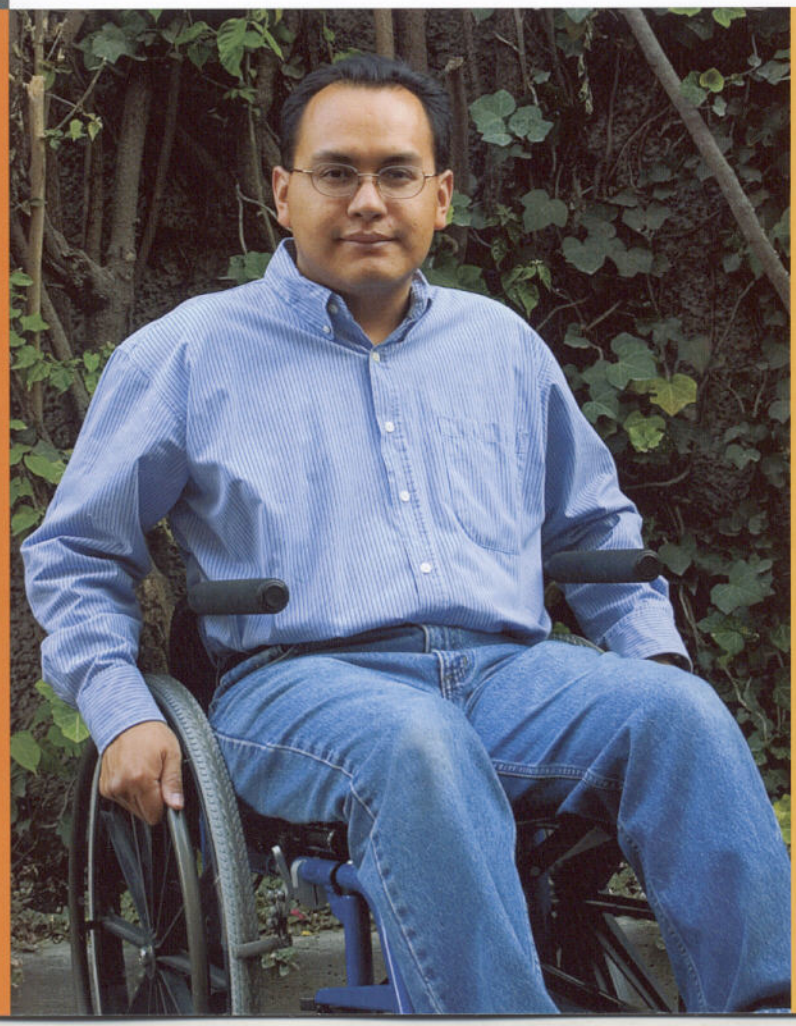
Vancouver Coastal Health

Promoting wellness. Ensuring care.

A Model for Improved Home Support in Vancouver



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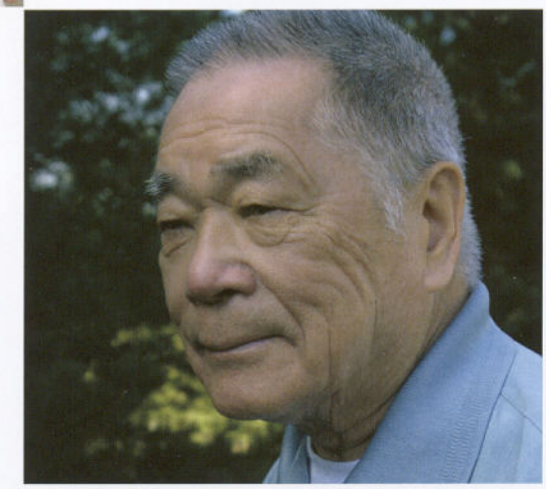

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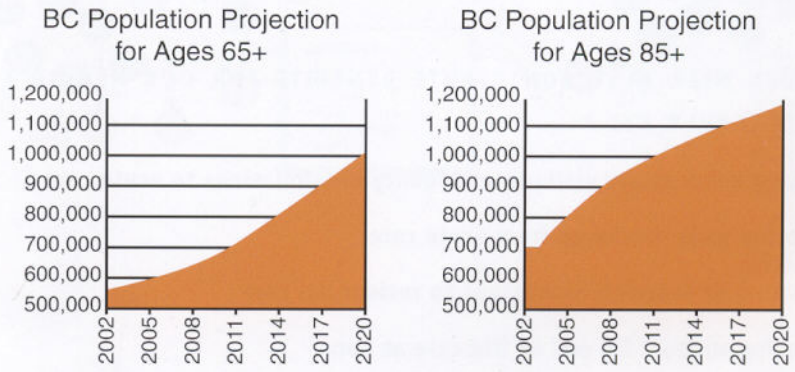
INTRODUCTION

As the Canadian population ages and the proportion of elderly people rises within the general population, health care systems across the country are facing increased demands for home-based services, including home nursing care, rehabilitation, case management, adult day centres, respite, meal programs and home support. People are living longer, many with multiple chronic disorders that require higher levels of care and support for them to live independently. As the numbers of older people increases in our population, so too does the demand for more caregivers to care for them. A new service delivery model that can improve client service, while at the same time reduce the average number of caregivers for clients living in higher-density residential areas and housing, will assist in meeting these demands.

POPULATION CHANGES

In the City of Vancouver the population over 65 years is projected to increase proportionally from 12.9 per cent in 2005 to 15.7 per cent by 2020.



Source: BC Stats Forecast 02/05

RESHAPING THE HOME SUPPORT MODEL

After more than a year of planning and consultation, Vancouver Coastal Health (VCH) is introducing a new home support service delivery system in Vancouver – the *Accountability, Responsiveness and Quality for Clients Model of Home Support* (ARQ Model).

Home support is one of the services provided to people in the community to enable them to remain living at home. This typically means a community health worker going to the person's home to provide a range of needed health services, such as help with bathing, dressing, mobility and medication. In Vancouver, approximately 5,000 people receive ongoing home support totalling about 91,000 hours of service per month. Most of these people are over 75 years of age. In addition, many more people receive short-term post-hospital care, palliative or convalescent home support services.

Historically, we have provided service as individuals have presented themselves to the system. Now we want to use existing funding and resources more efficiently, while striving to be more effective in supporting clients at home. To realize these goals, we must meet the growing complexity of needs through home support and provide an administrative system that can effectively respond to increased demands and changing care needs.

THE MAIN COMPONENTS OF THE ARQ MODEL ARE:

- **Greater integration and the use of cluster care in conjunction with block funding for certain high-density buildings and neighbourhoods**
- **The introduction of specific quality performance expectations and indicators to be tracked and reported by contracted home support providers**
- **The implementation of performance-based funding for home support providers based on measurable outcomes and established quality performance indicators.**

THE ARQ MODEL WILL ALSO CONTRIBUTE BENEFITS FOR OUR HEALTH CARE SYSTEM, PARTICULARLY BY:

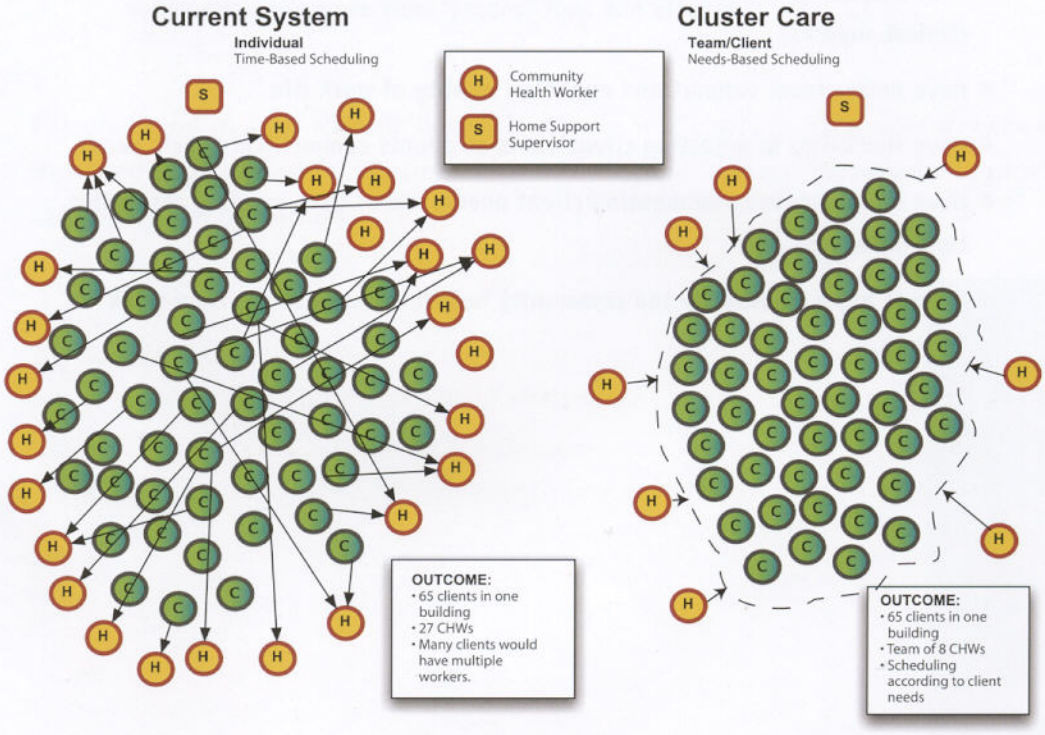
- **Reducing unnecessary visits to emergency or admissions to acute care**
- **Promoting early discharge from acute care**
- **Preventing or delaying admissions to residential care**
- **Increasing support for end of life care at home**
- **Offering respite and support to families and other caregivers.**

CLUSTER CARE FOR HIGH-DENSITY HOUSING

Cluster care is a method of organizing community health workers into teams to work with clients who live in close geographic proximity either within a particular building or neighbourhood. A significant benefit of cluster care is its ability to meet fluctuating client needs in a responsive, flexible and timely manner. The main features of cluster care include:

- **Shifting from strictly scheduled, hourly-based client visits to supporting clusters of clients based on their needs with a consistent care team**
- **Shifting from a system of individually approved service to one that allows more flexibility to respond quickly to clients' changing needs**
- **Shifting from traditional hourly based funding to block funding for high-density areas.**

SERVICE DELIVERY MODELS FOR HIGH-DENSITY HOUSING



For the Client

The current delivery system of home care services is limited by a rigid client fee and scheduling structure that makes it difficult for the provider to respond quickly to clients with changing or fluctuating needs. Under a cluster care system, clients will have:

- **More consistency in community health workers and care**
- **Prompt access to help for unexpected or fluctuating needs**
- **Increased service at times of greater need**
- **Enhanced quality of care due to improved continuity, communication and teamwork.**

For the Worker

Cluster care also responds to concerns expressed by community health workers who want to:

- **Work as part of a team with other community health workers and their clinical supports**
- **Have better team support and enhanced quality of work life**
- **Have flexibility in adjusting client visits as clients communicate their needs**
- **Have a greater focus on meeting client needs, rather than meeting restrictive time schedules**
- **Provide more stability in the community health worker's salary from week to week.**

For the System

Cluster care also provides important organizational efficiencies for high-density areas. Among the advantages are:

- **A more coordinated team approach to services, with clinical staff, community health workers, community developers, housing partners and other community organizations working together**
- **Encourages providers to schedule conference, education and meeting times to support improved client care**
- **Reduced travel time between clients for community health workers**
- **Reduced scheduling time for providers**
- **Funding stability for providers**
- **Decreased paperwork and time for case managers and clinical staff in approving requests for changes in client services**
- **Improved response time, process flow and efficiency.**

Clients living in areas that are not high-density will continue to receive services with increased expectations for quality and continuity, but will not necessarily be provided care by a team of workers.

IMPROVING QUALITY THROUGH PERFORMANCE MANAGEMENT

Performance management is a key component of the ARQ Model and has a direct link to funding for home support services. Home support providers will be expected to meet established performance indicators and reporting requirements based on literature reviews of evidence-based practice. VCH will continue to work with providers and other stakeholders to establish benchmarks and targets, as well as identifying areas where service providers are performing well. A performance management approach will improve the quality of service to home support clients by providing:

- **A focus on results, rather than activities**
- **Accountability and ensuring high quality services by accurately reporting performance**
- **Shared responsibility for meeting performance requirements, with improved outcomes as a joint responsibility between VCH and contract service providers.**

For home support providers, improved performance management will include tracking and reporting on measures such as continuity of care by community health workers for clients, client and caregiver satisfaction.

- **Accessibility in meeting demands for referrals and the complexity of client needs**
- **Matching competencies and skills of community health workers to the wide range of needs of clients from palliative care to dementia care**
- **Availability of the appropriate staff ratios and infrastructure to support better care**
- **Enhanced community health worker well being through ensuring educational opportunities and reducing lost time and costs due to illness or injury.**

A NEW PERFORMANCE BASED FUNDING MODEL

VCH has a goal of increasing the number of people who are able to remain living in the community and decreasing reliance on residential care options. The funding structure needs to be able to respond to changing client acuity in order to support these goals. The funding structure also needs to reimburse or reward providers for meeting more intense care and support needs of clients. To accomplish this, a new funding model will be introduced in Vancouver that provides a direct financial link between provider payment and performance.

The new funding model is designed to encourage adherence to performance indicators that enable better health outcomes by:

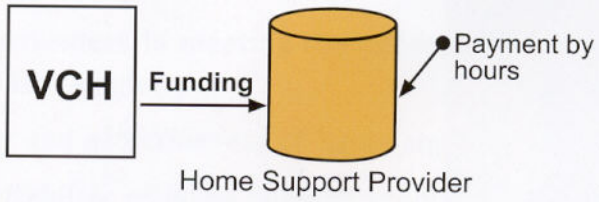
- **Improving continuity of care by having consistent community health workers or teams of workers**
- **Improving collaboration and coordination with health authority teams**
- **Providing better care for specific populations, such as clients with chronic disease, dementia and palliative needs.**

Overall, funding will continue to be based on billed hourly rates, but will be comprised of two components:

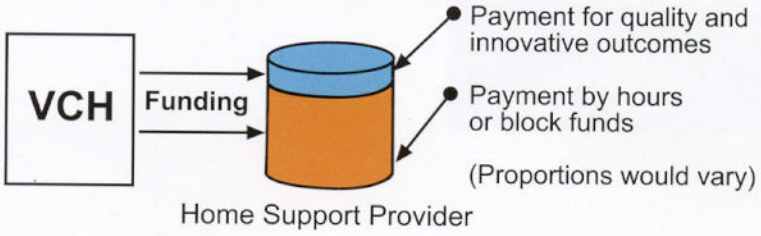
BASE RATE: This is an amount representing the cost of a direct hour of the community health worker's salary, plus relief and benefits and minimal fixed overhead costs.

PERFORMANCE RATE: This is a variable component of the billed hourly rate payment and is linked directly to meeting or exceeding expectations of selected quality performance indicators. Performance indicators are measurements of how the provider's goals and objectives are being achieved.

Current Funding Model



New Funding Model



Specific performance indicators for home support providers will have funding based on the following factors:

- **Greater continuity of community health workers or teams of workers for clients**
- **An increase in the percentage of clients served in cluster care models**
- **A greater match between clients needs with community health worker competency**
- **Client quality satisfaction ratings about their home support service**
- **VCH staff ratings regarding collaboration and effectiveness of home support service providers**
- **Reductions in the illness and injury rates of home support staff**
- **Timely submissions of accurate and complete financial statements.**

RESPONSIBILITIES OF VANCOUVER COASTAL HEALTH

To fully implement a more responsive and flexible home support delivery system, changes are also required within VCH. Specifically, VCH will:

- Commit to working collaboratively with home support providers and clients in planning and implementing strategies to improve clients' health outcomes.
- Communicate the vision of the ARQ Model of home support to staff, stakeholders, contracted service providers and other partners.
- Further work with home support providers to develop a performance management plan that reports on home support quality, effectiveness and areas for improvement.
- Establish funding models that support the shift from individual client scheduling and billing to funding that supports geographically based community health worker teams.
- Develop a performance management system to monitor and report on home support quality and outcomes, and also capture client feedback about their experiences with home support services.
- Establish processes for seeking regular client feedback on the quality of their home support services.

SUMMARY

The ARQ Model of home support is being implemented in Vancouver to improve:

- **Responsiveness in meeting the needs of clients and their caregivers**
- **Quality and effectiveness of home support services**
- **Accountability of home support services in the system.**

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