care in a community clinic. Another example is the community IV clinics in Winnipeg where between 30 and 95 clients are treated each day. While these are only two examples, clearly there is both the opportunity and the need to expand clinic services in the future. While it is more of a challenge to establish clinics in rural Manitoba there are population centres where it could be feasible. Given the experience of the WRHA home care program in establishing and operating community clinics it could share its expertise/resources with the rural regions. Not only are community clinics a more efficient way of using limited home care resources they may also result in an enhanced service. This area should receive increased attention in the future. However, care should be taken to ensure that clients who for reasons of lack of money, disability or lack of transportation are unable to attend a community clinic continue to receive the service at home.

Another question needing to be addressed is what the responsibility of primary care is in establishing community services/clinics that also serve home care clients. Currently the home care program typically takes the initiative in establishing these community services. Should primary care be playing a larger leadership role in establishing community services/clinics to serve clients living in the community? Should it be a partnership relationship between home care and primary care?

This section and the two recommendations flowing from it complement/support Recommendation 13 from the OAG Report which states that "available community resources" be clearly defined and processes be developed to verify client ability to pay where that is applicable.

Specific Recommendations

23. Home care services, in cooperation with primary care, define their respective roles and responsibilities in establishing community services/clinics to serve clients living in the community.
24. Review the expansion of support services to seniors.

g. Restorative Approach

In 2013, *Advancing Continuing Care: A Blueprint to Support System Change* (*The Blueprint*), developed in collaboration with key stakeholders, was released with the intent of providing a comprehensive approach to addressing priority service with the goal of sustainable health programs and services. *The Blueprint* highlights seven "Areas of Action" that align with the Department's priorities and goals. The following four areas target community/home-based supports:
1. Helping individuals to stay at home by investing in community supports and focusing on wellness, capacity-building and restoration when delivering home care services;
2. Improving access to home care services;
3. Strengthening and promoting co-operation among health care partners to keep people at home; and
4. Committing to dedicated health technology to help improve the quality and coordination of care and in making informed decisions and policy.

In response to *The Blueprint,* the Department developed actions for each of the objectives identified in the seven Areas of Action. The Department continues to work at implementing its response to *The Blueprint*.

The Blueprint addresses many of the same items/issues addressed in this report. In many instances the recommendations in *The Blueprint* reinforce or supplement the recommendations contained here. As with the OAG report, *The Blueprint* should be considered a strong supplementary report supporting many of the items contained in this report.

This section will focus on the restorative approach as described in *The Blueprint*. This is being done since the continued development of a restorative approach is very important for the future of home care services. According to *The Blueprint* "traditional home care programs are often not as successful as they could be because they lean too far towards an out-dated model of service, rather than focusing on activity, independence and successful aging". (p. 17) The *Blueprint* goes on to state restorative approaches aim to go beyond traditional home care goals of maintenance and support toward improvements in functional status and quality of life. A restorative approach typically refers to intensive, time-limited inter-professional home care services developed for people with poor physical and/or mental health, to help them learn or relearn the skills necessary

to manage their illness and to maximally participate in everyday activities. As an example, according to *The Blueprint* "there is particularly strong evidence that occupational therapy and health education, often undertaken by nurses visiting people at home, contribute to improved functional and health status. Treatment plans include various combinations of exercise and training, behavioural changes, environmental adjustments, adaptive equipment, counselling and support, training and educating patients, families and friends, adjusting medications and recognition of the importance of the social support aspect of home care. The emphasis is on a social care model, rather than a medical model of rehabilitation and restoration". (p. 17) In relation to specific components of the restorative approach, *The Blueprint* states "evidence suggests that comprehensive occupational therapy interventions may have a positive impact on the social ability and quality of older adults and that participation in physical programs can often have a positive impact on psychosocial health" (p. 17).

At the time *The Blueprint* was being prepared, the RHAs were in the beginning stages of designing and implementing rehabilitation pilot projects. At that time, the pilot projects were varied and included rehabilitation programs related to preventing falls, maximizing the independence of supportive housing residents, implementing or expanding community stroke services and providing services to individuals whose functioning is compromised by chronic disease and are being discharged home from hospital. *The Blueprint* goes on to state that implementing restorative approaches into home care services will also more closely align the program with recent models of healthy aging.

The Blueprint proposes an action plan to develop and test a restorative model of home care that focuses on improving clients' functional outcomes, while meeting their health care needs. Key features of the Restorative Home Care Model:
- Program would be accessed through referral to Home Care. Initially, only new clients would be assigned to the restorative program.
- Initial in-home assessment would be completed by rehab professionals (ex. Physiotherapists, occupational therapists) with OTs taking the lead.
- Comprehensive assessments would ensure services are tailored to best suit the complexity of the client's needs. There would be strong emphasis on functional assessment.

At the current time, the RHAs continue to test restorative models utilizing the key features of the Restorative Home Care Model as outlined above. The RHAs should continue to pursue this path of testing restorative models with the intent that in the future the restorative approach would become an integral part of home care services.

Specific Recommendations

25. Develop and test restorative models/approaches in home care.

h. Integration with Other Services

Integral to home care is the coordination of other services on behalf of the client/family. Specifically, the case coordinator is responsible for the coordination and delivery of a broad range

of professional and non-professional services. On the basis of a needs assessment the CC works closely with family and other health care team members to develop a care plan that provides optimum health care to the client. In the provision of services the CC liaises with agencies, facilities and community services involved with the clients and their family caregivers.

There is a high level of coordination/integration of services between home care, the hospitals and PCHs. The RHA home care programs and the hospitals have either formal or informal guidelines in place to manage the discharges from the hospital to home care. In Winnipeg the formal guidelines involve a close working relationship between the hospital CC and the community CC. As a specific example, the Community Stroke Care Service CC begins working with clients who are about to be discharged from three hospitals in Winnipeg and continues to support and coordinate their care needs in the community setting. In the rural regions the CC might go to the hospital to review the case or attend discharge planning meetings. In the case of PCHs and Supportive Housing home care is responsible for the panelling process to determine admission to these facilities.

Other examples of coordination include the working relationship between home care and Support Services to Seniors. Through the global funding provided by the Department, RHAs support the initiatives of SSS. Across the province home care is an integral part of palliative care. There are numerous examples of the coordination/integration of services in Winnipeg. The WRHA Integrated Children's Services operates in partnership with the Department of Families, Children's disAbility Services. An enhanced home care project began as collaboration between two assisted-living facilities and the WRHA home care program to ensure the residents received home care services more effectively. This involved the region relocating resource coordinators to the assisted-living facility. In an effort to manage increasingly complex medical cases at home the WRHA has launched hospital home teams, consisting of physicians, nurses, nurse practitioners, occupational therapists and other health professionals. These teams provide many of the resources of a hospital to individuals in the community.

As the above examples indicate home care is making a real effort to coordinate/integrate its services with those provided by other health care providers as well as those services provided by other departments - such as the departments serving families and housing needs. However, there is much more that can and should be done. Therefore, an over-arching provincial approach should be considered. As a beginning response, there are at least three areas that should receive more attention. The first area is primary care. While there are areas where this is occurring successfully the coordination/integration of physician services remains a challenge. A major initiative being undertaken by the Department is the development of My Health Teams (MyHT). MyHTs are made up of a variety of health care providers, including doctors, nurses, nurse practitioners, dieticians, pharmacists, mental health workers, social workers, physiotherapists, occupational therapists that work together to provide the individual with high-quality primary care. The long-term goal is for every Manitoban to have access to a MyHT when needed. One of the features of MyHTs is coordinated care. MyHTs will provide case management, integrated chronic disease management and will coordinate seamless transitions in care, especially for patients with complex health needs and multiple providers. RHAs will play the lead role in developing transition protocols to support care coordination, within and across health regions, as well as across levels of care. The objectives of this program are very similar to the objectives of home care and as a consequence home care direct service workers should be full participants in the My Health Teams.

A second area requiring intensive effort to coordinate/integrate with home care is physician groups, independent fee-for-service primary care providers and other primary care providers such as nurse practitioners and physician assistants. The RHAs will have to continue to work diligently at this task. The physicians in private family practice are frequently the first and primary line of contact with the individual and are familiar with the individuals needs, including the need for home care. What makes it particularly difficult to achieve coordination/integration with family doctors is that they are self-employed and paid on a fee for service basis.

A third area, also closely linked with the successful implementation of My Health Teams, as well as the integration of the other groups identified, is the use of Information and Communication Technology (ICT). This topic is addressed in more detail in the ICT section of this report. ICT is a critical component of home care service delivery. As an example, shared electronic access to health records can facilitate collaboration between professional and other care providers as well as external organizations. With electronic connectivity better integration of the knowledge and skills among health care providers can be achieved.

Specific Recommendations

26. Home Care becomes a full partner in My Health Teams, including access to their ICT client records.
27. As ICT is developed, ensure home care has full access to the health system electronic records to facilitate coordination of services.
28. Request RHAs explore where and how integration/coordination of services could be enhanced with particular focus on independently practicing physicians.

i. Standardization of Baseline Services

In a province as large and diverse as Manitoba it is always difficult to achieve uniformity of services across all areas of the province. At the highest level there is a single province-wide home care service. The purpose of home care is the same across the province – to keep people living at home as long as safely possible. The delivery structure is the same – needs assessment completed, care plan jointly developed with the client/family. For all Manitobans home care services are supplemental to what the family and informal caregivers can provide. In each RHA a core basket of services is provided. It is on this last point where the differences in service are most apparent. Examples of differences in the provision of core services include: nursing availability not the same in all communities, some services only available in the larger centres, household maintenance and laundry services vary between communities or are available as an exception only, variation between RHAs in the provision of home care equipment and supplies.

There are a number of primary reasons for these differences both within the RHAs and between RHAs.
- The amalgamation of home care services following the move from the former RHAs into five RHAs is not yet complete. This may result in a single RHA having multiple

policy/administrative manuals which do not align resulting in a lack of standard practice across the region.

- Differences in service as a result of a difference in policy across the regions. A significant example of this is the provision of light housekeeping services. In Winnipeg these services are available by policy while in rural Manitoba they are only available on an exception basis. At the same time there is no approved provincial policy in place mandating this difference.
- Lack of a clear definition of core services across the regions. While the main list of core services is uniform there are some RHAs that include additional services on the list.
- Differences in service resulting from isolation and other geographical factors. It is not possible to provide all the services in isolated areas and/or communities with small populations. This may be due to travel issues or the inability to recruit HCAs.
- The inability to recruit the necessary personnel in all areas of the region and the difficulty in filling vacant positions. This may in some areas produce wait lists or a limitation in services e.g. nursing services. The matter of insufficient resources is not uniform across the province.
- Winnipeg, due primarily to its size and greater resources, is able to provide a wider range of services than rural or northern regions. This is particularly so in the provision of specialized services. This difference is historic impacting other health services as well. To a lesser degree this difference applies in other urban centres as well.

As must be apparent some of the reasons for the differences cannot be overcome. The reality is what it is. Other factors can be eliminated or at least contained. As an example there should not be a difference in the services provided across the province because the policy is different for different parts of the province. The internal differences resulting from RHA amalgamation should be overcome in time. However, one of the major obstacles in achieving greater uniformity of service is the lack of a standardized provincial policy manual to replace all current regional policy manuals.

Specific Recommendations

29. Set a timeline to complete the amalgamation of home care services in each of rural/northern RHAs. (e.g. one home care policy manual for the region).

j. Delegated Tasks

There has been an ongoing increase over the years in direct service nurses delegating tasks to an HCA. While currently the delegated task process is utilized primarily, if not only, by DSNs other regulated health professionals could similarly transfer tasks to an unregulated health care provider, such as an HCA. The process currently involves a DSN delegating a specific task for a specific client to an HCA. Each time the delegated task involves a new client the HCA must undergo training again.

This process of delegating a task to an unregulated care provider is performed by DSN working within the practice direction as outlined by the College of Registered Nurses of Manitoba (CRNM).

In its practice direction the CRNM outlines a three-part process: assessment of the client and their situation as well as assessment of competence of the care provider; delegation of the task, and supervision. The DSN is responsible for the ongoing assessment of the appropriateness of the delegation as well as for the ongoing assessment of the client's health status and plan of care. It should be clarified that the delegation process and the procedures governing it are regulated by the CRNM and not by the employer.

The number and kind of delegated tasks has continued to expand. According to the information provided by one RHA, there are now 20 tasks being delegated including: eye drops, transdermal patch, inhaler partial assist, aerochamber full assist, compressor and nebulizer, protective dressing, glucometer assist and many others. Tasks that do not require delegation should not be included in this list. At least one RHA has taken steps to remove from the list those tasks that do not require delegation.

Both the professional and non-professional staff was supportive of tasks being delegated to the HCAs and HSWs. They felt the number of delegated tasks should continue to increase. It was their opinion task delegation was a good use of available resources and also enriched the role of the HCA. However, they found the process of delegating the task very time consuming and unnecessarily repetitive. The question was raised as to why an HCA who has been trained in the delegated task once must undergo training again when a new client is involved? This is a matter that should be raised with CRNM to determine if the process could be changed to make it less cumbersome.

A nurse delegation working group has been established by the WRHA with the Southern Health-Santé Sud RHA as a member. The scope of the work includes: developing a proposed list of approved delegated tasks, developing delegation guiding principles, and outlining the proposed future state for delegation. The working group plans to meet with the CRNM executive director as well other impacted colleges to ensure alignment with the regulatory bodies' standard of practice. All these documents are still in draft stage. It could be helpful if at some point the Nursing Advisory Council was drawn into this process as well to ensure a province-wide approach.

This section and the three recommendations flowing from it support Recommendation 24 of the OAG Report, which recommends that an approach be developed to identify and manage nurse-delegated tasks consistently, efficiently and in accordance with acceptable professional practice.

Specific Recommendations

30. Continue to expand, as appropriate and resources allow the use of the delegated task process.
31. The Provincial Nursing Leadership Council request that the CRNM review the current policy governing the delegation of tasks and as part of the review determine if the process could be streamlined.
32. Develop a provincial list of tasks that may be delegated to HCAs and HSWs.

k. EFT Project Related Issues

In the interviews with different levels of home care staff and with clients/caregivers/ stakeholders many comments were shared regarding problems present in the service today stemming from the implementation of the EFT project. It is not within the scope of this project to review the EFT Project or to propose any corrective actions. However, there are two items, in addition to general scheduling issues, which are of significance both in the current and future operation of the home care services.

Assignment of task – One concern expressed was insufficient time was allocated for the satisfactory completion of a specific task in a way that allowed the worker to feel good about the quality of their work. If more than the allocated time was taken the worker was frequently late for their next appointment. Frequently the amount of time allowed for travel as part of the task time was insufficient. The greater concern was that home care was becoming so task driven it was focussing less and less on the needs of the whole person. It was often stated that taking time for some social interaction or getting to know the client's environment allowed the client to feel more fully supported and contributed to their sense of wellbeing.

Continuity of worker – A major concern heard from staff, clients and informal caregivers related to the number of staff who would rotate through the client's home. This assignment of a large numbers of workers made it more difficult to provide continuity of care. It was difficult for so many workers to get to know the client and their needs or the layout of their living space. Additionally, it became more difficult to develop an effective relationship between staff and client. This problem seemed more prevalent in some jurisdictions than in others and seemed to be related to how the scheduling was organized. Where workers were organized by "cluster" there appeared to be less of a problem.

The home care system is fully aware of the concerns that have resulted from the implementation of the EFT project. The following steps have been taken by the employers (RHAs) and the Manitoba Government Employees Union (MGEU) to address these concerns. The two parties have established a joint committee to optimize scheduling practices. The mandate of the committee is to assess scheduling practices across the province and make recommendations to the Deputy Minister of the Department regarding the development of scheduling changes to improve the delivery of home care services, create an effective sustainable system, and also meet the needs of home care staff and clients. The joint committee is to complete its work early in 2017.

This section and the recommendation flowing from it complement/support Recommendations 19, 20, 21 and 22 from the OAG Report. The OAG recommendations address the following areas: monitor the number and consistency of workers assigned to individual clients; review the reasonableness and consistency of the standard time allocations; require resource coordinators to clearly explain and document scheduled travel time and avoid scheduling multiple visits in the same time slot, and the WRHA and Southern Health-Santé Sud enhance their oversight of the EFT initiative by better matching guaranteed hours to client assignments, monitor the cost and percentage of total EFT unmatched to client and evaluate if the EFT initiative is improving staff recruitment and retention.

Specific Recommendations

33. Strongly encourage the employers (RHAs) and the MGEU to continue the process currently underway to resolve EFT related concerns/issues until they are satisfactorily resolved for both clients and workforce.

IV. OPERATIONS AND SYSTEMS

Beginning with Leadership and Organization this section will address six areas/systems that provide support in the delivery of home care services. While these support systems, in themselves, do not directly deliver home care services, each one of them if properly resourced and effectively managed, play an important role in the delivery of quality province-wide home care services.

A. Leadership and Organization

When home care was established in 1974 it was decided it be centrally managed with decentralized delivery of service. Overall, the service was to be administered by the Community Operations Division of the Department of Health and Social Development. It was to be delivered from regional and sub-regional offices and the newly formed Health Centres. A provincial director for home care was appointed along with a small support staff. This office was responsible for total budget preparation and for the administration of service delivery. While different organizational alternatives were examined at the time this model was seen as having some very important advantages. These advantages included: those responsible for coordinating the program had authority to do so; one integrated home care service could be offered in the context of all other provincial programs; one integrated care program could be offered as a continuous component of a progressive or graduated care system; continuity of care was most simply assured with a minimum of jurisdictional confusion; the costs of home care services could be most efficiently budgeted, accounted, controlled as well as other advantages.

When the RHAs were established in 1997, full operational responsibility for the delivery of home care services was transferred to the RHAs. This arrangement continued the decentralized service delivery of the earlier model but with a significant change in that the Department was no longer to assume any operational responsibility for the delivery of service. At that time the roles and responsibilities of the Department and the RHAs were systematically defined as presented below. This assignment of responsibilities remains in effect today.

Roles and Responsibilities – Manitoba Health
Manitoba Health is responsible for:

- strategic planning for priority populations;
- home care policy development and interpretation;
- monitoring and analysis of program activity and its impact on the target population and the health care delivery system;
- development and monitoring of standards and provincial outcomes;

- research on, and development of, program benchmarks and best practices;
- management information system standards and development in conjunction with the Regional Health Authorities and;
- liaison with other components of the health system in Manitoba and Canada.

Roles and Responsibilities – Regional Health Authorities
The Regional Health Authorities have operational responsibility for home care including planning, delivery and ongoing management of the services. The RHA's are responsible for:

- accepting referrals and determining eligibility for home care services, based on a multi-disciplinary assessment;
- developing a plan of care which takes into account the needs of the individual and family as well as available community resources;
- determining the amount and type of services to be provided by home care;
- securing, scheduling and supervising the appropriate resources to meet home care service requirements;
- developing and maintaining a "pool" of service providers and resources to ensure continuity in the availability of resources;
- establishing quality assurance processes for ongoing care planning, monitoring and evaluation of services, including documentation of regional policies and procedures;
- managing the personal care home placement process for individuals whose care can no longer be provided in the community;
- developing and maintaining liaisons with other components of the health care system to ensure a collaborative and coordinated approach to the delivery of health services across the continuum of care;
- establishing and maintaining a quality improvement process that perpetuates practices that contribute to and enhance quality in service delivery, and that identifies areas that require improvement; and
- collecting and analyzing data related to the delivery of home care services for the purposes of critiquing existing practice and planning for future home care service demand.

The Continuing Care Branch, on behalf of the Department, has never been able to fully assume its assigned responsibilities for home care mainly due to the lack of resources. This lack of effective centralized monitoring and oversight has resulted in the RHAs taking on more and more responsibility for defining the services to be delivered in their regions. As a result there is a decrease in the uniformity of home care services delivered by the different RHAs and less of a standardized provincial home care service than is desirable. Additionally, there is a lack of monitoring of home care standards or in the gathering of statistics and data on a province wide basis.

This imbalance in the organizational structure between centralized and decentralized responsibility was not intended when the current organizational structure was put in place in 1997. What is required is not a new organizational structure, or a new and different division of responsibilities, but rather what is required is that the CCB be provided with adequate resources. It is not necessary or desirable to return to the more highly centralized organizational model that

was established at the beginning (though the more centralized organizational arrangement does have some advantages in achieving provincial uniformity).

Notwithstanding the above, there is one aspect of the current organizational model that should receive further attention: the nature of the accountability relationship between the Department and the RHAs. Simply put how does the Department ensure home care policies and objectives are fully and consistently implemented by the RHAs? At the moment this is partly addressed in the current model in that the Department is to set standards and policies and monitor the performance of the RHAs on an ongoing basis. The Government of Saskatchewan has more fully addressed this issue of linkage and oversight in its Ministry of Health Home Care Policy Manual (Home Care Policy Manual, 2015). The Manual goes on to state: " This manual provides direction and guidance to regional health authorities. The policies represent a statement of required course of action. Guidelines, on the other hand, are provided as recommendations to assist in meeting the expectations of policies. Adherence to the policies is one of the conditions under which funding is provided to the Regional Health Authorities by the Minister of Health" (preamble to the manual).

For the Department to implement a similar position would require the development of a comprehensive provincial policy manual for home care. The present provincial policy manual is not comprehensive or complete. A statement similar to that in Saskatchewan's policy could then be incorporated in the new comprehensive manual. Such a statement would give the Department an additional avenue by which to ensure a consistent and uniform home care service is delivered province-wide. It would also hold the RHAs to a very high standard of accountability.

In order for CCB to fulfill its assigned responsibilities it would need to have the capacity to provide overall leadership for the program, including policy direction and program oversight (possibly the addition of a home care director position). It would also need to have staff resources to collect and analyze the data provided by the RHAs, to establish and monitor program standards and develop a comprehensive policy manual. Administrative support would also be required. Home care would remain fully incorporated into the Continuing Care Branch. The addition of any new resources should be reviewed after a year to determine if CCB is increasingly able to fulfill its mandated responsibilities.

Finally, it is imperative that CCB has the capacity to provide provincial leadership in addressing the major demands home care will experience over the next few decades. The RHAs will not, as decentralized entities, have the capacity to provide the necessary provincial leadership to address major provincial issues. One issue requiring a provincial approach is the development of uniform province-wide Information and Communication Technology systems. It is absolutely imperative a province-wide system be put in place rather than continuing with the current nonexistent or fragmented systems.

This section and the recommendations flowing from it complement and/or support Recommendations 4, 5, 6, 7, and 14 of the OAG Report which address the following items: the Department identify key home care standards and require the RHAs to review their compliance with these standards and report the results to the Department; the Department review the monthly statistics from the RHAs to ensue they provide all the key information; the Department monitor the information provided for completeness and reasonableness particularly where the

information is made available to the public and the Department should analyze RHA statistical information in conjunction with their financial reports. The ICT recommendation to develop a plan for province-wide implementation of the RAI-HC is also addressed in the section on technology.

Specific Recommendations

34. Provide the Continuing Care Branch with the appropriate resources for it to fulfill its defined leadership role.
35. Develop a comprehensive central policy manual that reinforces consistent province-wide home care services.
36. Develop home care standards and benchmarks and a process for monitoring the RHAs performance.
37. Require the RHAs to follow central policies in order to receive home care funding.
38. Ensure systems and forums are in place for monitoring trends and innovation/best practices in order to anticipate future needs, enhance the home care services and introduce new efficiencies.

B. Public Accountability

For the purposes of this report a distinction is being made between client/customer accountability and public accountability. There are many examples of accountability within the home care delivery system at the client level. As an example, the care plan is developed jointly, and then signed by the CC and the client and/or family member. Furthermore, since the service is provided in the client's home the case coordinator and the HCA are accessible to answer questions or discuss the care plan. There is also a formal appeal process available if a client or family member is not satisfied with the home care service.

What is lacking is effective public or system accountability. This form of accountability can be exercised in a number of different ways: public reporting on the performance of home care, implementing a formal complaints process, making the home care policies readily available, publicising information about home care services in many different venues, creating advisory bodies that allow the public to have input to the service and its delivery and in other ways.

Currently, some of the above mechanisms are being utilized but typically only in a limited fashion. Information about home care services, including how to make an application is being shared on the Department's and RHAs' websites. The departmental annual reports provide further information though it is doubtful many individuals access this source. There are complaint processes available – by contacting the RHA or the Department. Currently no performance statistics on home care are being systematically provided to the public. The provincial home care policy manual is not being posted on line or made available to the public in other formats.

In regard to consultation, there is some limited consultation with the public. The WRHA has established a Home Care Advisory Council (the Council) comprised of individuals with lived experience in relation to Home Care services, along with family members, natural supports and

concerned citizens. The Council provides input into the planning, implementation, and evaluation of the WRHA home care program. The RHAs, as part of the community health assessment – completed every five years – solicit public input on the current delivery of the health services by the RHA and on suggestions for the future. Also, as a result of a recent amendment to the RHA Authorities Act, the RHAs are to establish Local Health Involvement Groups (LHIGs), which are to explore and discuss a variety of health topics, and provide local input and insights to the Board of Directors. As part of the Caregiver Recognition Act, passed in 2011, a Caregiver Advisory Committee was established. This committee is an advisory body to the Minister of the Department. This committee reviews the latest research, examines issues, identifies priorities, discusses potential solutions and provides recommendations to the Minister. It also provides information about caregivers and caregiver supports, including programs, services, policies and legislation. While this committee is not directly linked to the Continuing Care Branch its input is nevertheless of benefit to home care.

Currently the lack of a provincial ICT system severely limits the ability of the CCB to systematically gather provincial performance/clinical information. Until this issue is rectified the Department will not be in a position to publicize performance/clinical information on a province-wide basis (The WRHA does gather relevant clinical information that could be shared in the meantime). The establishment of additional avenues for public input should be explored including avenues for client/caregiver input on policy issues. A recent example of public input into the current and future operation of the home care services is the public consultation process utilized in this review. This online survey provided valuable information both for the review and on an ongoing basis for the Department in understanding how clients/caregivers/home care staff view the current home care services and how the services might be improved in the future. More than 300 individuals chose to respond to this online survey. Such an online survey could be initiated in the future – possibly every two or three years.

This section and the recommendations flowing from it complement Recommendations 3, 7, 8 and 23 of the OAG Report which recommend that home care standards and policies be made public, that home care promote greater awareness of its services with doctors and the public, and that the complaint process be more effectively managed.

Specific Recommendations

39. Post provincial performance/clinical data on-line once available.
40. Explore the option of the WRHA posting its performance/clinical information on-line in the mean time.
41. Complete a public survey around specific questions every three years.
42. Explore different avenues for public input including client input into policy development and other forums and the expansion of the WRHA Advisory Council in rural RHAs.
43. Post the central policy manual on-line when complete.

C. Finances

Since its inception in 1974 home care has been a government-funded service and continues to this day to be publicly funded. In 1974/75, the first year of operation, home care funding was projected at $4-$5 million. In the past 40 years funding has grown dramatically.

In 2104/15 the total home care funding received by the RHAs from the Department was $324m. These funds were part of the RHA global budget and were not protected/designated funds. Financial data from the past 15 years was made available to the Consultant. In 1999/2000 Department funding was $150m. The amount of home care funding more than doubled (116%) in those 15 years at a yearly increase equivalent to 7.7%. (In that same period the number of clients served increased by approximately 9%.) In the eight years between 1999/2000 and 2007/08 funding increased by 67%. In the next seven years the percentage increase over that span was reduced to 29%. During these two periods the yearly increase in funding was reduced from an equivalent of just over 8% to an equivalent of just over 4%. For the three year period 2012/13 – 2014/15 funding has increased at a yearly equivalent of 1.3%

It is useful to put the amount spent on home care in Manitoba into the context of the total annual health care expenditures. In 2014 the total health expenditures were $5,807m and the per capita health expenditures were $4,473. The expenditures for hospitals and other institutions were just over $3 billion or over 50% of the total expenditures or a per capita amount of $2,426. Physician expenditures were 1,151.7m or $901 per capita. The total home care expenditures in 2014 represented approximately 6% of the total health expenditures or $250 on a per capita basis.

According to a report prepared for Health Canada in 2014, (Keefe, J., et al, 2014) in addition to Manitoba, there were two provinces and three Territories that did not charge for home care services (Ontario, Prince Edward Island, NT, NU & YT). The remaining jurisdictions charged a fee for various personal care and homemaking services while professional services such as nursing, occupational therapy, and physiotherapy are provided free of charge. Each of these jurisdictions indicated home care cost subsidization is available based on financial need, although their methods of determining need and the maximum amount charged differs. The proportion of total health expenditures, as well as per capita expenditures, varies between the different jurisdictions.

While past experience is of value when projecting future cost and trends this approach cannot replace the level of accuracy achievable from detailed short term budgets or financial projections.

Specific Recommendations

44. Develop a detailed financial projection for the next 3-5 years.

D. Human Resources

Home care can be compared to a milking stool. The home care services represent the seat of the stool resting on the three legs of human resources/workforce, funding and ICT. HR/workforce,

funding, and to a lesser extent ICT, are the primary determinants of the future sustainability of home care. These determinants, in turn, are impacted by the projected future volume increase in the home care services. Funding and HR/workforce are inextricably linked since approximately 80% of total home care expenditures are workforce related.

This section will deal selectively with the issues and topics related to the whole area of human resources/workforce. As well, it should also be noted that HR related items are addressed in other sections of the report. The terms of reference for this review did not include completing a comprehensive review of the human resources area. Such a comprehensive review would represent a major assignment in its own right. As a result, only those HR topics and issues that have a significant relationship or impact on the primary purpose of this review – the future effect of the aging of the population on home care services – will be examined in this section. A much more fulsome presentation prepared by a Support Unit member and titled *Health Workforce in Home Care: Today & the Future* was made to the Leadership Team. This presentation went beyond the areas addressed in this review and is a valuable background document that could form a basis for future study of HR. Included in this background document are recommendations pertaining to such HR topics as: a system-level HR strategy for health; addressing discrepancies between collective agreements; comprehensive workload reviews of RC/DSN/CC positions to determine workload benchmarks; evaluation and standardization of job descriptions for SC/RC/CC positions as well as HCA and HSW positions; and evaluation of specific competencies required for success in the different positions, plus other topics.

In the consultation process there were many comments on HR issues, including many comments related to the perception of insufficient staff resources. References to these comments are included in other sections of this report. What is of particular note is that the public on-line responses also identified HR issues, including insufficient staff resources, as areas of major concern. There were occasional comments made in the consultation process regarding the issue of racism. In order to determine if this may be a significant issue it should be included in the HR section on future work (item 3).

Characteristics of the Workforce
Today's province wide home care workforce is composed of just over 3,500 EFTs. The following chart represents the workforce position breakdown. (Stevens-Chambers, K., 2016. *Health Workforce in Home Care Today and the Future*)

Table IV.1: Manitoba Home Care Workforce

Staff Grouping	IERHA	NRHA	PMH	SHSS	WRHA		Totals:
RNs	19.15	5	17.71	22.93	238.28	303.07	
LPNs	7.8	11	14.23	14.13	104.55	151.71	
Total Front Line DSNs:							454.78
HCAs	214.39	95	277.275	366.88	1334.55	2,288.095	
HSWs	0.5	7	2.25	0	251.36	261.11	
Total Front Line DSWs:							2549.205
Case Coordinators	26	8	37.4	30.4	135.73	237.53	
Hospital Based Case Coordinators	0	0	4	n/a	55.8	59.8	
Total Case Coordinators:							297.33
Resource Coordinators	29.2	4	29.5	32.1	113.84	208.64	
Scheduling Clerks	10.1	3	9	2	27.11	51.21	
Total Scheduling/Resource Coordinators:							259.85
TOTAL WORKFORCE							3561.165
Note: includes only FTE positions.							

HCAs and HSWs represent approximately 70% of the workforce; RNs/LPNs represent approximately 13%; case coordinators represent approximately 8% and resource coordinators/scheduling clerks represent approximately 7%. In addition to the above personnel home care also employs occupational therapists, physiotherapists, respiratory therapists, contracted personnel, etc. This section on workforce will focus particularly on Direct Service Workers (DSW-HCAs/HSWs) and Direct Service Nurses (DSN includes both RNs and LPNs) since these nonprofessional and professional personnel represent nearly 85% of the total home care workforce and are also the "public face" of home care. It is important to note that in attempting to define/describe the current workforce and project future workforce needs the review was hampered by the lack of complete data, including simple demographic data, more complex data - how many staff are certified, sick time, etc, data on the workforce for services provided by private agencies and workforce data on SFMC.

According to the WRHA data (provincial data not available) 80-85% of HCAs/HSWS in WRHA are female; average age of HCAs/HSWs is 46 years; over 90% of all job applicants in the WRHA for HCA/HSW positions were not born in Canada and up to 60% of these individuals became employed by WRHA home care. Provincial data indicates that nearly 80% of provincial HCAs are certified, with the WRHA at essentially 100%, and that rural RHAs employ 38% of HCAs/HSWs and the WRHA employs 62%. In all likelihood Manitoba is very similar to the rest of the country when it is projected that HCAs provide up to 80% of the direct care to the seniors population. (Stevens-Chambers, K. 2016. *Health Workforce in Home Care Today and the Future*).

Major Issues

Certification/regulation - As expressed in the consultation process there was broad agreement that HCAs should be certified. It was felt that this was particularly important as the complexity and acuity of cases continues to increase. The RHAs have had certification of HCAs as an objective for some time and the number of HCAs that are not certified has been steadily decreasing. According to the information in the regional scan three RHAs employ only certified HCAs while in the two other RHAs the number of HCAs that are not certified is currently unavailable. It will continue to be a challenge for some of the rural RHAs to employ only certified HCAs due to recruitment and other difficulties.

There has been no real discussion, at this point, regarding the possible regulation of HCAs. Such an initiative is in all likelihood premature since it would require HCAs not only be certified but to have graduated from an approved educational institute offering a standardized curriculum. There is a provincial example of HCA regulation. In 2013 the BC health ministry created the British Columbia Care Aide & Community Registry. The registry was created to improve the standards of care and protect residents and clients receiving care from health care assistants. Health care assistants must register to be able to work in any publicly funded health care setting in BC.

Education and Training – Manitoba has four provincially funded educational institutions and several private vocational institutes that educate HCAs. The province does not have a provincial curriculum governing health care aide education. However, the provincially funded public colleges have collaborated to utilize similar learning outcomes. In 2012 an HCA Training Environmental Scan completed by the Department indicated there were differences in the duration of practicum requirements but, nevertheless, the private institutions may provide a program that is adequate. At least six provinces/territories have provincial/territorial curricula in place.

Clearly, it is urgent Manitoba proceed with developing a standardized provincial curriculum that must be followed by all institutions – public and private – when educating HCAs. This curriculum should include mandatory education on dementia, managing challenging behaviour, and mental health issues for all DSWs.

Recruitment and Retention – There are a number of issues/challenges related to recruitment and retention. Included are the following:

- **Compensation and Benefits**– Over time the difference in compensation between community HCA 2 positions and facility Health Care Aides has been addressed – currently there is only a 1% difference between the two. However, there continues to be disparity in benefits and pension between these two categories of employees. These differences exist across the whole spectrum of benefits, e.g. sick time, life insurance, extended health as well as pension. Clearly these differences make recruitment more difficult and they also contribute to HCAs seeking transfer to health facility positions.
- **Supply and demand** – As we move forward there will continue to be an increased demand for home care employees. It should be noted that currently, at any one time, there is an 8-10% vacancy rate among home care staff. This vacancy rate will only be exacerbated by the additional demand for services in the future. There are at least five contributing factors to an increased demand for home care personnel:

- Reduction in availability of informal caregivers. Increasing numbers of clients with no families or small families.
- Increasing senior population.
- Advancing technologies enabling individuals to return home who historically were cared for in other care settings.
- Increasing life expectancy.
- Increasing preference of clients to receive care in their own home.

- **Employment of Immigrants** – As has already been noted over 90% of WRHA applications for HCA/HSW positions were not born in Canada, and 60% of these became employed in home care. The number of DSWs not born in Canada is lower in the rural areas. What is readily apparent is that should there be a change in governmental immigration policy resulting in a reduction in the number of immigrants entering the province, home care services would experience serious difficulty in maintaining an adequate workforce. According to the information provided in the workforce presentation to the Leadership Team, since 1999 Manitoba has welcomed >125,000 permanent residents with the majority selected due to their ability to contribute to the economy. In 2012 the countries of origin for the largest number was Asia & Pacific and the second largest number was Africa & Middle East. Many individuals from these countries of origin experience significant language and cultural challenges. While the inability to effectively communicate in English and/or lack of cultural knowledge is a detriment in providing good client care, a workforce from diverse backgrounds is of benefit when providing care to home care clients coming from diverse cultural backgrounds (Stevens-Chambers, K. 2016. *Health Workforce in Home Care Today and the Future*).

- **Workforce turnover** – In the consultation process it was suggested that HCA/HSW positions were frequently seen as an entry point to better paying and/or professional positions in the health field and that HCAs would move on as soon as these positions became available. As mentioned already the difference in benefits/pension can be a strong motivating factor to change employment. Constant staff turnover represents significant cost in recruitment, training and scheduling efforts, and at the same time has a detrimental effect on client care.

- **Millennials** – As indicated in the LT presentation it is expected that by 2020-2025 millenials (born 1981-2000) will represent about 50% of the global workforce. The presentation provides further observations and insights regarding this age group. Millennials are growing up as the first true digital generation and along with a global orientation have their employment expectations shaped by these experiences (Stevens-Chambers, K. 2016. *Health Workforce in Home Care Today and the Future*). Many of their expectations are dramatically different from those of their parents and grandparents. These employment expectations may run counter to the requirements of the current, and likely future, home care. Examples of differences in expectations include:
  - So connected to ICT that they will have little tolerance for paperwork.
  - Insistent on harmony between personal lives and work lives will mean less likelihood for working overtime, traditional excessive work hours of management, etc.

- Traditional hierarchical structure of healthcare may cause a struggle – they are looking for engagement, participation in decision-making and control over their work more so than previous generations.
- Task driven schedules and rigid work schedules may cause issues.

In brief home care will need to find ways to foster flexible work arrangements, channels for career advancement and offer more cutting edge technology. Health care organizations that are able to offer truly integrated and collaborative health care team environments will offer a workplace environment that will be more attractive to millennials.

Direct Service Workers and Direct Service Nurses challenges/issues

This section will briefly identify issues/challenges/questions as they relate to home care DSWs and DSNs. Much of this information is drawn from the input received in the consultation process.

Home Care Attendants – For HCAs there is a potential loss in job satisfaction as more emphasis is being put on a task driven scheduling concept and as autonomy continues to decrease. There are insufficient training opportunities available to maintain competencies. Limited contact with supervisors can contribute to feeling of isolation and greater dissatisfaction with the job. Ever more complex schedules are leading to confusion, frustration and potential burnout. HCAs, in increasing numbers, are being asked to work in team based environments for which they may not have the skills, e.g. block home care and in assisted living environments. HCAs are expected to deal with an increase in the complexity and acuity of cases, e.g. dementia, managing challenging behaviour, mental health and other emerging health issues, without being provided with the appropriate on the job training by the RHA.

Although the issues/challenges identified above are real, when asked if they enjoyed their job, the HCAs' answer, nearly without exception was an unequivocal "yes."

Home Support Workers – HSWs have a limited but important scope of practice in meeting incidental activities of daily living (IADL) needs of clients such as meal preparation and household maintenance and laundry. HSWs are seldom employed in the rural RHAs due to a difference in policy/practice between Winnipeg and the rest of the province, vast geography, travel time and lack of sufficient resources. The biggest question facing the HSWs in the future is - where do they fit, is there a continued role for them, are they limited to working in urban centres only? This review is recommending HSWs remain an integral component of the home care services. These functions can be performed by either an HCA or an HSW depending on the circumstances.

Direct Service Nurses – As with HCAs movement towards more and more task driven schedules is resulting in less autonomy and a loss in job satisfaction. The increasing importance of task delegation to the HCA workforce is leading to a new role for the DSN, that of supervisor. Is this the correct direction for the future?

This section and the recommendations flowing from it complement/support Recommendations 26 and 28 from the OAG Report, which recommend that the two regions monitor whether mandatory training and security-checks are being done, ensure client file reviews are being done, develop standard templates to ensure consistent file reviews and identify areas where staff may

require more training. Many of the other OAG Recommendations also have HR/Workforce implications.

Specific Recommendations

45. Efforts should continue undiminished to ensure that all HCAs in home care are certified.
46. Develop a standard provincial curriculum to be followed by all provincial institutions – public and private – when educating HCAs.
47. RHAs provide mandatory education/training for all DSWs on dementia, managing challenging behaviours, mental health and other emerging health issues.
48. Increase support and presence of DSW supervisors, particularly in the field/in client homes.
49. Develop a coherent, system-level HR strategy for home care which would include, but not be limited to, strategies designed to attract and retain millennials and immigrant workers in the workforce.

E. Information Communication Technology and Home-Based Technology

This section is divided into two parts. The first part will deal with Information Communication Technology that focuses on the use of technology by home care personnel and the broader home care system. The second part will address technology-enabled home care. In this latter case technology is used to support health outcomes in the home setting. Both sections will deal selectively with issues and topics related to the use of technology. A much more fulsome presentation entitled *Technology in Home Care – Today & Tomorrow* was made to the Leadership Team by a Support Unit member. This presentation provided a more detailed examination of the issues, challenges and opportunities related to technology, and is a valuable background document that could form a basis for further study of ICT and home-based technology.

ICT in Manitoba
The consultation process shone a light on the current state of technology in Manitoba home care services. There was unanimous agreement the technology currently available in home care was totally inadequate. Frequently what does exist is old. While electronic charting systems exist, they are not accessible to those who require access. As a result, there is significant paper charting still happening. A clinical assessment/information program is not in operation in rural Manitoba. Spotty Internet access throughout the province interferes with needed access to the various programs/systems. Workers are not provided with mobile phones, the use of which would enhance scheduling, cancelling or changing appointments, consulting with supervisors, etc.

Further systems issues were identified in conversation with representatives of WRHA and Manitoba ehealth, including: software systems do not connect with each other – while there is work happening around integrating health records, our systems in the care planning sector do not connect well with the service delivery sector. Efforts are being made to resolve this by using software interfaces, but this is a piece-meal system at best. (Simply put, Electronic Medical Records (EMR) do not connect with Procura software; budget and reporting software systems that connect to Quadrant Human Resources program (QHR) do not connect to Procura; clinical

assessment tools used in WRHA home care and PCHs use the same assessment and outcome language, but staff do not have access to each others' tools, limiting the continuity of communication and assessment data across the health care sectors, etc.)

ICT systems in place in the regions include the following: Procura is a scheduling program that is used across the province with the exception of Brandon. Brandon utilizes the clinical component of Procura only. InterRAI –HC is a clinical assessment/information tool used only by the WRHA. Brandon utilizes the clinical component of Procura. The rest of the province does not operate any computerized programs that provide clinical assessment. All the regions except WRHA use the QHR for payroll. The WRHA uses SAP® software for payroll and HR management.

Even when different RHAs are using the same application system integrity is a concern. There has been no standardization of definitions for various fields creating data integrity issues. Since critical data elements may not require mandatory fields it may result in templates being filled with blank values. There is also the issue of connectivity. Much of the province is still on T1 cabling even though there is a huge difference between fiber optic and T1 cabling. The system is dependent on one vendor, Manitoba Telephone System, and that vendor decides where/when to upgrade to fiber optics, etc. There are also concerns about the ability to upgrade technology due to aging health infrastructure and buildings and with the current back-up system for health information.

The current inadequate ICT system has wide ranging implications for both workers and the overall system. Without province-wide programs/systems it is impossible to gather reliable provincial data and statistics that can be posted on the Internet to increase public accountability. What has become very apparent in this review is the paucity of reliable, timely province-wide data/statistics at the Department level that can be used for the monitoring of clinical and system performance, policy development, setting of standards, monitoring trends, etc. It is impossible for the CCB to fulfill its designated responsibilities without access to reliable and timely data and information. In a similar manner the regions also require access to accurate data on a timely basis so they can effectively fulfill their responsibility to provide quality home care services. At the level of DSWs, DSNs, RCs and CCs there is an urgent need for these personnel to be provided with mobile phones to improve communication, scheduling and other work related tasks.

The consultation process provided some insight into what home care personnel and clients/families thought home care technology might look like in the future. They believed there would be a greater use of tablets replacing paper charting; more apps to assist with client care, and more apps to help the family in their caregiving role. They foresaw an expansion of tools to assist with medication reminders and medication management; tracking devices to assist in monitoring clients with dementia and technology that capitalizes on tools like smart phones, internet access, etc. There would also be increased access by clients and their families to their own health information. As is obvious, many of the above comments blur the distinction between information and communication technology used primarily by the worker and the system and those home-based technologies that directly address the care needs of the client.

Home-Based Technology of the Future
The following section will briefly identify/describe innovative home-based technology of the future. The background document referred to above *Technology in Home Care – Today & Tomorrow* addresses these technologies in more detail. Many of these technologies are still in the beginning stages of development and not broadly available. It is anticipated much of this technology will be in common usage, though not necessarily in Manitoba, during the time span projected by this review. The next 20 years should allow time to explore this whole area in more detail and develop a provincial strategy for the appropriate use of this technology. Included in the development of such a strategy should be the examination of the role of private business in making this technology available to home care clients, how, and if, the cost of the technology should be shared between home care and the client as well as other issues.

Technology groupings
This section of the report will be divided into the same six broad groupings used in the presentation to the Leadership Team.
1. Home Telemonitoring/Health monitoring – These types of technologies use automated processes for the transmission of data about the client's health status from the home to the health care setting.
2. Home Telecare – These technologies provide ongoing support from a distance to clients within their own home. The equipment is actually providing care to the client. Examples include home oxygen, infusion pumps, dialysis, ventilators, and heart pumps.
3. Home Telemedicine – This technology involves the direct provision of clinical care, including diagnosis, consultation and treatment via telecommunication technologies. Strong examples of this include the current Manitoba Telehealth system. It is used most often in the provision of specialist consultations to improve access to health services for remote or disadvantaged individuals.
4. Assistive Technologies – these technologies are used to increase the comfort, independence and safety of the client. There is considerable growth in the use of this assistive technology for clients with dementia and to support caregivers in their caregiving role. Much of this technology allows for monitoring at great distances.
   a. Client movement monitoring – This includes driveway sensor products to monitor movement outside the home; wireless cameras with LCD light to provide night time surveillance- can be carried by the caregiver to know where dementia client is at all times; wireless home security devices installed in the home to alert caregiver when client with dementia attempts to exit doors.
   b. Prevention of injuries – Includes MedicAlert and Safe Return programs which assist a third person when the client with dementia is found in the community; bed occupancy sensors and alarms; falls management systems - including programs such as Lifeline where a person in need of assistance presses a hand held button to summon help; canes equipped with sensors which can prevent falls by compensating when a senior misses a step.
   c. Medication management technologies – Various alerts and alarms that can either be set to remind the client or caregiver that medications are due.
   d. Robotics – is in its infancy – Current uptake relates to robotic devices to assist with the home and its management, e.g. devices that can vacuum floors, wash floors, etc.

     e.   Others – Eyeglasses that will help as a memory aide helping seniors to recognize people.

5. Electronic Medical Systems/Client Records – Clinical data storing system for client medical records which track and manage individual client health information. Examples of this include Procura, EMR, interRAI -HC, eChart, etc. The goal in Manitoba is one integrated client medical record – still a long way from getting there. Demand is mounting to make these technology systems more portable and allow data to be entered in real time.

6. Social Media – Via internet and social media networking clients are forming communities, sharing notes, etc.

Even a limited understanding of technology suggests these technologies could have real benefit both for the client and the caregiver and for home care staff delivering the service. In particular many of these technologies increase the capacity for family and informal caregivers to monitor family members from a distance. These technologies appear to have real benefit in caring for persons suffering from dementia, from various chronic illnesses, or seniors experiencing physical limitations. It is always important, however, to note that new technologies usually bring with them new problems and they may not always deliver everything promised.

This section and the recommendations flowing from it complement/support Recommendations 5 and 14, which recommend that the Department review home care monthly statistics to ensure they provide key information, analyze statistical reports in conjunction with financial reports and that the Department develop a plan for province-wide implementation of the RAI-HC client assessment tool.

Specific Recommendations

50. Develop a comprehensive province-wide ICT strategic plan to include, at minimum but not limited to, addressing outstanding issues related to scheduling, clinical assessment/information, HR, connectivity and the availability of appropriate communication technology for home care personnel.
51. Establish the appropriate leadership and technical capacity to oversee the development of the ICT strategic plan and to lead the systematic implementation of the plan.
52. In the short term continue to plan and implement province-wide a clinical information system that includes the most up to date version of the RAI-HC assessment tool.
53. In the short term explore making appropriate mobile technology, e.g. smart phones, available to DSWs, DSNs, CCs and RCs.
54. Research all the issues related to the application/use of home-based technology, including but not limited to, cost sharing, role of private businesses.

F. Equipment and Supplies

There is a policy on equipment and supplies, last revised in July 2012, in the provincial policy manual. It states "Clients…may have access to home care equipment and some supplies to support earlier discharge from hospital settings and prevent readmission; to prevent or delay entry into long term care facilities; and to support their remaining in the home"(Policy 207.9 Equipment and Supplies, p.1) . Typically, certain equipment is provided on loan through home care particularly when it is required for safe care. Eligibility for equipment and supplies is determined as part of the assessment process. The above policy also outlines the procedures that are to be followed in providing equipment and supplies.

Currently, there is a lack of consistency in the procurement and management of home care equipment. Some HC equipment is currently provided through Materials Distribution Agency (MDA) to the RHAs without a documented service purchase agreement (SPA). As well, the RHAs may have equipment contracts with other companies although there is no uniformity between RHAs on this.

Government funding is provided annually for equipment as part of the RHA home care budget. It is the responsibility of each RHA to make an annual allocation for equipment and supplies from the global budget. The amounts allocated vary from RHA to RHA. As an example, in a recent year the WRHA spent approximately $5m on equipment and supplies, the three rural RHAs of PMH, SHSS, and IERHA spent between $400,000 and $500,000 and the northern RHA spent approximately $40,000.

There is currently no approved standardized list of equipment or a process to modify the list. According to the regional scan completed by each RHA in 2015 the equipment and supplies provided to the client varied somewhat from region to region. Typically each RHA provides electric lifts, hospital beds including mattresses and bed rails, commode chairs, special sleep surfaces and mobility aids such as transfer belts and sliders. Again there is variation in the provision of supplies by the RHAs but wound care supplies and continence products are typically provided when the client is assessed as eligible for home care services.

In 2007 a draft detailed equipment and supplies list was developed identifying all the equipment and supplies potentially required and which were the responsibility of home care and which were the responsibility of the recipient (it is unclear as to whether this document was formally approved). The Consultant was informed that two staff members from CCB, in collaboration with the RHAs, is setting up a regional survey/scan to determine what equipment and supplies are provided both in the community and in PCH. Their hope is to align the lists as much as possible. It is important this process be completed and the 2007 draft document is updated and formally approved.

A review should also be completed on how funding for equipment and supplies is currently provided as part of the global budget. The review should address the issue of consistent and adequate funding for these two items. The review should also include a review of what the client is expected to pay. There is also a need for the RHAs to establish an equipment monitoring/tracking

system to keep track of all the equipment assigned to clients. It goes without saying over the next few decades, as the number of clients significantly increases, there will be an increased need for equipment and supplies.

Specific Recommendations

55. Complete the review of equipment/supplies currently underway.
56. Develop a standardized list of equipment, a process to modify the list, and define client payment requirements.
57. The Department and the RHAs collaboratively establish provincial policies and procedures for tracking the assignment of equipment and for monitoring trends.

V. NATIONAL/INTERNATIONAL LITERATURE SCAN

This section will provide a brief summary of the state of the home care in Canada by showing the similarities and differences in the different provinces. This scan will provide a description of Manitoba's position in the current Canadian home care scene. The international scan identifies the similarity of issues that are being grappled with in home care in Manitoba and a number of European, Nordic and Oceania countries. It is very apparent we should be able to learn from each other.

A. National Scan

The following two publications on home care in Canada were a major resource for this review: *Portraits of Home Care in Canada 2013* (CHCA, 2013) and the paper prepared for Health Canada entitled *Provincial/Regional Variation in Availability, Cost of Delivery and Wait Times for Accessing Home Care Services to Address Avoidable Admissions to Long Term Care, Alternate Level of Care Bed Days and Hospitalization* (Keefe, J. et al., 2014). A third document that was very helpful was the poster presentation to CHCA in 2014 entitled *Mapping the Landscape of Home Care in Canada* (Ogilvie, R., et al., 2014). This one page poster provides a succinct summary of the major characteristics of home care services in Canada. The services are mapped under five headings: Referral Source, Access, Funding Structure, User Fees and Basket of Services.

The mapping shows there is considerable similarity in home care services across Canada but there are also significant differences. Home care is not an insured service so each province/territory (P/T) has the responsibility to design and deliver its own program. The following shows how Manitoba compares with the other provinces/territories in each of these five categories.
- **Referral Source** – In Manitoba anyone can make a referral, including self-referrals. This is similar to the majority of the provinces/territories.
- **Access** – In Manitoba access is through the RHAs. There are a number of other provinces that also have decentralized access through RHAs or similar organizations. The other provinces/territories have centralized access typically via the home care program itself.

- **Funding Structure** – Manitoba and two other provinces and three Territories (Prince Edward Island, Ontario, North West Territories, Yukon Territories and Nunavut) provide full funding coverage for homemaking, personal care, nursing and allied health professional services. Typically the other provinces have no charge for nursing and allied health professional services but do have a charge for homemaking and in some cases personal care services. The payment arrangement for the client can take various forms including, an hourly charge, and income scaled, etc.
- **User Fees** – Manitoba, and the same five provinces/territories listed under the Funding Structure have no user fees.
- **Basket of Services** – In the mapping document these services are listed under four categories: Homemaking Services, Personal Care Services, Nursing Services and Allied Health Professional Services.
    - **Homemaking Services** – All the provinces/territories provide light housekeeping, laundry, meal preparation (in Manitoba in some areas provided only by exception). Some of the provinces, but not including Manitoba, also provide errands/appointment services.
    - **Personal Care Services** – All the provinces/territories provide mobility, nutrition/feeding, lifts/transfers, bathing /dressing, grooming, toileting with the exception of one province and two territories that provide some but not all of these services.
    - **Nursing Services** – In this category there is significant variation between the provinces/territories in the type of nursing services being provided. Of the ten different nursing services identified Manitoba provides the following seven services – administer narcotics, care for infusion pumps and central lines, care of ventilator, infusion therapy, manage home oxygen, hemodialysis and wound care.
    - **Allied Health Professional Services** – Again in this category there is significant variation in service between the P/Ts. All the P/Ts provide Physiotherapy and Occupational Therapy services. While some of the P/Ts provide additional allied health professional services Manitoba provides only the two identified.

B. International Scan

It is readily apparent in scanning the Internet the topic of home care is of significant interest across the western world. As part of this review a Support Unit member completed a literature review and came up with a list of over a100 articles and reports. The emerging themes from these articles included the following: informal care, telehealth/ehealth, integration, restorative /re-ablement home care, education/training, patient centered care, cash for care, care models, dementia patients remaining at home, etc. As is readily apparent this review is addressing very similar themes.

In 2014 the British Columbia Ministry of Health sponsored an international forum on the theme "Best Practices in Home Care for Seniors". The goal of the forum was to provide an opportunity for BC participants to learn how other jurisdictions are addressing the shared challenge of providing sustainable home care for seniors. Six speakers from different jurisdictions made presentations on best practices in home care for seniors. The Synthesis Report coming out of this forum presented a

brief summary of the presentations and the lessons learned. The forum included the following presentations.
- Home care re-ablement services: England, Scotland and Wales
- Restorative and preventive care approaches: Australia
- Review of the Nordic system: Denmark and Finland
- Integrated community care system: Japan
- Benefits, challenges and recent reform proposals: Italy
- Variations in cash payment and integrated care services, and policy development for individuals with dementia: Germany.

Without going into detail on any of the best practices presented at the forum it is safe to say Manitoba is also facing the challenge of providing sustainable home care for seniors. While Manitoba can, and should, learn from other jurisdictions the province is attempting to tailor its responses and initiatives to the specific set of circumstances in Manitoba.

Still continuing on the above theme there are a number of additional articles/reports that are of value. In 2008 the World Health Organization published a report titled "The Solid Facts: Home Care in Europe" (Tarricone, R., and Tsouros, A., 2008). What is most striking about this report is how similar the European issues are to the ones that we are facing in Manitoba, including: demographic shift, funding for home care, integration of home care and other services, effect of technology on the development of home care and the challenges for health policy and decision-makers.

The publication "Health and Social Care in the Community" published a number of articles and/or special issues addressing similar themes to the themes already identified. The topics addressed in these articles included:
- The Netherlands: the struggle between universalism and cost containment (Da Roit, R. B., 2012)
- Home care for older people in Sweden: a universal model in transition (Szebehely, M., and Trydegard, G., 2011)
- Important features of home-based support services for older Australians and their informal carers (McCaffrey, N., et al 2015)
- Norwegian home care in transition – head for accountability, off-loading responsibilities (Vabo, M., 2012)
- A comparison of the home-care and healthcare service use and costs of older Australians randomized to receive a restorative or a conventional home-care service (Lewin, G., et al, 2014)

Any one of the above entries on home care themes and best practices can be followed up further to determine if, and how, they might apply to the Manitoba situation. What is certain is that the different jurisdictions, including Manitoba, are facing similar challenges.

VI. SUSTAINABILITY

This topic will be divided into two major sections – financial and HR/workforce – and a lesser section on ICT and other costs. It should be noted that as a Consultant I am not in a position to determine what level of home care funding is sustainable since it is solely up to the government to determine the amount of resources to be allocated to home care. What I am able to do is to describe some scenarios outlining potential future projected costs and HR requirements. These scenarios are illustrative in nature rather than definitive. It might be noted that sustainability can be achieved in more than one way. If government finds itself unable to fully fund the growing home care service there are three potential options. The first option would be to reduce the number of services forming the core basket of services; the second option would be to initiate some form of user pay for select services, and the third option would be some combination of the other options.

A. Financial

As has already been described in the earlier section on Finances the total home care funding in 2014/15 was $324 million. This represented approximately 6% of the total health expenditures and $250 per capita. The percentage spent on home care as a proportion of total health expenditures has typically hovered around 5.5% - 6% annually.

Before presenting some possible scenarios there are a number of factors that should be identified. There appears to be little relationship between the annual increase in home care funding and the growth in the number of clients or the units of service. As an example in the 15 year period from 1999/2000 – 2014/15 the home care funding increased by approximately 116% or 7.7% annually, while the number of clients for that same period increased by 9% or less than 1% annually. This directly leads to a second factor, that of fixed costs. Fixed costs are mainly composed of compensation, benefits and pension for the home care workforce and to a much lesser extent an increase in the cost of supplies and equipment as well as inflation. The Provincial Health Labour Relations Secretariat completed a survey of salary increases for the HSW, HCA 1 and HCA 2 positions for the past 19 years. During that period HCA 2 positions experienced an 80.27% cumulative increase in salaries or approximately 4.2% annually. HCA 1 positions had a cumulative increase in salaries of just over 50% and HSWs a 56% cumulative increase. Of these three categories of home care personnel the largest proportion is composed of HCAs. In addition to salary increases there was also an improvement in benefits/pension. It may be of some relevance that the home care funding for the 9 year period (2005/06 – 2014/15) increased at a yearly equivalent of 4.8% while, at the same time, there was little growth in the number of clients. The likely conclusion to be drawn is that most of this increase in funding was mainly, if not entirely, due to fixed costs. Both of these approaches have a very similar result.

When it comes to determining the level of funding for home care it is important to remember when home care does not provide the services as outlined in the care plan it may result in the client accessing services from other parts of the health system and frequently at a higher cost e.g., hospitals. Typically, home care is the least costly option available.

What follows are three different scenarios projecting future funding levels for home care. While the scenarios are presented for illustrative purposes only they all indicate a similar trend upward in home care expenditures.

Scenario 1
Manitoba Bureau of Statistics released a study in 2015 entitled *Health Care Spending in Manitoba 2012 to 2037* (MBS, 2015)*.* The report states that "From the present 2015 healthcare expenditure of $5,985 million, it is estimated to rise in 2025 to $8,182 million, an increase of 36% while in 2035, it rises to $11,119 million which is an increase of 86%"(p. 2). According to this analysis, the 2014/15 home care funding of $324m would increase by approximately $279m for a total home care funding of approximately $603m by the year 2037. A slightly different variation could be to project a doubling in home care expenditures by 2037. This would represent an increase of $324m, for total home care funding of $648m by the end of that period. It should be noted that the MBS report goes on to state "Without significant federal government intervention, the provincial health care system in its current form is not sustainable" (p. 2).

Over the past 3 years home care funding has been increasing at a yearly equivalent of 1.3%. Whether this low rate of increase is sustainable in the long term is an open question. Nevertheless, assuming the 1.3% represents fixed costs and, as projected, the yearly increase in the number of clients is the equivalent of 3.5% the total annual increase would be 4.8%. In 22 years this represents a doubling of home care funding. This is very similar to the above variation.

Scenario 2
The second scenario is based on the assumption the future will look very similar to the past. Over the 15 year period described above, the funding increased by a total of 116% or a yearly equivalent of 7.7%. Based on that experience, a future 22 year period (2015 -2037) would represent an increase in funding of 170% (22 x 7.7%). Using as a base the 2014/15 funding of 324m funding would increase by approximately $550m for total home care funding by 2037 of $874m. This scenario does not break down expenditures by fixed cost or volume increases.

Scenario 3
This scenario is based on future fixed cost increases and volume growth. According to the analysis provided in Section I: Demographic and Clinical Changes the growth in the number of clients and units of service is projected at a yearly rate equivalent to 3.5%, for a total growth till 2037 of 77% (22 x 3.5%). It is however much more difficult to project the future increase in fixed costs. The collective agreement bargaining process between the Manitoba government and the unions largely determines these costs. Extrapolating from the information provided by the Provincial Health Labour Relations Secretariat on the growth in compensation/benefits for the past 19 years it could be estimated that compensation cost going forward might increase at a similar yearly equivalent rate of 4 or 4.5%, plus any increase in benefits/pension and the cost of equipment and supplies. This projected increase in fixed costs is very similar to the 9 year experience, mentioned above, of annual funding increases of 4.8% - since there was little increase in the number of cases it can be reasonably assumed that this funding increase is due mainly to fixed costs. When combining projected volume growth and fixed cost increase in this scenario the annual increase in expenditures until 2037 would be in the range of 8-8.5% annually (3.5% + 4-4.5%) or 177% over

the 22-year period. The amount of increase in this scenario is very similar to the increase in Scenario 2 (7.7% annually over 15 years - $573m)). It should be noted the percentage increase using this scenario could be substantially less depending on what happens with collective agreement compensation/benefits/pension increases.

In conclusion, of the three different methodologies used, Scenario 1 projects the lowest increase in home care funding over the next 22 years while Scenario 2 and Scenario 3 project similar increases depending on what happens with collective agreement increases. Depending on that, Scenario 3 would project the highest increase in funding. It should be acknowledged we are not able to project with any degree of certainty what is going to transpire over the next 20 years. The three scenarios describe an annual increase in funding of 4.5% at the low end and 8% at the high end. Given the uncertainty of what will unfold over the next 20 years the projections should be reviewed at regular intervals – possibly every five years.

ICT and Other Expenditures
This review identifies there will need to be a substantial investment in ICT systems over the next 20 years. This review includes no estimate on what those costs might be although in all likelihood most of these costs will be in addition to the funding increases identified in the above scenarios. It will require strategic planning and the development of detailed funding models to determine these costs.

The cost for individual recommendations has not been determined. Many of the recommendations either represent no additional costs or are already included in the funding scenarios outlined above. There are some situations/recommendations, however, that may require additional resources beyond what is included in the scenarios. Included are such items as: improving the hospital discharge process, establishing more community services/clinics, standardization of services province-wide, increase of resources for the Department, and enhanced recruitment efforts.

B. Human Resources

While it will be a major challenge for government to fund the increase in home care services over the next two decades, an even greater challenge will be recruiting and retaining the necessary workforce. Currently the total home care workforce is composed of approximately 3,500 EFTs (see section on Human Resources for more detail).

Projecting future workforce requirements is more straightforward than projecting future funding requirements. The number of units of service (unit equals one hour) provided by home care can be used to calculate the size of the workforce. For the period 2008/09 – 2012/13 the average number of units of service provided annually by HCAs and HSWs was 5,521,472 units of service. This represented the equivalent of approximately 2,600 HCA/HSW EFTs (one full time EFT HCA/HSW position represents 2080 hours of work annually). Using the projected growth in the units of service of a yearly equivalent rate of 3.6% or 80% for the 22 year period approximately an additional 2,000 HCA/HSW EFTs will be required in that time period. This represents

approximately 90-100 new positions each year. This is in addition to filling vacant positions in the current workforce (at any one time the vacancy rate is 8-10%).

The number of additional registered nurses (RNs) that will be required can also be calculated. For the period 2008/09 – 2012/13 the average number of units of service provided by RNs annually was approximately 560,000 units. This represented the equivalent of approximately 280 EFTs – the actual number as provided by the RHAs was approximately 300 RN EFTs (one full time RN position represents 2,015 hours of work annually). Using the projected growth in units of service of a yearly equivalent rate of 3.6% or 80% for the 22 year period approximately an additional 220 RN EFTs will be required in that time period. In regard to licenced practical nurses (LPNs) the average number of units of service for the five-year period provided annually was approximately 225,000 units. This represented the equivalent of approximately 115 LPN EFTs – the actual number as provided by the RHAs was approximately 150 LPN EFTs (one full time LPN position represents 2,015 hours of work annually). Again using the projected yearly growth in units of service of 3.6% or 80% for the 22-year period approximately an additional 90 LPN EFTs will be required in that time period. In addition to the above front line workers there will also be a need for more scheduling clerks, case coordinators, resource coordinators and administrative staff.

Recruiting all of these additional staff will represent an extreme challenge. Since HCAs must be certified, this will require additional educational capacity. Also this work force will remain very dependent on recruiting immigrants. In all likelihood millenials, who will form a major component of the future work force, may not be attracted to home care positions (see the HR section for more detail). All of this suggests that extraordinary efforts will have to be put into the recruitment and retention of personnel.

VII. RESPONSE TO OAG REPORT AND SINCLAIR/ALEXANDER INQUESTS

What follows is a two-part response on the follow-up to the OAG Report Recommendations. Additionally there is also a brief response on the follow-up to the recommendations from the Brian Sinclair and Frank Alexander Inquests.

A. Response to OAG Report

Continuing Care Branch Response
The Department has reviewed the report and its recommendations and is actively working on meeting these recommendations. Even though the OAG only conducted their detailed audit on the two RHAs, the Department took an "all RHA" approach in accepting and planning the response to the recommendations outlined in the report. All RHAs have reviewed the report and specific recommendations focused at the RHA level.

Responding to the recommendations will be a multi-year process and will require dedicated time and human resources to be able to fulfill the recommendations effectively.

The following steps have been taken to date:
- In collaboration with the CHCA, a Knowledge Network HUB, with representation from each RHA has been established to support the work underway to address the recommendations contained in the OAG report. The HUB will utilize the CHCA's expertise and the Home Care Knowledge Network to facilitate the implementation of the recommendations.
- The HUB's first goal is to define core HC services and to what extent they are available in the regions. This determination is central in meeting many of the other OAG recommendations (Recommendation 2a).
    - Consultations were held in each RHA to identify gaps and explore potential solutions in meeting this goal.
    - The HUB is in the process of reviewing policies and standards in order to prioritize those that will be updated first. As policies are revised, performance measurement will be included to improve accountability and provide for greater forecasting and analysis of future trends and current conditions (Recommendations 4, 5, and 6).
    - A jurisdictional scan is in progress to assess for key performance measures and standards. The HUB is in the process of evaluating present performance measures used within each RHA with respect to service timeliness and reliability. Further work is planned to develop key client outcomes so that provincial standards can be determined and evaluated in the future (Recommendation 6).
- A review of the Home Care Guide and revisions will be made as policies and core services are defined. Additional information will be provided to stakeholders and the public through the Department website (Recommendations 2b and 7).
- The province-wide implementation of the clinical client assessment tool, the RAI-HC (Resident Assessment Instrument – Home Care) has begun. System requirements have

been gathered to determine which information system will best support the HC clinical functions. Vendor demonstrations have occurred. Phase 1 of this project is underway to upgrade the RAI-HC tool in the WRHA and implement in PMH. Phase 2 will include the implementation of the IT solution throughout the remaining three RHAs (Recommendation 14).

- Collaboration with Manitoba eHealth, the RHAs and the Department is occurring in the development of a clinical information system that support and identify client/patient information to be shared between community and acute care teams and stakeholders at transition points in care, especially for the vulnerable population or those under the Public Guardian and Trustee (Brian Sinclair Inquest Report).
- The Department is in the process of reviewing the RHA responses and is determining priorities and setting benchmarks for evaluation of the RHAs in implementing the recommendations.
- Active work is underway particularly in WRHA and SHSS to address the recommendations. Since only two of the five RHAs were participants in the audit, some different trends/recommendations may be determined. These will be shared with the RHAs and collaborative efforts will be undertaken to meet the recommendations.
- Regular updates on progress have been received and reviewed. Many of the regional recommendations hinge on the development of departmental policies and standards e.g. Improved awareness of home care services to public and physicians can only occur once the core services are identified and policies regarding provision are defined (Recommendation 8); case coordinators will be better able to assess and negotiate once standardized assessment tool is available throughout the province and core services are defined (Recommendation 12a and 12b).
- Specific recommendations that have been addressed or are in progress are:
  - WRHA has hired a process-improvement specialist to help reduce the overall time of processing referrals. The RAI-HC Contact Assessment is in the process of being implemented. This tool will assess client urgency (Recommendation 10).
  - SHSS through education, revisions to documentation guidelines and clinical audits has made significant improvements in the completion of needs assessments (Recommendations 11, 15).
  - WRHA has implemented weekend staffing of hospital case coordinators and resource coordinators. PMH also provides weekend staffing of hospital case coordinators. Improvements to hospital discharge processes are underway in WRHA with the support of the process engineer (Recommendation 17).
  - Procura©, the electronic scheduling tool, is being upgraded throughout the province to prevent multiple visits being scheduled in the same time slot. WRHA has completed this task. (Recommendation 21b).
  - A committee with representation from the RHAs and Manitoba Government Employees Union (MGEU) to review task times and scheduling issues and enhance oversight of the EFT initiative has been established and is currently working to optimize scheduling in home care. (Recommendations 17, 18, 19, 20, 21a, and 22).
  - All RHAs have developed a complaints policy in place with a tracking component. (Recommendation 23).

- WRHA and SHSS are working collaboratively with the Colleges to determine what tasks require delegation and to ensure alignment with the regulatory bodies standards of practice (Recommendation 24).
- SHSS has included conflict of interest policy and information as a part of the employee package upon hiring (Recommendation 27).
- SHSS has made significant progress on improving their quality assurance processes. An audit tool has been developed and trialed with respect to the referral process and service delivery. It was reviewed with three focus groups comprised of CC and RC's. Evaluation of the information is underway and further refinements will be made to align it with strategic priorities and identify action plans. SHSS's treatment clinics participated in advance access where work on identifying supply and demand requirements were undertaken with the goal of providing clients with same or next day appointments (Recommendation 28).

Review Response to OAG Report

This Report explicitly identifies those sections where the narrative and the recommendations flowing from the narrative complement or support specific OAG Audit recommendations. The specific OAG recommendations are not repeated in the review Report recommendations. However, when both sets of recommendations are taken together they reinforce each other and provide a more comprehensive picture, current and future, of the home care services and the issues needing to be addressed.

B. Response to Brian Sinclair and Frank Alexander Inquests

Response to Brian Sinclair Inquest Report

The following Recommendations from the Sinclair Inquest are relevant for home care services. A brief description of the RHAs response follows the listing of the Recommendations.

- Recommendation 2 - That RHAs review policies and procedures to ensure that home care updates service providers concerning any hospitalization of their clients.
- Recommendation 3 - That RHAs review policies and procedures to ensure that each home care service provider is made aware of the specific care plan for each Committee.
- Recommendation 4 - That RHAs review policies and procedures to ensure that when a home care medical service is put on hold, suspended or withdrawn from any client for any reason, that there is an alternate plan in place or that the hold be reviewed on a regular basis.
- Recommendation 5 - That RHAs review policies and procedures to ensure the provision to service providers of relevant background information of home care vulnerable clients.
- Recommendation 35 - That the RHAs review the feasibility of a seven-day workweek for the office of the case coordinator.

The RHAs have identified two policy areas to address the recommendations 2 to 5. These two policy areas include having alternate plans in place when putting home care services on hold, and ensuring that service providers have the relevant information on vulnerable clients. The

implementation of practices/policies began March 31, 2016 in all the RHAs. The implementation continues to be rolled out. At the same time provincial policy is under development in these two areas. The new policy will set out the need for RHAs to have policy or procedures in place to address these areas along with a process to monitor/audit compliance with the policy.

In terms of Recommendation 35, the WRHA and home care services in Brandon have, to some extent, implemented a seven-day a week service. Further work will be done on Recommendation 35 as part of the follow-up to the hospital discharge section of this Report.

Response to Frank Alexander Inquest Report
The following Action Statements (AS) from the Alexander Inquest report are relevant to home care.
- AS 12 – The RHAs will determine a process, incorporating a three-month follow-up, for client situations where home care services assessment has been refused and the client has dementia.
- AS 13 – The RHAs will develop a process/system to track those client situations requiring three-month follow-up.

Plans are underway in the RHAs to track client situations as outlined above. Given the lack of ICT systems manual tracking in these instances is required as a first step. Electronic charting, assessment and recording tools are lacking in many of the home care programs, particularly in the rural RHAs. Availability of these tools would greatly assist in the completion of these Action Steps.

VIII. THE WAY FORWARD

This review has attempted to project the long-term demands on home care services and the nature of the program going forward. While it is primarily the future that is being addressed in this review the implementation of certain major recommendations cannot be delayed - the way forward begins now. Having the implementation process receive priority should assist home care to be ready to serve the approaching wave of aging baby boomers that will increasingly require the services of the health care system. It will also help ensure a strong foundation is in place to meet the future operational and service demands.

The following major issues/areas should receive early attention (the linkage with other issues will become apparent at the same time). Addressing these issues, however, cannot be fully achieved within the available current resources.
- There is a crucial need for an effective province-wide Information and Communication Technology system. As described in this report (see section on ICT and Home-Based Technology), without such an ICT system in place the necessary information is not available for province-wide monitoring and evaluation of the home care services, for the efficient utilization of the home care workforce, for increasing public accountability and other related issues.
- The Continuing Care Branch must be provided with sufficient resources for it to fulfill its designated role (see section on Leadership and Organization). In order to be able to

address significant future demands on the home care services strong provincial leadership will need to be in place.

- There is a variety of HR/workforce issues that require immediate attention (see section on HR). These issues include recruitment and retention of staff, particularly HCAs; development of a standardized provincial curriculum for the education of HCAs; EFT related issues (see section on EFT Related Issues), such as, scheduling, insufficient task time and continuity in the assignment of service providers, and others.

IX. ITEMS REQUIRING FUTURE WORK

Home care services would benefit from further study of the following items since each one is important for the future sustainability of the service. In order to move this process forward in an orderly fashion the items should first be prioritized and then a study plan should be developed for each item. The following is not an exhaustive list of topics and others may be added as this work proceeds:

1. Study how government legislation, regulations, policies and programs, e.g. social, family, workplace, taxation, might be used/adapted to support family and informal caregivers.
2. Using the presentation *Technology in Home Care – Today & Tomorrow* as a resource, study the whole area of home-based technology and its application. This research should include, but not be limited to areas such as: the role of the private vendor in the use of technology, payment for the technology – by the client or home care, introduction of the technology into the home and many other related items.
3. Using the presentation *Health Workforce in Home Care: Today & the future* as a resource, study the broad area of human resources. The topics should include, but not be limited to: addressing discrepancies between collective agreements; comprehensive reviews of RC/DSN/CC positions to determine workload benchmarks; evaluation and standardization of job descriptions for SC/RC/CC as well as HCA and HSW positions, evaluation of specific competencies for success in the different positions, and other topics.
4. Carry out further study on housing with health services models to determine which models are the most effective, efficient and client friendly from a home care service perspective.
5. Complete further study on the possible merits of separating SFMC into two distinct streams – Self Managed Care in the one stream and Family Managed Care in another stream.
6. Research different funding models for home care and their possible use in Manitoba. Most of the other provinces/territories have instituted some variation of co-payment, fee for service, or other shared cost arrangements. These shared cost models should be studied to determine their pros and cons and how applicable they could be in other jurisdictions.

APPENDIX A

HOME CARE LEADERSHIP TEAM MEMBERS

NAME	PROVINCIAL LOCATION	DESIGNATION - STAFF/CAREGIVER/STAKE HOLDER
Vikas Sethi	Urban	Home Care Director
Shannon Gillich	Urban	Resource Coordinator
Christine St. George	Urban	Direct Service Nurse
Katherine Bayes	Rural	Program Director, Home Care/Services to Seniors
Sarah Monias	Northern	Nursing Care Coordinator
Tara Henderson	Rural	Resource Coordinator
Lisa Holloway	Rural	Home Care Attendant
Terry McIntosh	Urban	Stakeholder - Disability Community - Client
Ellen Karr	Urban	Stakeholder - WRHA Home Care Advisory Council and Family Caregiver
Brenda Black	Rural	Family Caregiver
Denise Miller	Rural	Family Caregiver
Lorraine Dacombe Dewar	MHSAL	Executive Director, Continuing Care Branch
Reg Toews	Chair	Project Consultant

APPENDIX B

HOME CARE SUPPORT UNIT

NAME	TITLE
Lorraine Dacombe Dewar	Executive Director, Continuing Care Branch Manitoba Health, Seniors and Active Living
Roxie Eyer	Director, Continuing Care Branch Manitoba Health, Seniors and Active Living
Margarete Moulden	Program Consultant, Continuing Care Branch Manitoba Health, Seniors and Active Living
Karen Stevens-Chambers	Regional Director, Home Care and Palliative Care Services Interlake-Eastern Regional Health Authority
Lori Mitchell*	Researcher, Home Care Program Winnipeg Regional Health Authority

*Lori Mitchell, PhD researched and prepared Section I Demographic and Clinical Changes.

APPENDIX C

SUPPORT UNIT PRESENTATIONS TO THE LEADERSHIP TEAM

TITLE	PREPARED/PRESENTED
Home Care in Manitoba	Prepared and presented by Roxie Eyer
Population Aging, Projections and the Future of Home Care	Prepared and presented by Lori Mitchell, PhD
Advancing Continuing Care *A Blueprint to Support System Change*	Prepared by Lorraine Dacombe Dewar & Roxie Eyer and presented by Roxie Eyer
Supporting the Informal Caregiver	Prepared and presented by Margarete Moulden & Lori Mitchell, PhD
Technology in Home Care - Today and Tomorrow	Prepared and presented by Karen Stevens-Chambers
Self and Family Managed Care (SFMC) - Today and the Future	Prepared and presented by Margarete Moulden & Roxie Eyer
Health Workforce in Home Care - Today and the Future	Prepared and presented by Karen Stevens-Chambers
Population Aging, Projections and the Future of Home Care Part II	Prepared and presented by Lori Mitchell, PhD

REFERENCES

Advancing Continuing Care: A Blueprint to Support System Change. Winnipeg, MB: Manitoba Health, Seniors and Active Living.

Best practices in home care for seniors: Synthesis report from the 2014 international forum. Michaels Smith foundation for Health Research. BC, Canada: Ministry of Health.

Anderson, W., & Wiener, J. (2015). The impact of assistive technologies on formal and informal home care. *The Gerontologist* 55(3). doi: 10.1093/geront/gnt165

Butler, S., Brennan-Ing, M.,Wardamasky, S., & Ashley A. (2014). Determinants of longer job tenure among home care aides: What makes some stay on the job while others leave? *Journal of Applied Gerentology. Vol 33*(2).

Berta, W., Laporte, A., Deber, R., Baumann, A., & Gamble, B. (2013). The Evolving Role of Health Care Aides in the Long-term Care and Home and Community Care Sectors in Canada. *Human resources for health*. doi: 10.1186/1478-4491-11-25

Canadian Healthcare Association. (2009). *Home care in Canada: From the margins to the mainstream.* Ottawa, ON.

Canadian Home Care Association (2013). *Portraits of home care in Canada 2013.* Canadian Home Care Association.

Canadian Home Care Association (2015). *Technology-Enabled Home Care.* http://www.cdnhomecare.ca/media.php?mid=4442

Canadian Institute for Health Information (2011). *Health care in Canada, 2011: A focus on seniors and aging.* Ottawa, ON: CIHI.

Caring For you. (September/October 2014). *Celebrating 40 years of home care in Manitoba.*

CARP (2008). *A national caregiver strategy: Submission to the house of commons standing committee on finance.* Retrieved February 15, 2014, from http://www.continuingcarewatch.com/pdf/CARP%20National%20Caregiver%20Strategy%20submission%202008.pdf

Chappell, N. (2011). *Population Aging and The Evolving Needs of Older Canadians: An overview of the policy challenges.* IRPP Study 21. Montreal: Institute for Research on Public Policy.

Conference Board of Canada. *Future care for canadian seniors – Why it matters.* Briefing October 2013. Retrieved November 17, 2015, from http://ab-cca.ca/uploads/files/Communique/Communique%202013/November/14-125_FutureCareSeniors.pdf

Conference Board of Canada. *Future care for canadian seniors. A status quo forecast.* November 3, 2015. Retrieved December 8, 2015, from http://www.conferenceboard.ca/e-library/abstract.aspx?did=7374

Da Roit, B. (2012). The Netherlands: The struggle between universalism and cost containment. *Health and Social Care in the Community,* 20(3), 228-237. doi/10.1111/j.1365-2524.2011.01050.x

Doupe, M. (2016). *Supportive housing for seniors: Reform implications for Manitoba's older adult continuum of care*. Winnipeg, MB: University of Manitoba, Manitoba Centre for Health Policy, 1-9.

Faul, A., Schapmire, T., et al (2010). Promoting sustainability in frontline home care aides: Understanding factors affecting ob retention in the home care workforce. *Home Health Care Management & Practice. 22*(6) 408-416.

Fausset, C., & Harley, L. (2014). Designing home health technologies for older adults: The human systems integration approach. *Biomedical Instrumentation & Technology* 48(5).

Giannasi, W. (2012). *Innovations in home care: A public policy perspective – uncovering the systemic issues in home care*.   Howegroup.

Gilbert, J. (2011). The millennials: A new generation of employees, a new set of engagement policies. *Ivey Business Journal*.

Guthrie, L. (2009) *The next generation of workers*. The Ken Blanchard Companies.

Halamandaris, V. J. (2013). Technology and home health. *Caring: National Association for Home Care magazine* 32(8).

Harrefors, C., Axelsson, K., & Savestedt, S. (2010). Using assistive technology services at differing levels of care: Healthy older couples' perceptions. *Journal of Advanced Nursing* 66(7). doi: 10.1111/j.1365-2648.2010.05335.x.

Harris, M. (2010). Technology and education…..What if? Home Health Care Management & Practice 22(4).

Health Council of Canada (2012). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* Retrieved January 26, 2014, from http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

Health Council of Canada (2013). *Better health, better care, better value for all: Refocusing health care reform in Canada.* Retrieved January 26, 2014, from http://www.healthcouncilcanada.ca/content_bh.php?mnu=2&mnu1=48&mnu2=30&mnu3=53

Hewko, S., Cooper, S., et al. (2015). Invisible no more: A scoping review of the health care aide workforce literature. *BMC Nursing*. doi: 10.1186/s12912-015-0090-x.

Hirdes, J.P., Poss, J.W., & Curtin-Telegdi, N. (2008). The Method for Assigning Priority Levels (MAPLe): A New Decision Support System for Allocating Home Care Resources. *BMC Medicine, 6(9)*, http://www.biomedcentral.com/1741

Home Care Administrative Policy Manual 207 (2012). *207.1 Role of the Family / Informal Caregiver.* Canada: Government of Manitoba.

Home Care Administrative Policy Manual 207 (2012). *207.16 Household Maintenance and Laundry Service.* Canada: Government of Manitoba.

Home Care Policy Manual (September 2015). Canada: Government of Saskatchewan.

Keefe, Janice (2011). *Supporting caregivers and caregiving in an aging Canada.* Institute for Research on Public Policy, No. 23. Retrieved February 15, 2014, from http://irpp.org/wp-content/uploads/assets/research/faces-of-aging/supporting-caregivers-and-caregiving-in-an-aging-canada/IRPP-Study-no23.pdf ISSN 1920-9436 (Online) ISBN 978-0-88645-265-0 (Online)

Keefe, J., Légaré, J., Carrière, Y. (2007). Developing new strategies to support future caregivers of older canadians with disabilities: *Projections of need and their policy implications.* Canadian Public Policy Vol. 33, Supp. Retrieved Jan 26, 2016, from http://www.msvu.ca/site/media/msvu/2007%20Developing%20new%20strategies%20to%20support%20future%20caregivers%20of%20the%20aged%20in%20Canada(1).pdf

Keefe, J., Ogilvie, R., Stevens, S., MacPherson, D., Stoddart, N. (2014). *Provincial/Regional variation in availability, cost of delivery and wait times for accessing home care services to address avoidable admissions to long term care, alternate level of care bed days and hospitalization*. Health Canada.

Keltgen, J., & College. J. Do millennials deliver generational angst to healthcare? http://www.augie.edu/sites/default/files/do_millennials_deliver-keltgen.pdf

Lewin, G., Allan, J., Patterson, C., Knuiman, M., Boldy, D., & Hendrie, D. (2014). A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a

restorative or a conventional home-care service. *Health and Social Care in the Community,* 22(3), 328-336. doi: 10.1111/hsc.12092

Lipschults, A. (2014). Health Care Technology Is on the Move. *Biomedical Instrumentation & Technology* 48(1).

Manitoba Bureau of Statistics (2015). *Impacts of Demographic Change on Manitoba, 2015.* Winnipeg, MB: Manitoba Bureau of Statistics.

Manitoba Bureau of Statistics (August 2015). *Health care spending in Manitoba 2012 to 2037.* Winnipeg, MB.

Manitoba Bureau of Statistics (November 2015). *Disability in Manitoba 2012 to 2036*, 3-8. Winnipeg, MB.

Manitoba Department of Health and Social Development. *The Home Care Program in Manitoba, Policy Paper No. 3, 1976*

Manitoba Department of Health and Social Development. *1974 Annual Report (excerpt)*

Manitoba Health and Social Development. *Home Care Working Group Report 1974*

Mauirits, E., deVeer, A., van der Hoek, L., Francke. A. (2015) Autonomous home-care nursing staff are more engaged in their work and less likely to consider leaving the healthcare sector: A questionnaire survey. *International Journal of Nursing Studies*.

McCaffrey, N., Gill, L., Billingsley, K., et al (2015). Important features of home-based support services for older A ustralians and their informal carers. *Health and Social Care in the Community,* 23(6), 654-664. doi: 10.1111/hsc.12185

McKenzie, B., Bown, M.E., Keys, K., & Bulat, T. (2013). Safe home program: A suite of technologies to support extended home care of persons with dementia. *American Journal of Alzheimer's Disease & Other Dementias* 28(4). doi: 10.1177/1533317513488917

Mitchell, L., Hirdes, J., et. al. (2015). *Informal caregivers of clients with neurological conditions: Profiles, patterns and risk factors for distress from a Home Care prevalence study.* BMC Health Services Research. 15: 350; doi 10.1186/s12913-015-1010-1

Morris, J. N., Fries, B. E., Bernabei, R., Steel, K., Ikegami, R., Carpenter, I., Gilgen, R., DuPasquier, J., Frijters, D., Henrard, J., Hirdes, J. P., & Belleville-Taylor, P. (2002). *RAI-Home Care (RAI-HC) Assessment Manual for Version 2.0 (Canadian version).* Washington, DC: interRAI Corp.

Ogilvie, R., & Keefe, J. *Mapping the landscape of home care in Canada.* NS, Canada: Mount Saint Vincent University.

Peeters, J. M., Wiegers, T.A., & Friele, R.D. (2013). How technology in care at home affects patient self-care and self-management: A scoping review. *International Journal of Environmental Research and Public Health* 10(11). doi:10.3390/ijerph10115541

Putre, L. (2013, September 1). The march of the millennials: Your hospital staff in 2025. *HHN Magazine.*

Redfoot, D., Feinberg, L., and Houser, A. (August 2013). *The aging of the baby boom and the growing care gap: A look at future declines in the availability of family caregivers*. AARP Public Policy Institute. Washington, DC, from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf

Ritchot, S. (2012). *Canadian educational standards for personal care providers*. *Environmental scan*. The Association of Canadian Community Colleges and the Canadian Association of Health Care Aide Training Environmental Scan Follow-up Report.   Manitoba Health, Health Workforce Strategies.

Sinha, M. (2013). *Portrait of caregivers 2012. Spotlight on Canadians: Results from the General Social Survey.* Statistics Canada. Catalogue no. 89-652-X — No. 001 ISBN 978-1-100-22502-9. Retrieved March 2, 2014, from http://www.ccc-ccan.ca/media.php?mid=378.

Sloane, P.D., Zimmerman, S., D'Souza, M. F. (2014). What will long-term care be like in 2040? *North Carolina Medical Journal.* 75(5), pp 326-330. Retrieved January 26, 2016, from http://www.ncmedicaljournal.com/content/75/5/326.abstract?etoc&cited-by=yes&legid=ncm;75/5/326

Statistics Canada (2015).

Statistics Canada (2015a). *The Annual Demographic Estimates: Canada, Provinces, and Territories, 2015* (Statistics Canada Catalogue no. 91-215-X). Ottawa: Statistics Canada.

Statistics Canada (2015b). *Population Projections for Canada (2013-2063), Provinces and Territories (2013-2038)* (Statistics Canada Catalogue no. 91-520-X). Ottawa: Statistics Canada.

Stone, R., Sutton, JP., Bryant, N., Adams, A., & Squillace, M. (2013). The home health workforce: A distinction between worker categories. Home Health Care services quarterly, 32(4), 218-233. http://dx.doi.org/10.1080/01621424.2013.851049

Szebehely, M., & Trydegard, G., (2012). Home care for older people in Sweden: A universal model in transition. *Health and Social Care in the Community,* 20(3), 300-309. doi: 10.1111/j.1365-2524-2011.01046.x

Tarricone, R., & Tsouros, A. *The solid facts*: *Home care in Europe*. World Health Organization Europe, from htthttp://www.euro.who.int/__data/assets/pdf_file/0005/96467/E91884.pdf

The Conference Board of Canada. (2012). Home and community care in Canada: An economic footprint. Ottawa, ON.

Toews, R. (2016). Consultation Notes.

Vabo, M. (2012). Norwegian home care in transition – heading for accountability, off-loading responsibilities. *Health and Social Care in the Community,* 20(3), 283-291. doi: 10.1111/j.1365-2524.2012.01058.x

Victorian Order of Nurses for Canada. (2008*). Health starts at Home: VON Canada's vision for home and community care.* Ottawa, ON.

Yan, L., Lix, L., Jiang, D., Einarson, K., and Dube, S. (2014). *Manitoba Population Projections: 2013-2042.* Winnipeg, MB: George & Fay Yee Centre for Healthcare Innovation.

Zwijsen, S. A, Niemeijer, A.R., & Hertogh, C.M. (2011). Ethics of using assistive technology in the care for community-dwelling elderly people: An overview of the literature. *Aging & Mental Health* 15(4). doi: 10.1080/13607863.2010.543662.