

# HOMECARE 2012

- Achievements
- Challenges
- Opportunities

Presentation to the John K. Friesen Conference,  
May 17, 2012

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# HOMECARE 2012

- What is Homecare and what does it do?
- Who receives Homecare?
- Who provides Homecare?
- Who pays for Homecare?
- Current challenges.
- Future opportunities.
- Policy decisions that lie ahead.

# What is Homecare?

## Theory

### CIHI DEFINITION 2001

*“An array of services which enable clients incapacitated in whole or in part to live at home, often with the effect of preventing, delaying or substituting for long-term or acute care alternatives. These services may be provided by a number of different agencies or individuals.”*

### CHCA 2004

*“An array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver.”*

# WHAT IS HOMECARE?

## Reality

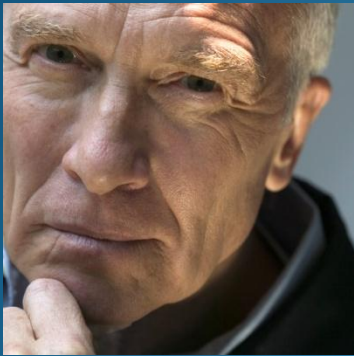
- A wide range of services, some clinical, some not.
- Clinical →
  - Chemotherapy treatments
  - Intravenous therapy
  - Dialysis
  - Wound care
  - Post-operative care
  - Physiotherapy
  - Blood pressure monitoring
  - Injections
  - Catheterization
  - Nasogastric and gastrostomy feeding/medication
  - Tracheostomy care
  - Electrical modalities
  - Chronic disease management (SARIN project) delivered by health care professionals and para-professionals.

- Non-clinical (often referred to as home support or homemaker).
  - Housekeeping
  - Bathing assist and bathing programs
  - Shopping
  - Social outings and socialization
  - Transportation
  - Day programs
  - Personal care (bathing, toileting, grooming)
  - Oxygen
  - Medications
  - Ostomy care
  - Catheter care
  - ROM
  - Lifts and transfers
  - 80% of homecare is non-clinical.

# ● WHAT DOES HOMECARE DO?

- Allows over 85,000 British Columbians to receive care at home.
- It saves money for the system when viewed as an alternative to long term care/hospitalization
- It leverages millions of hours of unpaid homecare provided by families.
- It leads to decrease in infection through reduced hospitalizations.
- It increases quality of life for most by facilitating their independence.
- It can, if not careful, create social isolation.
- It can, if not careful, result in sub-optimal care.

# LET'S MEET SOME HOMECARE CLIENTS



# ACUTE POST OPERATIVE EXAMPLE

- Could be receiving service for 1 day or 2-3 weeks.
- Could be a live in or overnight or hourly service.
- Nursing staff are coming by daily for dressing changes, wound management, catheterization, medication management.
- Physiotherapist coming by to establish exercise routine, ROM, goals for increased functionality.
- Occupational Therapist coming by to see if there are home adaptations that can facilitate a better recovery, i.e., raised toilet seat, bathing equipment.
- Nutritionist may assess the dietary needs, i.e., pureed foods, low sodium.
- Home support coming in daily to assist with personal care during recovery and/or ROM/meal prep and housekeeping.
- Expectation is the client is fully able to direct and the intervention is short term with the goal of full recovery to full independence.



# MENTAL HEALTH EXAMPLE

- Usually a chronic condition with the expectation of continued on-going support required.
- Trained mental health professional, i.e. case manager or social worker involved at the clinical level.
- Could also involve outreach workers in the community.
- Home support role needs to begin with building a relationship of trust.
- Focus is on cueing for independence, not about doing specific tasks.
- Hazard reduction, cleaning (i.e. client may never flush toilet, may never clean out fridge), think of some of the manifestations of OCD.
- Generally high function physically but have cognitive issues.
- Often interact with street population.
- In dense urban areas could be considered a homeless population.
- Usually a smoker.
- Usually living in low socio-economic areas.



# YOUNG DISABLED EXAMPLE



- MS/ALS/Quad.
- Client can direct own care.
- High level of cognitive function – many quads full function with responsible jobs – think Rick Hansen.
- High desire to express control over what independence they do have - often significant psycho-social needs.
- Performing personal care – sometimes at home, sometimes at the worksite, sometimes on the family vacation.

# FAIRLY INDEPENDENT SENIOR

- Usually less than daily.
- Usually a bath assist that can simply be having someone else in the home while the client bathes themselves.
- Some housekeeping.



# CHRONIC DISEASE MANAGEMENT CLIENT

- Could be a variety of conditions, diabetes or kidney failure for example or a combination of many factors.
- Client will be on homecare long term.
- Kidney failure client example:
  - Dialysis
  - Medication management
  - Catheter care
  - Nutrition
  - Many ADL tasks depending on fatigue level

# RESPITE CLIENT



- Client will likely have dementia – cannot be left alone.
- High cognitive impairment but may have low physical impairment.
- Respite will likely focus on engaging with clients – mental stimulation.
- Keep client awake during the day to prevent sundowner syndrome (awake at night, sleeping in the day).

# CONTINUING CARE CLIENT – EC LEVEL

- 3-5 times per day.
- High physical needs often combined with cognitive impairment.
- Personal care – toileting, pad changes.
- Preparing food and feeding (could be tube feed).
- Getting up and getting dressed.
- Bathing.
- Medications.
- Getting undressed and into bed.
- Getting outside for a walk.
- Some exercises.
- Re-assessing for changing needs.



# PALLIATIVE CLIENT

- Usually has hospice involved.
- Pain management.
- Psycho-social needs of client and family.
- Coordinating support as function diminishes.
- Support to client and family with meal prep, cleaning, personal care.



# WHO PROVIDES HOMECARE

## Clinical Professionals:

- RN's
- LPN's
- OT/PT
- Dieticians
- Social Worker
- Physician
- Pharmacists

Unpaid caregiver

Home Support/Community Health Worker

Outreach worker





# TRAINING

- Professional level training – i.e. nursing; OT/PT; social work as per discipline.
- Community Health Worker: 6 – 9 month training combination of theory and practicum.
- Moving toward standardization – the Care Aide Registry.

# SKILLS AND ABILITIES

- Able to work alone, in isolation.
- Able to deal with uncertainty and many changes (reflect on the profile of clients).
- Able to navigate to several different locations.
- Able to assess very different situations and respond appropriately.
- Respond with limited information to the situation at hand.
- Entrusted with significant autonomy and responsibility.

# TYPICAL DAY SOUTH ISLAND

- CRD – population 350,000+
- 2,800 homecare clients
- 3,000 visits per day
- 4,100 hours per day
- 6,500 kms per day
- 300 visits scheduled same day (within 24 hours)

# TYPICAL DAY FOR A CHW

- Look at schedule for day before 0700.
- Figure out where new clients are.
- Likely have 6-8 different clients each day.
- One to three will be new, one time only clients.
- Most visits are 30 minutes to 60 minutes.
- Only get paid for the hours of work.
- Arrive at client's home.
  - Review care plan
  - Review DOT – sign for
  - Receive a message from office to add another client
  - Noting in Communication Book

# WHAT AM I DOING FOR THE CLIENT?

- Getting them up.
- Personal care and toileting.
- Queuing.
- BP meds.
- Lifting and transferring.
- Charting and Reporting to the office any changes in client.
- Making meals – figuring out what is possible based on what is in home.
- Laundry.
- Taking out the garbage and other general risk/hazard reduction.
- Other.

# WHO PAYS FOR HOMECARE?

# BRITISH COLUMBIA

Homecare Clinical – services of CM; HCN; OT/PT; Nutritionist/Dietician provided free of charge to qualifying BC residents.

Home Support Services – are provided up to 120 hours/month or 12 days of live-in to qualifying BC residents.

Additional services to palliative and awaiting placement.

4.5% of the Provincial health care budget on homecare (over \$525 million) additional 20% form the client co-payment

# CHALLENGES

Client

Provider

Government



# CHALLENGES

## Client

- Expectations of service intersects with challenges of provider.
- Home becomes a workplace.
- Equipment – demands of provider.
- Family members – independence of client vs. desires of family.
- Is it best?
- Social isolation.
- Living at risk.
- Variations depending on geography.



# CHALLENGES

## Provider

- Staffing single biggest challenge.
- Funding to a lesser degree – if staffing issue resolved funding issued resolved.



# STAFFING H.R. CHALLENGES

- 24/7 nature of the work.
- Peak load scheduling problem – very few F/T jobs.

Time	Visit Count
0700	174
0800	322
0830	68
0900	243
1000	204
1100	119
1200	140
1300	138
1400	87
1500	70
1600	122
1700	186
1800	106
1900	84
2000	81
2100	68
2200	15

# CHALLENGES

## HR Staff

- Must have vehicle – must be comfortable going to new places.
- Deal with a variety of clients.
- Rapid changes – 30 minute clients.
- Fluctuating pay cheque.
- Higher standard of accountability.
- Challenge of a job with relatively minor training for tasks but extremely high level of trust and responsibility required – how to compensate?
- Little growth potential or progression, especially with the elimination of the housekeeping.
- Logistical problems in communication and monitoring – improving with technology.
- Need to have an honest conversation with our workforce and their union about needs for the future.

# CHALLENGES

## Government

### FUNDING

- Non CHA – private and public
- Major business in Canada → presents some powerful special interests.
- Competition
  - Lowest price → wages
  - Redundancy in efforts
  - Uncertainty in service providers = uncertainty for staff and client
- Always be a private market
- Cost per person differs by geography

# CHALLENGES

## Government cont.

### Decision of Funding:

- How much, to whom and for what
- Role and expectation of families to provide care
- Aligning incentives
- Measuring true costs to compare
- Accountability for spending – client centred funding

# TRUE COSTS

- Hourly rate for service – just the beginning
- Cost to manage the service
  - CM, billing, etc.
- Increased hospitalization over facility placement
  - Falls
  - Med errors
  - Wounds
  - Decreased socialization → depression
  - Decreased mobilization → physical decline

# CHALLENGES

## Government cont.

### ACCOUNTABILITY

- How are outcomes measured?
- How is quality (a) defined and (b) measured.



# FUTURE OPPORTUNITIES

- Pharmaceuticals
- Technology

# Pharmaceuticals

- Increased drug therapies that will allow people to live at home and replace some acute care intervention.



# Technology

- Increase the number of symptoms and conditions that can be dealt with at home
  - i.e., wound management; SARIN; BP monitor; glucose monitoring.
- Technology that will facilitate connection with distant families to co-manage cases.
- Alert systems
- Medication dispensing and monitoring.
- Technology can greatly increase effectiveness of the delivery of service – i.e., scheduling; current client information.
- Can significantly increase the training of the staff – specifically the CHW.
- Realistic about technology and client group.

# POLICY DECISIONS THAT LIE AHEAD

What is Provincial, what is National?

Decide if there will be a national level:

- Definition
- Standards
- Entitlement
- Payment schemes and incentives

Or if it remains provincial

- Where does it fit with the CHA

The role of the private sector.

The role of family and family caregivers.

# SUMMARY

- Homecare will grow as number of seniors increases and as those seniors age without spouse or children nearby.
- How will it be funded: Federal, Provincial, Consumer. Very big question along with what is included.
- Who will provide the service may be the single biggest challenge.
- Where is the balance between the wants of the client and obligation of government to provide care in the home versus a congregate or institutional setting.

Thank You

Questions?