



Provincial Home Support Program

Agenda

- Provincial Home Support Program
- Program Review
- Improvement Opportunities- Some Highlights
 - Clinical Assessment and Support Planning
 - Financial Assessment
 - Home Supports Delivery
 - Policy Reform and Performance Management
 - Individualized Funding
- Vision and Guiding Principles

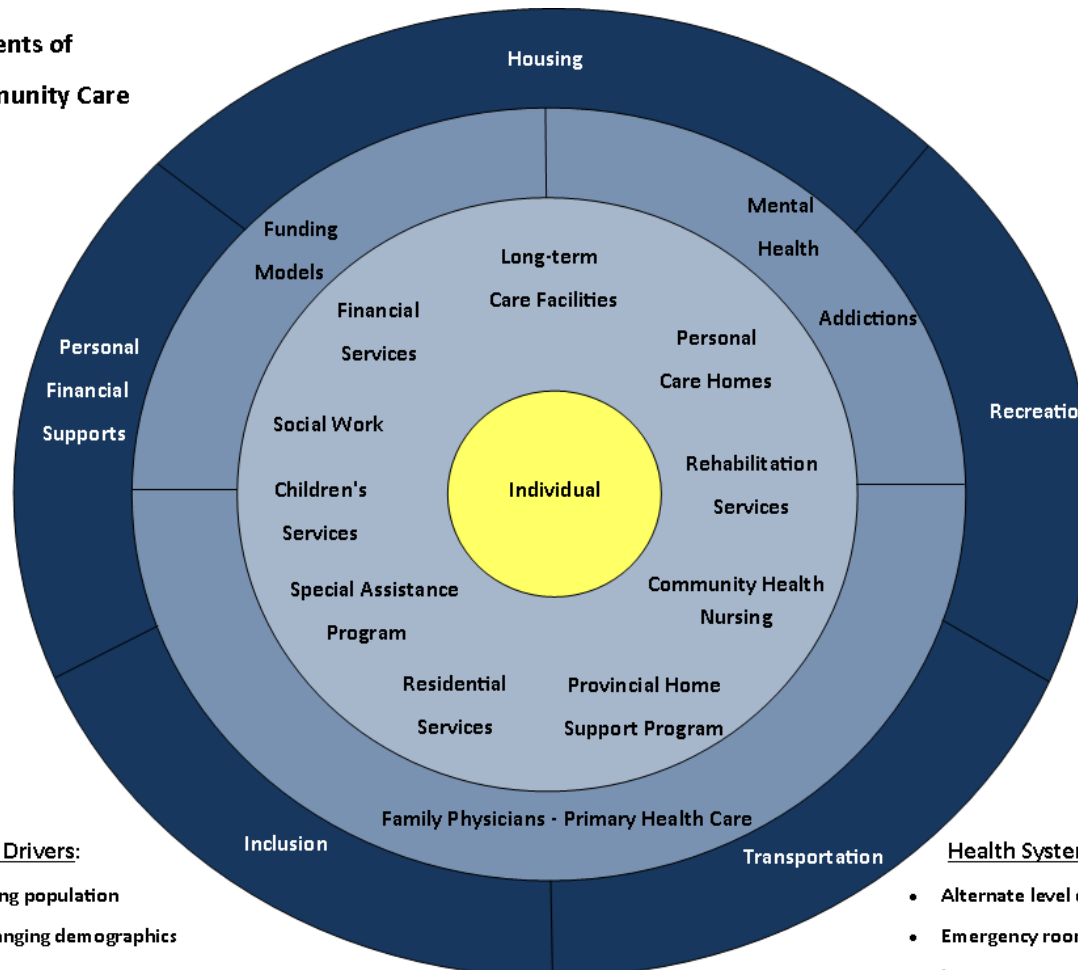
Provincial Home Support Program



- A program to provide, personal, behavioral, respite and homemaking supports to children, adults with disabilities and older adults
- Eligibility determined through clinical and financial assessment
- Intent is to support people to live in their own homes and communities; to avoid facility based care
- Delivered through the regional health authorities under the broader program of Community Support Services
- Adjacent services include residential services for adults with disabilities, community health nursing, rehabilitation services and Intervention Services
- In 2015/16, there was an average of 7200 clients availing of the PHSP per month, (9200 throughput)

Elements of Community Supports

Elements of Community Care



Social Drivers:

- Aging population
- Changing demographics

Health System Drivers:

- Alternate level of care
- Emergency room utilization
- Long-term care bed utilization

Why a review?

- Concern with the future sustainability of the program- expenditures increased significantly due to increase in overall caseload, increased cost of operating the program
- Concern with the effectiveness and efficiency of the program
- Concern with quality of services provided - qualifications of home support workers, recruitment and retention issues and client dissatisfaction with service
- Increasing number of exceptions to policy indicating standards were no longer effective
- Increasing emphasis on supporting people in their own homes and communities
- Need to decrease unnecessary utilization of facility based care

Key Findings

- Significant variation between the RHAs in delivering the program
- Clinical assessment process had significant limitations
- The financial assessment is resource intensive, burdensome and invasive
- Integration with other community programs was limited
- Monitoring and oversight of services was significantly limited
- Home support workers lacked qualifications contributing to issues with recruitment and retention
- Operational Standards were outdated and limited attention to program performance management
- Costs would increase by \$52M by 20/21 and overall workload would increase by 14%

Pillars of Reform

- Program Intake & Referral
- Assessment, Planning and Coordination, (including financial assessment)
- Home Supports Delivery
- Monitoring & Policy Standards

Program intake & referral

- Review found that eligibility screening varied, service delivery model was fragmented, information about the program was not easily accessible;
- Recommended that:
 - Promote the program using “home is best philosophy”
 - Develop accessible online resources
 - Implement a provincial centralized intake model
 - Develop strategies to improve collaboration to support referral from other providers including physicians

Clinical Assessment

- The review highlighted inconsistencies in the clinical process (who participates, fragmented documentation systems, lack of support for ineligible clients)
- The financial analysis demonstrated greater efficiency could be achieved from improvements in clinical processes (demonstrated over servicing of clients)
- Review recommended;
 - Enhance the clinical assessment tools
 - Consider risk based reassessment and delegation to paraprofessionals
 - Professional development of staff
 - Develop provincial standards to support the clinical assessment process
 - Delegate reassessments to paraprofessionals
 - Develop a clinically based allocation of support policy

Care Planning & Coordination

- Review found that clinical assessments were not being translated into support plans, little communication between service providers, little evidence of integrated care planning, planning lacked a holistic view;
- Recommended that;
 - Develop integrated care plans to improve continuity of care across the health care system
 - Develop policy standards to guide the development of service plans and communication to key service providers including home care agencies or private workers
 - Expand choice for individuals receiving supports through individualized funding models and shared service models

Financial Assessment

- Review found that clients process large volumes of paperwork, experience different assessments depending on the service, and significant RHA resources were required to support the process;
- Recommended that;
 - Streamline the financial assessment process across all programs and services
 - Optimize financial eligibility criteria and client co-payment
 - Develop financial policies that support a community-based approach to health care

Home Supports Delivery

- Review found that home supports delivery was fragmented, coordination of care was limited, services were not well monitored, no educational standard for HSW;
- Review recommended;
 - Implement service level agreements
 - Develop and implement funding models based on clinical outcomes
 - Actively engage and communicate assessments and service plans with agencies and other HSW
 - Explore the potential use of technology to support clinical monitoring and outcomes
 - Establish qualification standards for home support workers

- Review found that program policies need to be modernized, no overall performance framework, or program governance and flawed information management systems;
- Review recommended that;
 - Implement a performance management framework
 - Enhance program governance
 - Develop strategies to improve information management systems
 - Develop modernized consistent policies for the program

Vision and Guiding Principles



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

Guiding Principles

- Client centered
- Collaboration
- Client choice in delivery of services
- Timely access to home support services
- Promote independence, safety, social and community inclusion
- Integration with other health and community services

A New Health Services Delivery Plan

Embracing a new approach to health services delivery in alignment with the Triple Aim Framework

- A focus on more appropriate utilization of services
- A focus on supporting improved health status
- A focus on lowering the cost of service delivery



(Source: US Institute for Healthcare Improvement)

Questions/Discussion

Thank You!