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Bridging the Islands

Re-Building BC's Home & Community Care System

A Policy Paper by BC's Physicians

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Table of Contents

Executive Summary

This paper examines British Columbia's Home and Community Care (HCC) system. The image of islands provides an apt metaphor to describe the services in British Columbia's HCC system. Just as our ability to cross islands easily depends on the quality of the bridges between them, so does a patient's ability to move between services depend on the quality of the links between components of the system. If there is one message from both the literature and our survey respondents, it is that greater investment in and integration of the islands of care is necessary to improve the quality of care, manage resources effectively, and meet the needs of our aging population.

To understand the challenges and opportunities facing the system, the British Columbia Medical Association (BCMA) HCC Project Group reviewed the relevant peer-reviewed literature, government reports, and policy papers and conducted surveys and in-depth interviews of BCMA members and HCC case managers from across the province. For purposes of this paper, HCC is defined as the range of services for dependent people who require help with day-to-day living, life skills, and chronic disease management over an extended period of time. While a primary focus is on older populations who make up the majority of HCC patients (e.g., frail elderly), it also includes those who require home and community care services but for whom appropriate resources are lacking (e.g., patients with brain injuries, addictions, chronic mental illness). Given the unique needs of hospice, palliative, and post-acute care patients, we exclude them from our analysis.

International Experiences

The first chapter of the paper examines international experiences in home and community care. Canada's spending on home and community care is largely consistent with OECD averages. Canada ranks slightly above the middle in expenditures for long-term care nursing, and among the 14 countries that report data on home nursing care expenditures, Canada ranks tenth.

Upon reviewing the HCC systems in 19 countries, the OECD concluded that HCC programs "must achieve a better balance between institutional and community-based care." To understand how this can be implemented, we examine HCC systems in three countries: Australia, Denmark, and the United States. The Danish model provides the most compelling example of how to achieve this balance. In the 1980s, Denmark issued a moratorium on the construction of new nursing homes while simultaneously expanding home care and home support. The shift towards community-based care has maintained the health status and social support systems of the elderly with the help of extensive service networks integrating health, home care, and personal care. Denmark's experience shows that the shift from institutional to more community-based care is possible, but it must be appropriately funded. In 2004, Denmark was proportionally the third-highest spender on HCC in the OECD at 1.9% of GDP, substantially higher than the Canadian (1.3%) and OECD (1.8%) averages.

Canadian Experiences

While the international data suggest that Canada is neither particularly over- or under-funding its home and community care system, such comparisons tend to ignore significant inter-provincial differences. Chapter 2 of the paper looks at how BC compares to other Canadian jurisdictions in terms of HCC spending, supply, and use of services.

For several measures, BC does not compare favourably. In 2005/06, BC had the lowest number of residential care beds (36.5 per 1,000) for those aged 65 and over, well below the Canadian average (47.1 per 1,000). While having more residential care beds is not necessarily better, this statistic is symptomatic of relative under-funding across the HCC system. For example, BC had the lowest average annual growth in real per capita spending on home care (2.4%) between 1994/95 and 2003/04 in Canada. Additionally, BC was only one of two provinces where the number of home care users decreased, despite an aging population, while home care spending went up. This may suggest that access to home care services have become increasingly restricted for only patients with higher medical needs.

Canadian experiences with Integrated Service Delivery Systems (ISD) suggest a path for reform in BC. ISDs are organizations that provide or arrange for a coordinated continuum of services. Research shows that such systems are effective and deliver appropriate care to HCC system users. Quebec's PRISMA model and Alberta's CHOICE model are ISDs that have demonstrated positive impacts on patient health. The federal Veterans Independence Program (VIP) has been successful in substituting community-based support services for residential care. Importantly, of these models all incorporate what can be described as the most central function of ISDs: case management. By using case managers to coordinate care and, in some cases, act as the single point of entry to the system, these systems achieve a level of integration that would otherwise be impossible.

British Columbia's HCC System

Chapter 3 reviews BC's HCC system, beginning with an overview of the system's development since the early 1980s, a description of the services currently offered, and review of trends in supply and funding of those services.

The Provincial Government's reduction in residential care beds without an increase in community-based care is of great concern. In 2001, the government promised to build 5,000 new not-for-profit long-term residential care beds by 2006. Shortly thereafter, the 5,000 residential care bed target was changed to 1,500 residential care beds and 3,500 independent living beds (primarily assisted living but also some supportive housing). Two years after this deadline, the government announced that it was "on-track to meet its commitment." However, a closer look at the data reveals that the province opened only 3,677 "new beds or units" without specifying either how many of these were new residential care facility beds or whether this figure represented a net increase in the total provincial bed capacity. Under the unlikely assumptions that all 3,677 beds were in residential care facilities and that this is a net increase in the available total, the government still falls short of its goal by over 1,300 beds. This is consistent with earlier research suggesting that, from 2001 to 2004, there had actually been a net decline of 1,464 residential care beds, with the rate of residential care beds falling to 13% below the national average. The government has been critiqued for changing definitions and numbers to conceal the fact that although new beds are being created, many beds are also being closed.

Access to publicly funded home support services has been decreasing in BC since the mid-1990s. As services have become more narrowly focused on medical tasks, the public system provides fewer and fewer daily living services such as meal preparation, shopping, housekeeping, and social contact. The impact of reductions in home support services on the health care system is potentially significant, as home support is a form of preventive health care that can delay the need for institutional care.

Such a critique is not meant to deny those positive aspects of the current system which include establishing publicly-subsidized assisted living and supportive housing as a care option, implementing a new standardized home care assessment instrument,

and using case managers as a single entry point to HCC. BC's physicians credit what integration there is in the HCC system to case managers, describing them in one instance as "doing an excellent job of integrating services for patients." Supporting and strengthening the case manager role should be central to reform of the HCC system in BC. To the extent that BC can emulate successfully integrated, community-based HCC systems elsewhere, it can improve quality and reduce costs.

Survey Results

The BCMA conducted two studies to understand its physician members' views on home and community care issues. The first was an e-mailed survey to a sample of the entire BCMA membership. This was followed by a more focused set of in-depth telephone interviews of selected physicians. In addition, we conducted an online survey of HCC case managers. The survey included many open-ended questions and was designed to elicit in-depth responses appropriate for this kind of qualitative analysis. Results included the following findings:

- The findings suggest a system in decline, largely because of deteriorating access to services. When asked about changes in access to, supply of, and quality of the HCC system over the past five years, physician and case manager survey respondents consistently stated that things have become worse.

- Physicians and case managers are less concerned about the quality of care provided by formal caregivers *per se* than they are about how pressures on the HCC system (e.g., growing population of elderly, limited access to services) will affect their ability to continue to provide high quality care.

- A major barrier to maintaining or improving the state of the HCC system is the fragmentation of services. Key challenges cited by physician respondents were the insufficient number of residential care beds, impeded patient flow from the hospital to the community, and lack of adequate home care and community services to prevent unnecessary admissions to hospitals and residential care facilities. Three-quarters of physician respondents reported having HCC patients needing a higher level of care than was currently offered.

- Case manager respondents consistently state that their high caseloads and the shortage of case managers have contributed to longer waits for HCC services and a shift from in-depth case management to crisis management.

- The plight of informal caregivers requires serious attention. If access to formal HCC services continues to decline, the burden on informal caregivers, who are primarily unpaid and female, will grow substantially. Eighty-three percent of physician survey respondents stated that the complexity of patients cared for by informal caregivers has grown over the past five years.

- The HCC system demands that physicians provide excessive amounts of indirect care. While some of this is inherent to the practice of this type of medicine, much is an artefact of the current organization of HCC services and could be reduced.

Summary of Recommendations

The paper concludes with 15 recommendations for government. The recommendations cover three broad areas:

- *Building bridges:* creating the linkages that support a continuum of care. Linking together the various home and community care services requires appropriate leadership to guide the creation of a truly integrated service delivery system, a central role for integrated case management, and the timely flow of information. An overarching objective in the development of such a system should be to ensure dignity and respect for patients' wishes. **Importantly, wait time benchmarks for accessing Home and Community Care services must be**

implemented. For a case manager assessment, the maximum allowable wait time should be one month from the time of GP request. For placement in the appropriate care setting, the maximum allowable wait time should be one month from the time of case manager assessment.

- *Developing the islands:* ensuring that the services offered meet current and future demand. To ensure that the home and community care system can meet the current and future needs of the population, some services such as home care and home support must be expanded and the recent decrease in residential care beds must be reversed. **The Provincial Government must immediately increase funding to home health care and home support programs, at a minimum, to the national average in order to both increase the number of users and expand the range of services offered.** *Aging in place* needs to be promoted to recognize that patients want to remain autonomous for as long as possible. In addition, the number of physicians providing such care must be increased, and additional supports for informal caregivers, who will assume increasing responsibilities over the coming years, must be provided. The gap between the demand for home and community care and skilled providers is growing especially with the high number of skilled health professionals nearing retirement age. Finally, reducing the administrative burden on physicians delivering HCC care would help ease the already substantial indirect care component associated with HCC patients.

- *Funding for the future:* making available the financial resources to realize these objectives. Ensuring the sustainability of the home and community care system requires re-examining previous assumptions and expanding the opportunities for both public and private sources of funding. The Federal government should follow the BC government's plan to study the feasibility of establishing tax-sheltered savings account for HCC services (e.g., home care support, assisted independent housing, and supportive housing). **The BCMA calls on the Federal government to create personal, tax-advantaged funds to meet future home and community care needs.** BC's Premier, along with other Canadian First Ministers, should jointly seek an enhancement of the comprehensiveness principle of the Canada Health Act to include home care and home and community care services. Similarly, the Provincial Government should expand the Medicare Protection Act and any all other legislation that addresses community health services.

The solutions to the current and, even greater, future challenges facing the home and community care system require the political will for reform and an ongoing commitment to implement change. Successful collaborative projects between the BCMA and the Ministry of Health (e.g., development of integrated health network initiatives for frail seniors, the practice support program, chronic disease management programs) suggest that these two organizations can work together to implement such change. The most promising area for reform of the HCC system is in creating integrated service delivery systems to facilitate *aging in place* through community-based services. These systems have operated elsewhere with demonstrable improvements in quality and access to care. With such experiences providing the blueprints for action, we can build the bridges and develop the islands to link our services into a continuum of care.

Recommendations

Building Bridges

1. To ensure that the Provincial Government has in place the leadership structure necessary to ensure a sustainable, integrated home and community care system, the BCMA endorses the 2006 recommendation of the Premier's Council that the Premier appoint a Minister of State Responsible for Aging.

2. The Ministry of Health and other appropriate government ministries should support the creation of an integrated service delivery system for home and community care services. At a minimum, such integration requires:

   a. increased emphasis on integrated case management, and

   b. increasing the number of case managers in each region and reducing average case loads.

3. To improve the flow, usefulness, and public accessibility of information across the home and community care system, the Ministry of Health:

   a. must increase accountability by measuring and publicly reporting system capacity (e.g., bed rates per 1,000 population, wait times) and outcome (e.g., morbidity and mortality rates, recidivism) data across the home and community care system, and

   b. should facilitate the flow of patient clinical information among those providing care in the community.

4. Upon entry into the home and community care system, physicians should, as early as possible, document patients' wishes for end-of-life care. This information should be made available to other providers within the home and community care system wherever appropriate.

5. The Ministry of Health and Health Authorities should promote flexible, practical, and patient-centric policies for placement in institutionally-based care settings. Patients should be cared for as close as possible to their family and community support networks. Rigid application of the first available bed policy should be discouraged. In addition, Health Authorities should publicly commit to providing patients with their desired care when practical and medically appropriate.

6. Wait time benchmarks for accessing home and community care services should be implemented. For a case manager assessment, the maximum allowable wait time should be one month from the time of GP request. For placement in the appropriate care setting, the maximum allowable wait time should be one month from the time of case manager assessment.

Developing the Islands of Care

7. In 2001, the Provincial Government committed to create 5,000 new residential care beds by 2006, but in fact the number decreased by 1,464. The Government must honour its original promise, and these beds must be:

   a. a net increase in actual beds relative to the number of beds available in 2001, and

   b. above and beyond any increases to the number of assisted living units or other types of HCC services.

8. The Provincial Government must immediately increase funding to home health care and home support programs, at a minimum, to the national average in order to both increase the number of users and expand the range of services offered. Particular emphasis should be placed on restoring the homemaker role

and extending eligibility requirements to include a broader range of patients, in order to ensure proper monitoring of patients' health status and provide preventive care before a crisis occurs.

9. The Provincial Government and Health Authorities should make available educational opportunities and support programs for informal caregivers.

10. The Provincial Government must work with the BCMA to address the physician shortage in home and community care by improving training opportunities and continuing support for physician incentive payments[1].

11. The Ministry of Health should form a task force, with membership including the medical profession, to streamline home and community care forms and eliminate duplication. The task force should make recommendations to the Ministry of Health by June 30, 2009.

Funding for the Future

12. The Federal Government should increase support for informal caregivers by expanding respite care and indirect compensation to informal caregivers.

13. Health Authorities should explore opportunities such as alternative funding models to increase integration and collaboration among physicians, nurses, and case managers when planning and delivering care.

14. The Federal Government should allow the creation of personal, tax-advantaged funds to meet future home and community care needs.

15. BC's Premier, along with other Canadian First Ministers, should jointly seek an enhancement of the comprehensiveness principle of the Canada Health Act to include home care and home and community care services. Similarly, the Provincial Government should expand the Medicare Protection Act and any all other legislation that addresses community health services.

[1] In 2006, a Facility Patient Conference Fee and a Community Patient Conference Fee were made available to better support GPs in working with patients, other health care providers, and patient family members in the review and ongoing management of patients in a facility, and for creation of a coordinated clinical action plan or the care of community-based patients with more complex needs, respectively. As of April 2008, GP visits to long-term care facilities increased by 44% (fee code 13114 & 00114) and 64% (fee code 00115).

Introduction

Many British Columbians are familiar with islands; indeed, they are an integral part of the provincial landscape. And anyone who has waited too long for a ferry to arrive or a closed bridge to re-open will attest, moving between islands can be sometimes difficult. During such disruptions, movement stops and those left on the wrong side of the water find themselves in a place other than where they should or want to be. Unable to get off the island, they must make do with dwindling resources until a connection is re-established. But when things run well – when ferries are on time, enough bridges are in place, and the islands themselves are equipped to support their inhabitants – one becomes almost oblivious to the water that separates them. Transitions are smooth, and people move with ease on and off the islands as necessary.

Like moving between islands in an archipelago, moving between components of our provincial home and community care system poses a unique, yet surmountable, challenge: making the group of islands feel and operate less like a collection of isolated units and more like an integrated continuum of care. Such moves are seamless if the appropriate infrastructure and systems are in place, or to use our analogy, if there are enough adequately developed bridges between islands to meet the demands of the additional traffic.

The literature on our health care system often makes this sound impossible. The common and dire statistics about the impact of an aging population tend to be apocalyptic, with some portraying the impending demographic shifts as a force of nature that will overwhelm existing services, bankrupt the health care system, and leave thousands of elderly without care. It is as if the bridges connecting the islands of home and community care are expected to collapse under the weight of so much traffic.

Such predictions tend to ignore experiences, both in Canada and abroad, where public health care systems have responded successfully to changes in the demand for home and community care services. These experiences show that it is possible to reform proactively, anticipating the demands of a growing number of elderly whose needs can be met while maintaining or even improving the quality of care and without bankrupting the health care system. *Aging in place* can be promoted to recognize patients' desire to remain autonomous for as long as possible. The key to the success of these experiences has been the creation of integrated service delivery systems – building the bridges and developing the islands – so that care is given across the continuum of services, meeting patient needs as they move between components of the home and community care system.

Past experience in British Columbia's home and community care system offers some room for hope. The adoption of the Continuing Care Planning and Resource Allocation Model in 1989, which continued the expansion of home care and home support services begun in the 1980s, was consistent with recommendations from the academic literature and was a model for other jurisdictions. Providing basic medical care and assistance with daily living activities in patients' homes, including seniors with limited needs, can offer opportunities for cost containment, particularly as a means to avoid or delay inpatient hospitalizations and the use of residential care facilities. Today, the key remaining element of that system – the use of case managers to coordinate care and act as a single point of entry – is credited by physicians as one of the system's most valuable components, perhaps the biggest "bridge" linking the islands of care. In short, BC has a history of adopting and successfully implementing aspects of an integrated service delivery system for home and community care.

Recent experiences, however, suggest movement away from this model towards an increasingly fragmented system that is unable to meet current needs, let alone future demand. The persistent problems of alternate level of care patients in hospitals and growing case loads for case managers, suggest that too few bridges are being built, and those that remain are too narrow to handle the traffic. We have lost our capacity to monitor the frail elderly and to know when the time has come for them to transition to another island of care. Even if we fix these problems, it would be a bit like building bridges to nowhere: the reduction in residential care beds, home support services, and home care has left us with underdeveloped islands unable to support the inhabitants.

This criticism should not be interpreted as fatalism. The physicians of British Columbia reject assertions that the collapse of the home and community care system is inevitable. We do not lack blueprints or working models on which to base reform. Lack of funds should not be (but nonetheless is often made to be) a serious issue, since cost-effective reforms such as an increase in home support services are one of the few ways to make the system sustainable. Nor do we lack the administrative know-how. Senior administrators have done a fair job allocating extremely limited resources rationally. But no amount of administrative finesse can compensate for the chronic underfunding that characterizes the current home and community care system.

In this policy paper, the physicians of British Columbia offer 15 recommendations for government to create a sustainable, smoothly functioning, and integrated system of home and community care. These recommendations were developed after reviewing international (Chapter II), Canadian (Chapter III), and British Columbian (Chapter IV) systems. We also conducted surveys and focus groups of our members and case managers (Chapter V) to ensure that these recommendations reflect the experiences of frontline caregivers. Finally, to ensure that the scope of our paper and its recommendations resonate with the Provincial Government, we chose a definition of HCC that is consistent with Ministry of Health's definition and reflects the range of services commonly considered "long-term care." We define Home and Community Care, and consequently the scope of our paper, as follows:

Home and Community Care is the range of services for dependent people who require help with day-to-day living, life skills, and chronic disease management over an extended period of time. While a primary focus is on older populations who make up the majority of HCC patients (e.g., frail elderly), it also includes those who require home and community care services but for whom appropriate resources are lacking (e.g., patients with brain injuries, addictions, chronic mental illness). Given the unique needs of hospice, palliative and post-acute care patients, we exclude them from our analysis.

I. International Experiences in Home and Community Care

The challenges facing BC's HCC system are not unique. Many developed countries struggle with providing adequately for the needs of a growing population of older people and ensuring that existing systems will be able to meet future demand. This section begins with a review of data from the Organization for Economic Cooperation and Development (OECD) in order to place Canada in an international context. This is followed by an examination of three countries – Australia, Denmark and the United States – whose innovations in HCC may provide lessons for British Columbia.

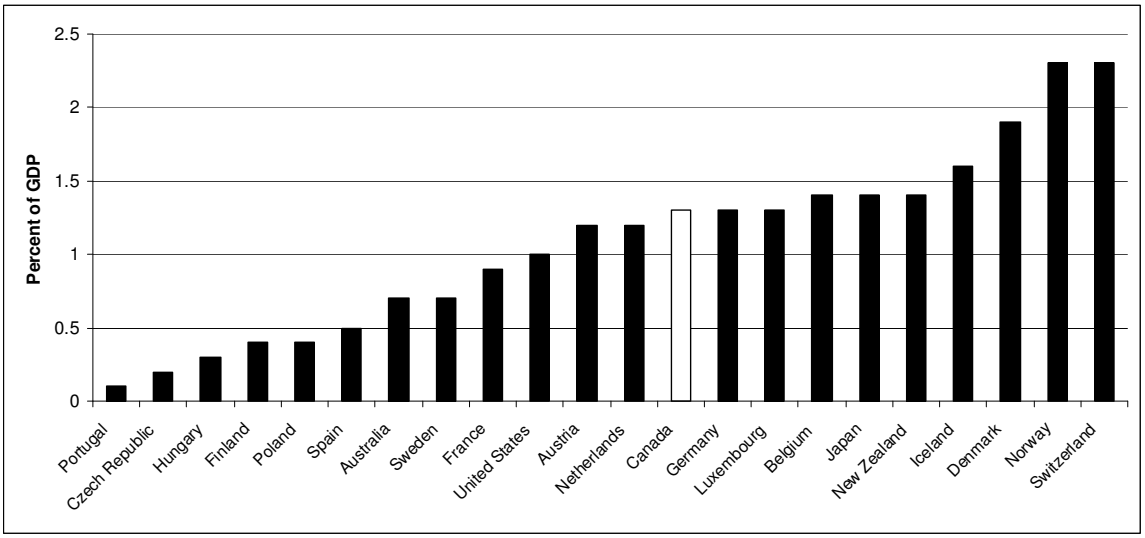
The International Context

International comparisons have the potential to reveal patterns in health expenditure and answer questions that cannot be solved with purely domestic data. For example, where does Canadian spending on HCC rank relative to its peers? Is Canadian spending consistent with international trends over time? If not, how has it diverged?

While there are no complete, recent (less than five years), and comparable data on total expenditures for home and community care, OECD does compile data on spending for long-term care (LTC) nursing services.[2] Figure 1 shows how Canada compares to other OECD countries on LTC nursing care expenditures in 2004.

[2] The OECD Health Data 2007 dataset does include a variable for "total expenditure on long-term care." However, there are no Canadian data available, and the most recent year of data (2005) only includes data for nine of the 30 countries.

Figure 1
Expenditures on services for long-term nursing care as percent of GDP, 2004

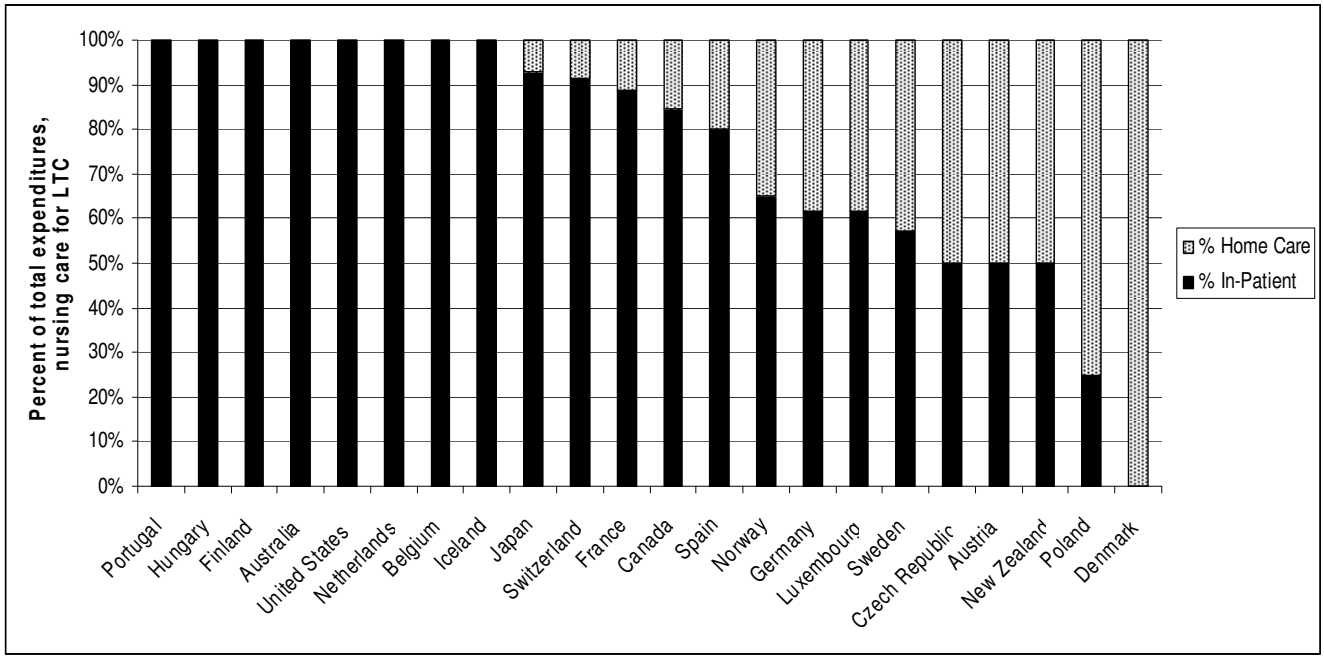


Source: OECD Health Data 2007. 2004 was the most recent year for which data were available. Only countries reporting data in 2004 were included.

Among the 22 countries reporting expenditures on long-term care nursing in 2004, Canada ranks slightly above the middle at eighth place, tied with Germany and Luxembourg. However, because the high levels of spending in Norway and Switzerland skew the average upward, Canada actually falls below the OECD average (1.3% versus 1.8% of GDP). There is wide variation across countries, with Portugal and the Czech Republic at less than 0.2% of GDP and Norway and Switzerland at more than ten times that figure (2.3%). Interestingly, the data show no direct correlation between percent of the population over age 65 and expenditure on long-term nursing care. As the OECD has concluded, the aging population is not an important cost driver for long-term care (see below).
OECD countries spend, on average, 25% of their long-term care nursing expenditures on home nursing care.

The OECD defines nursing care at home as "medical and para-medical (nursing) health care provided to patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living" (OECD 2000). Again, there is wide variation across countries, some of which reflects real differences in the relative allocation of resources while other variations are due to different accounting methods. For example, Denmark defines retirement homes and homes for the elderly as the home of patient; hence its reporting of 100% of in-patient nursing care as home care (OECD 2007). While Canada is not among the eight countries that report zero expenditures for home care nursing in 2004, neither is it among the highest. Among the 14 that do report data on home nursing care expenditures, Canada ranks tenth at 15% (Figure 2).

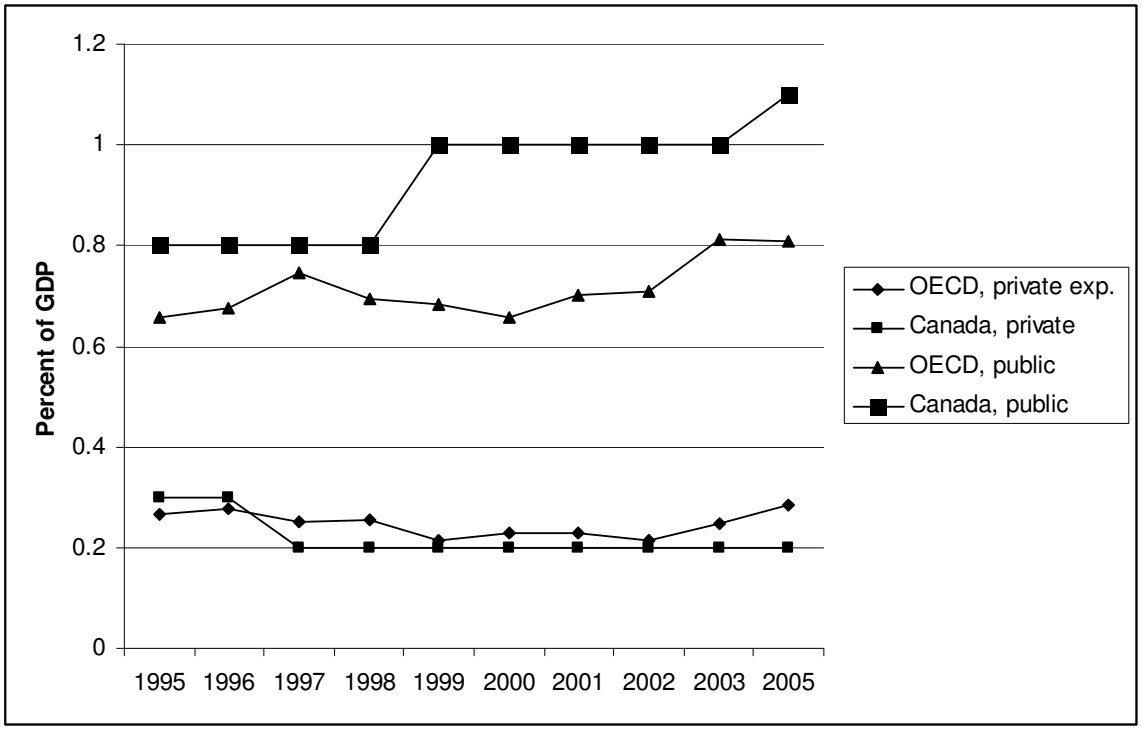
Figure 2
Home Care and In-Patient Nursing Care Expenditures as Percentage of Total Nursing Care Expenditures for Long-Term Care, 2004



Source: OECD Health Data 2007

When examined over time, the data show that Canadian trends for long-term care nursing expenditures are largely consistent with those in the OECD (Figure 3). All countries, including Canada, show an increase in such expenditures from 1995 - 2005. The Canadian portion of public spending has remained consistently above, and the private portion consistently below, the OECD average.

Figure 3
Canadian and OECD average expenditures (total, public, and private) for long-term care nursing as a percent of GDP, 1995 - 2005



Source: OECD Health Data, 2007.

To the extent that expenditure data on long-term care nursing serve as a proxy for HCC spending overall, they suggest that Canada is neither particularly over- or under-funding its home and community care system. Although somewhat outdated, OECD data on total HCC expenditures as a percentage of GDP in 2000 confirm this: Canada ranked sixth out of 12 countries measured (OECD 2005). The Canadian figures, however, mask inter-provincial variations, including British Columbia's relative under-funding of its HCC system (see Chapter III). Canada places near the middle of the pack in terms of total funding and home care nursing funding as measured as a percentage of GDP, while the level of public funding for services remains above the OECD average.

In 2005, the OECD published one of the most comprehensive reviews of HCC programs across the developed world. The review included analyses of 19 members' countries,[3] examining HCC delivery, consumer choices, quality monitoring and payment for care (OECD 2005). They provided several observations:

1. *The aging population is not the most important HCC cost driver at this time.* Despite a common perception that HCC expenditures will grow exponentially in the face of an increasingly older population, the data collected suggest that program design differences (e.g., varying public-private mix of funding, use of informal caregivers), and not population structure, are the most important cost drivers. As evidence, data comparing the percentage of persons over the age of 80 with expenditure on HCC as a percent of GDP show only a very weak correlation at the present time. Most growth in

[3] Australia, Austria, Canada, Germany, Hungary, Ireland, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Spain, Sweden, Switzerland, United Kingdom, and the United States.

spending is associated with the initial set-up of new social programs. Note that this does not mean that the aging population is not a factor in expenditure growth, but rather that most of the variation in expenditures cannot be explained by aging alone.[4]

2. *HCC programs are increasingly focusing on home care as a lower cost alternative to institution-based care.* This shift has marked an important change in direction across much of the OECD countries, as resources and care are shifted to encourage "aging in place."

3. *Reform of HCC is driven by concerns over quality.* Questions about the quality of HCC services have driven reform in several countries. Improved access, increased spending and the introduction or improvement of existing regulations are among the results of these reform efforts. The manner in which HCC services are financed is also important and can affect the quality of care. Boundaries between health and social services funding can create problems in the transfer of patients from one service to another.

The report concluded with several recommendations:

- *HCC systems that are universally available protect against catastrophic costs.* These programs also greatly reduce the need for, and cost of, social assistance programs.
- *Private insurance to cover cost sharing should be considered to make HCC programs more sustainable.* This can also be combined with more targeted benefits and increased emphasis on prevention.
- *HCC programs must achieve a better balance between institutional and community-based care.* This is true when new programs are created and necessary, given demographic and social trends (e.g., growing number of very old persons who live with their spouses).

Chapter III will examine the implications of these recommendations for BC's HCC system.

Australia: Extended Aged Care at Home

The election of a new government in March 1996 marked a shift in policy focus for Australian HCC programs. Greater emphasis was placed on management of costs. Two approaches were taken. First, the costs of care and operations in the funding of residential care were separated and user charges were extended. Importantly, the extension of user charges was accompanied by a requirement that facilities admit a certain number of "financially disadvantaged" patients to ensure patients' access to services, with government providing a "concessional resident subsidy" to offset costs (Howe 2000).

The second approach was the targeting of community services. Using data generated by Aged Care Assessment Teams (i.e., case managers), policymakers determined that the most effective allocation of funding would be toward (1) maintaining high-need patients in the community; (2) improving functioning and independence across a wider target group, not just high-needs patients; and (3) supporting caregivers (Howe 2000). Consistent with these objectives, the current system incorporates multiple and integrated HCC services:

- Residential aged care
- Community Aged Care Packages (CACPs)
- The Home and Community (HACC) Program
- Day therapy centres
- Flexible care services
- Extended Aged Care at Home (EACH) Packages
- Aged Care Assessment Teams (ACATs)

Although many elements of the system are similar to what is offered in BC, the EACH Package is

[4] Similar conclusions have been drawn using data from British Columbia. McGrail et al. found that hospital costs rise with age, but proximity to death is a more important determinant of cost. On the hand, aging had a larger impact on nursing care and social costs. See Age, costs of acute and long-term care and proximity to death: evidence for 1987-88 and 1994-95 in British Columbia. McGrail K, Green B, Barer ML, Evans RG, Hertzman C, Normand C. Age and Ageing. 2000;29:249-253.

worthy of special mention. EACH was originally piloted in 2000 and offers administration and delivery of clinical care and support for activities of daily living, recreational activities, and home maintenance. The program supports people who prefer to remain at home but require care equivalent to that given in a residential care facility. Users pay a daily rate of 17.5% of their pension, or 17.5% of their income up to their pension level plus 50% of their income beyond the pension level with a cap on the daily rate. An evaluation of the program has demonstrated that frail aged people can be successfully and cost-effectively maintained in their own home (Australian Institute of Health and Welfare 2002). These results are consistent with experiences elsewhere, including the UK, where a recent study concluded that between 15% and 28% of new admissions to a nursing home could have been cared for in the community if given appropriate, cost-effective managed packages of care (Challis and Hughes 2002). Moreover, seniors receiving such care report higher life satisfaction and lower rates of depression than similar seniors who received no such services (Kuluski 2006).

Continuity of care is an important success measure of a system. Australia's National Strategy for an Ageing Australia is an example of a strategic framework aimed at improving the care continuum. Structures such as the Aged Care Assessment Teams and the Home and Community Care Programme (HACC) work to integrate the delivery of appropriate care. HACC "provides community-based support services, such as home nursing, personal care, respite, domestic help, meals, and transport, to people who can be appropriately cared for in the community while remaining at home" (Australian Institute of Health and Welfare 2002). Nonetheless, the Australian system is not without challenges. Persistent numbers of patients requiring alternative levels of care remain a problem, although a randomized controlled trial suggests that shifting such patients to an offsite "transitional" facility between the hospital and the residential care facility may be possible without any adverse effects (Crotty, Whitehead et al. 2005).

Denmark: Expanding Home Services

Denmark's national health care system is financed by general taxes, and provides comprehensive health and HCC services. Denmark's response to the aging population in the early 1980s was to expand their system of home- and community-based services while eliminating the construction of new nursing homes (Stuart and Hansen 2006). The resulting system comprises extensive service networks integrating health, home care, and personal care. A single organization is responsible both for home care and institutional care, meaning that the same staff provides assistance to elderly wherever they may be (e.g., nursing home, community). Service coverage is universal and responsibility for the administration and provision of services lies with local counties and municipalities (Stuart and Hansen 2006).

Denmark's most radical demonstration project was conducted in Skaevinge. The community converted its one nursing home into a centre that provides and coordinates community support services including a senior centre, day care, rehabilitation, 24-hour home care, and assisted living (Stuart and Weinrich 2001). Danes aged 75 and over are offered a home visit, and home visits are mandated twice a year for all elderly, regardless of their health status. In contrast to other European countries, there are no user fees for home help. Evaluation has shown that Danes have an increasingly optimistic attitude toward old age. In addition, their health has improved and, while their physical capacities may be unchanged, they are more satisfied with their health (Stuart and Weinrich 2001). A 2002 survey of elderly Danes found that 95% of elderly under age 82 did their own housework. For the frail elderly who do require assistance, it is provided free of charge (Stuart and Hansen 2006). Evidently, the removal of the nursing home and the implementation of extensive home care/support has not undermined the health status of elders in Skaevinge (Stuart and Weinrich 2001). Nor has it undermined family willingness to care for elders: the same 2002 survey found that Danish elderly's contact with their

children is as high as in other European countries with less comprehensive public HCC systems (Stuart and Hansen 2006).

The Danish shift to community services has been accompanied by a comprehensive system of assessment and management, with everyone above age 75 entitled to two yearly preventive visits. As an incentive to reduce the number of alternate level of care patients, municipalities, which cover home and community care, must pay the county, which runs the hospitals, whenever a patient must remain in the hospital because a residential care bed is unavailable (Merlis 2000).

The United States: Program for All-Inclusive Care for the Elderly (PACE)

PACE is a managed care program that provides integrated care for the frail elderly who meet state nursing home certifiability criteria. The objective of the program is to enable its participants to live independently in the community. The PACE program receives capitated funding from both Medicare and Medicaid and is responsible for providing and/or purchasing all of its participants' health care needs from primary to acute to HCC care. Seniors with relatively high levels of disability come to adult day care centres to receive services, in addition to receiving home care and meals at home. Care is provided by interdisciplinary teams that include primary care physicians, nurses, social workers, physical and occupational therapists, and health aides.

A number of studies suggest that PACE may be an effective model of care for the frail elderly by reducing the use of institutional care, controlling use of medical services, preventing functional decline, and providing care at a lower cost compared to traditional fee-for-service care (Eng, Pedulla et al. 1997; Wieland, Lamb et al. 2000; Mukamel, Peterson et al. 2007). The success of PACE as a demonstration led to its designation in 1997 as a permanent Medicare program. However, the program's growth has been limited. The actual number of PACE programs has grown by a few (one to four) each year even though legislative caps continue to allow an addition of 20 new programs per year. Barriers to growth include competition from state-funded home and community care programs and service-rich health care markets; less desirable program features such as the lack of physician choice and out-of-pocket costs; and high capital and start-up costs (Gross, Temkin-Greener et al. 2004).

The barriers of growth identified for PACE programs are likely to be important for other integrated care delivery models. While suitable for the very frail elderly, the PACE model does not appear to be an option for all. A single model of care and financing is insufficient to meet the variety of specific needs and preferences of the elderly population. Hence, a number of newer programs in several US states, which have been modeled on PACE, began to experiment with less restrictive models that do not require staff physicians, center-based care or formal interdisciplinary teamwork (Mukamel, Peterson et al. 2007). However, some studies have suggested that efforts to relax the PACE model's programmatic features may result in poorer outcomes (Kane, Homyak et al. 2006; Mukamel, Peterson et al. 2007).

Conclusion

The varied and innovative experiences in these three countries – Australia, Denmark, and the United States – present several lessons for British Columbia:

1. *A successful shift toward community-based care is possible when community services are appropriately funded.* Despite differences in organization and financing, all of the HCC systems examined here have adopted programs or implemented policies to shift the provision of care from institutions to the community – a recurring trend across the OECD countries. Australia's EACH program and the US's PACE program have been effective in maintaining the frail

elderly in the community. This transition was arguably most successful in Denmark, which put a moratorium on the construction of new nursing homes. However, the transition was not simply a cost-cutting move. Generous community-based programs were offered, and the system as a whole has been well funded: in 2004, Denmark was proportionally the third-highest spender on HCC in the OECD at 1.9% of GDP, well over Canadian spending (1.3%) and the OECD average (1.1%).

2. *High start-up costs can be a barrier to reform.* In its review of HCC programs, the OECD argued that one of the main drivers of HCC expenditures was the start up costs of programs. As the PACE program in the United States demonstrates, unless these start-up costs are adequately budgeted, even the most well-researched and proven initiative will be difficult to implement widely.

3. *Integration of care is an important component of success.* As the OECD notes, boundaries between health and social services funding can create problems for patients who use these services. Some of the success of the Danish, Australian, and American (PACE program) programs have been due to the integration of care, both clinically (e.g., interdisciplinary care teams, same personnel providing community and institutional care) and in terms of funding.

While governments may see community-based care primarily as a lower cost alternative to institutionally-based care, the evidence suggests that the most cost-effective option is to target community care appropriately to those who need it most. Although this presents a potential win-win situation for both governments and the population, challenges remain. "Targeting" should not become a by-word for cutting services, either in institutions or the community. Policy makers may be tempted to cut, or at least refuse to increase, the number of residential care beds in favour of funding community-based HCC services. While some reduction in residential care beds may be appropriate, such a move done in isolation of other reforms would only exacerbate the significant current access problems to HCC services. As the Danish experience shows, creating a well-functioning HCC system requires more than adopting a simple – and simplistic – cost-cutting measure. An effective HCC system should integrate the delivery and funding of community and institutional services while emphasizing longitudinal care coordination by case managers and other care providers. International experience has shown that physicians, along with other providers, can play a key role in improving the continuity of care for the elderly in the form of interdisciplinary care and improved linkages with case managers.

II. Canadian Experiences in Home and Community Care

Interprovincial Comparisons on HCC Expenditure, Supply, and Utilization

Examining how BC compares to other Canadian jurisdictions in terms of HCC spending, supply and utilization can help answer whether or not BC is ahead or behind the curve nationally in terms of system reform. To date, comprehensive comparable data is only available for residential care and home care.

Residential Care

A provincial comparison of residential care facilities[5] shows sizeable differences. On a per-capita basis (for those aged 65+), the Territories, Prince Edward Island, Saskatchewan, and Manitoba spent the most on residential care, while BC and Alberta spent the least. In 2005/06, per capita spending ranged from $1,874 in BC to $3,494 in Prince Edward Island, and $6,530 in the Territories. Similar to expenditure trends, BC had the lowest number of residential care beds per 1,000 population aged 65 and over in Canada at 36.5, which is well below the Canadian average of 47.1. Between 1990/91 and 2005/06, the number of operating residential care beds per 1,000 population for those 65 years old and over decreased 13.7% in BC compared to an average 8.5% decrease across Canada over the same time period (Residential Care Facilities: 2005/2006, Statistics Canada, 2007).

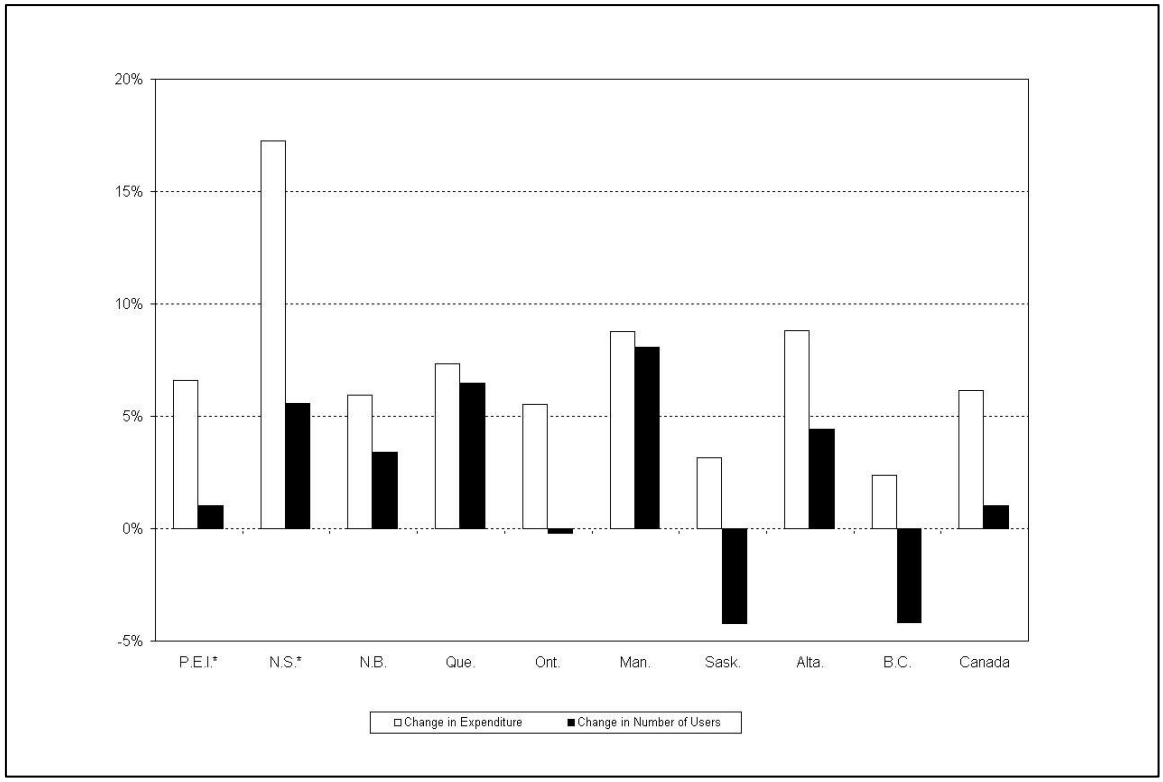
Home Care

Although BC had the lowest residential care expenditure and residential care bed supply per capita for those aged 65 and over, data from the Canadian Institute for Health Information (CIHI) do not suggest that the BC government has diverted expenditures to community-based HCC services as part of its shift of providing HCC care closer to home. BC, along with Prince Edward Island, Quebec, Saskatchewan, Alberta and the Territories, was below the national average ($91.15) in per-capita home care[6] spending in 2003/04. In addition, BC had the lowest average annual growth in real per capita spending on home care (2.4%) between 1994/95 and 2003/04 in Canada. For most of the other jurisdictions, the growth in real per-capita spending on home care was also positively correlated with the growth in the number of government-sponsored home care users except for BC, Ontario and Saskatchewan (see Figure 4). Between 1994/95 and 2003/04, the number of users per 1,000 population declined at an average annual rate of 4.2% in BC. In 2003, BC, Newfoundland and Saskatchewan had the lowest utilization rates for home care with about 20.0 government-sponsored home care users per 1,000 population in each of these three jurisdictions compared to the national average of 26.1 (Public-Sector Expenditures and Utilization of Home Care Services in Canada: Exploring the Data, CIHI, 2007). This may suggest that access to home care services have become increasingly restricted for only patients with higher medical needs.

[5] Residential care facilities include all residential facilities in Canada with four or more beds providing counselling, custodial, supervisory, personal, basic nursing and/or full nursing care for the aged. Excluded are those facilities providing active medical treatment (general and allied special hospitals), homes for senior citizens or lodges where no care is provided, and facilities providing care to persons with mental disorders or physical disabilities.

[6] Home care spending generally includes professional health services such as nursing care, physiotherapy, occupational therapy, speech therapy, respiratory therapy, nutrition, counselling, and social services. However, some provinces do confirm that there is some home support in their submissions to CIHI.

Figure 4
Average Annual Change in Provincial/Territorial Government Real per Capita Spending on Home Care and in Number of Government-Sponsored Home Care Users per 1,000 Population, Selected Jurisdictions and Canada, 1994/95 to 2003/04



Source: CIHI. Public-Sector Expenditures and Utilization of Home Care Services in Canada: Exploring the Data. (2007)

Home and Community Care Across Canada

Many provincial HCC systems, despite the best efforts of clinicians and administrators, are characterized by a lack of integration among hospitals, providers, home care services, residential care facilities, community-based support services, and public health initiatives. The result is inappropriate use of hospital and nursing home services by patients, higher costs, and a lack of continuity of care (e.g., multiple entry points, service delivery influenced by resource contacted rather than patient need). Ultimately, accessibility and efficiency of the system are compromised.

Nonetheless, some provinces have succeeded in implementing policies or programs to address these challenges. The results of these efforts hold important lessons for British Columbia. This section examines three programs and policies – in Quebec, Alberta, and the federal Veterans Independence Program (VIP). Because the adoption of elements of integrated service delivery systems (ISD) is a common factor across these examples, we begin first with a review of ISDs.

Integrated Service Delivery Systems

An ISD is a network of health care providers and organizations that provide or arrange for a coordinated continuum of services to a defined

population (Shortell, Gillies et al. 1994). ISD systems have been shown to be both effective and appropriate from a financial, administrative, and care delivery perspective (Hollander 2007). Figure 5 shows some core elements of an ISD.

Figure 5
Elements of an Integrated Service Delivery System

Element	Description
Provide a range of services	For home and community care, this would include home and community services, residential services, and hospital-based services.
Agreement among service providers	Providers agree to work together to provide optimal care.
Case management	Ensures coordination as patients move between service components.
Authority structure	Necessary to resolve disputes, provide overall stewardship, ensure that system functions according to agreed upon rules and procedures.

Source: Adapted from Hollander 2007

Some ISD systems, such as the PRISMA model in Quebec and Veterans Independence Program, aim at improving referral and transfer procedures between services (e.g., hospital to home care, hospital to rehabilitation). Others, such as the SIPA model in Quebec and the CHOICE project in Alberta, are more complex, creating an organization responsible for offering all services to a certain group of people, usually through capitation budgeting and contracts for some specialized services.

Integrated Case Management. Integrated Case Management is perhaps the most central component of an integrated HCC system. In many jurisdictions, care for the elderly is characterized by fragmentation and a lack of care coordination. The responsibility for delivering services to the elderly lies with many agencies, jurisdictions and professionals and thus remains poorly defined. Many jurisdictions have responded by developing a single entry point with case management provided for continuing care in the community and admissions to residential care facilities. Although this is an important step to reducing fragmentation and improving use of resources, studies have shown that is it not sufficient to "add on" case management without fundamentally changing the delivery of care and relationship between acute and HCC care (Bergman, Beland et al. 1997).

Several integrated care programs for the elderly emphasize case management with clinical and financial responsibility. In these systems, case management for the frail elderly can be the bridge between services and other levels of care, creating a seamless continuum of care that helps achieve an integrated service delivery system. Components required for integrated case management include (Phillips-Harris 1998):

- a system of risk identification;
- an ability to link information about patients between physicians and other providers;
- service flexibility;
- an interdisciplinary team approach;
- the ability to follow identified older patients over time; and
- longitudinal care coordination.

There is growing international literature on the impacts of integrated case management from models that can be found in Europe, US, and Hong Kong (Hollander 2007). In Italy, an integrated

community care program implemented by an interdisciplinary team, including a general practitioner and a case manager, reduced the risk of a hospital admission and length of stay in either the hospital or nursing home. Frail elderly who received integrated social and medical care and case management showed less physical and cognitive decline than those who received conventional care (Bernabei, Landi et al. 1998). The Darlington Project in the UK was a service model where case managers, with devolved budgets, were located in a geriatric multidisciplinary team to coordinate community care packages as an alternative for frail elderly requiring long-stay hospital care (Challis, Darton et al. 1991). Results have shown that elderly people receiving coordinated community care had a higher quality of life, without greater stress placed upon their carers, than a comparative group of similar patients in adjacent health district. The coordinated community-based service was a more cost-effective option than long-stay hospital provision (Challis, Darton et al. 1991). Another study in Hong Kong evaluated the cost-benefit of a case management project for older persons where case managers provided integrated care. The case management intervention was found to significantly reduce hospital admissions and the length of stay in hospitals with corresponding savings in total health care costs when compared to conventional care (Leung 2004).

Quebec

Quebec has developed two major delivery models to provide integrated care to the frail elderly: SIPA (System of Integrated Care for Older Persons) and PRISMA (Program of Research to Integrate Services for the Maintenance of Autonomy). The main difference between these two models is that SIPA relies heavily on integrating providers, whereas PRISMA is based on the coordination of providers. SIPA focuses on providing home care services by personnel hired by or under contract with the organization; PRISMA includes all the public, private or voluntary health and social service organizations involved in caring for older people in a given area. The key elements of these primary care based models are listed in Figure 6 (Hollander, Chappell et al. 2007).

Figure 6
Key elements of the SIPA and PRISMA models

The SIPA Model	The PRISMA Model
Geriatric assessment and management through the use of interdisciplinary protocols	Individualized service plans
Multidisciplinary teams	Single assessment instrument
Physician involvement in the care team	Single patient classification system
Responsibility for delivering integrated care through the provision of community health and social services	Computerized clinical chart available across care provider organizations
Coordination of hospital and nursing home care	Budget negotiations between partner organizations
Capitation payment (not implemented in the demonstration project)	
Elements common to both models: Single entry Case management Inter-organizational coordination	

Source: Adapted from Hollander and Chappell, 2002

Empirical evidence has demonstrated the effectiveness of both models. Researchers observed a declining trend in institutionalization, decreasing incidence of functional decline, greater patient satisfaction, and decreasing caregiver burden with the PRISMA model during the three years after it was implemented (Hebert, Durand et al. 2003; Tourigny, Durand et al. 2004). The PRISMA model did not have a marked effect on the use of services such as hospitalization and drug use apart from a smaller proportion of PRISMA patients returning to emergency within 10 days of a first visit.

Results indicate that SIPA, although cost neutral, succeeded in changing the configuration of care with a reduction in the overall acute hospital and nursing home use associated with a concomitant increase in community care. Patient accessibility was increased for health and social home care with increased intensification of home health care. There was a 50% reduction in hospital alternate level inpatient stays but no significant difference in use and costs of emergency department, hospital acute inpatient, and nursing home stays compared to usual care. Satisfaction was increased for caregivers with no increase in caregiver burden or out-of-pocket costs (Beland, Bergman et al. 2006; Beland, Bergman et al. 2006).

Alberta

The CHOICE (Comprehensive Home Option of Integrated Care for the Elderly) project in Edmonton, Alberta is an adaptation of the PACE (Program of All inclusive Care for the Elderly) projects in the United States. CHOICE provides a continuum of care (including a day health centre, health clinic, sub-acute care, home support, transportation and emergency response but not acute care and residential facility care) to older people with multiple, complex needs (including chronic mental health problems, multiple medical conditions, and cognitive impairment). CHOICE transports seniors to day centres, where they receive care through multidisciplinary teams. Unlike the American PACE program, which is funded under a managed-care capitation system, CHOICE receives from the regional Health Authorities block funding that is adjusted for the volume of participants.

A 1998 evaluation of CHOICE revealed a high degree of satisfaction with the program among participants and their informal caregivers (Pinnell Beaulne Associates 1998). A significant proportion of participants reported that either their general health was being maintained or that the decline in their health status had slowed down over the 10-week period following admission. Other outcomes included:

- Reduced use of ambulatory care (25%), inpatient services (30%), ambulance services (11%), and pharmaceuticals (86%) compared to the participants' utilization patterns prior to being admitted into CHOICE.
- An overall cost savings of $14 per day per patient, for an estimated annual cost savings of between $1.3 and $1.5 million for 270 to 300 patients.

The Veterans Independence Program

The Veterans Independence Program (VIP) is federally funded and offers home care services to veterans under a case-management model. Services include:

- Assistance with daily personal care (e.g., bathing, dressing);
- Health and support services provided by professionals (e.g., nurses, occupational therapists);
- Access to nutrition (e.g., Meals on Wheels);
- Housekeeping (e.g., laundry, vacuuming, meal preparation);
- Grounds maintenance (e.g., grass cutting, snow removal);
- Transportation to activities when transportation is not otherwise available;
- Home adaptations to facilitate access/mobility; and

- Nursing home care in the patient's community if/when he or she can no longer remain at home.

Most of the services provided by VIP are contracted out or accessed through provincial programs. The case manager plays an important role in assessing needs, planning care, managing access to appropriate care across the continuum, following up to ensure care continuity, and managing care transitions.

VIP has been successful in substituting community-based support services for residential care (Pedlar 2006). Under VIP, HCC services are targeted to individuals at risk of becoming ill or losing independence and are managed and integrated within the broader healthcare continuum. In response to a growing number of veterans who were on waiting lists for contracted beds in residential care facilities, the Overseas Service Veterans (OSV) At Home Pilot Project was launched in 2000. It offered wait-listed OSVs the option of VIP community care packages in their own homes or in settings such as supportive housing. An internal review of the pilot project showed that a large majority (88%) of the participating OSVs preferred to remain at home, with support, rather than accept a residential care facility placement even when a bed became available. Thus the pilot helped reduce waiting times and demand for residential care beds. Following the success of the pilot, OSV/VIP program was implemented nationally in 2002 (Veteran Affairs Canada 2006).

Lessons For BC

A mix of approaches for funding and delivering HCC services is used across Canada. The literature concludes that regardless of the funding and delivery approach used, the most notable successes involve initiatives that integrate and manage care across the continuum and that therefore permit HCC to be substituted, where appropriate, for the most costly care in hospitals and institutions (Hollander, Chappell et al. 2007; Williams 2007).

The experiences with ISDs across Canada suggest the following:

1. *ISDs are effective in improving patient outcomes and moving patients into more appropriate care settings than non-integrated systems.* Both Quebec's PRISMA model and the Alberta CHOICE model reduced the decline in patients' health. The federal Veterans Independence Program has been successful in substituting community-based support services for residential care. The successes of these systems are attributed to their use of core features of ISDs (e.g., case management, provision of a range of services within a single organizations or coordinated organizations).
2. *Case Management is, perhaps, the most central function of ISDs.* It is difficult to imagine how any integrated system could operate without an effective case management system, since most of the other core ISD functions depend on this (e.g., coordination of care across services). Indeed, case management and case managers feature prominently in both Quebec programs (PRISMA and SIPA).
3. *ISDs can be operated successfully and sustainably in Canada and, by extension, British Columbia.* Quebec's SIPA model demonstrated success in patient care while being cost-neutral; Alberta's CHOICE program generated an overall cost savings of $14 per day per patient. There is no reason to suspect that similar results would not be possible in BC.

III. British Columbia's Home and Community Care System

The HCC system in British Columbia has undergone a remarkable transformation over the past two decades, with much of the change occurring within the last 10 years. This chapter examines the current system in three sections. First is a review of the development of the HCC system. This section proposes that many of the features of an integrated, community-based system were in place in British Columbia in the early 1990s, but a shift in focus from 1994 onwards, combined with funding cuts starting in 2001, eliminated many of these features. The consequences of these changes are outlined in the second section, which reviews more recent funding and supply trends for publicly-funded HCC services. This section also presents a series of charts to illustrate how the care pathway of a typical HCC patient is characterized by delays and limited access to services. Finally, the chapter concludes with a brief discussion on recent government initiatives.

Development of the Home & Community Care System

British Columbia's HCC system has passed through multiple stages from prior to 1983 to the present. We draw in part on Hollander's description of these transitions (Hollander 2001):

1. *Prior to 1983: Growth Phase.* BC's Long-term Care program was initiated in 1978, integrating existing social and health services. Home care nursing services and the number of homemakers were increased.
2. *1983 - 1989: Restraint and Consolidation.* The Home Care/Long-term Care Program, which included the Community Physiotherapy Program and the Home Nursing Care Program, was renamed the Continuing Care Division (CCD). The CCD operated as a decentralized professional organization with services delivered and coordinated in the local community. As a response to tight budget constraints, home care nursing and homemaker services continued to increase, while residential care beds and residential care facilities decreased, marking a proactive shift away from institutionally-based services to community-based services.
3. *1989 - 1993: Planning Model.* BC implements the Continuing Care Planning and Resource Allocation Model. The model expanded upon previous models, which considered exclusively residential care bed projects and home care, by modelling care needs across the spectrum of home and community care services. As a result, and consistent with recommendations from the peer-reviewed literature, the increase in home care nursing and homemakers was accelerated, while the reduction in residential care beds and residential care facilities continued.
4. *1994 - Present: Regionalization.*[7] This phase marked a dramatic shift away from the Continuing Care Planning and Resource Allocation model. While the reduction in residential care beds and residential care facilities continued from earlier phases, several changes were introduced:
   - A reduction in the total number of homemaker hours provided, with a dramatic decrease in the support offered to lower-needs patients.
   - An accelerated reduction in the number of residential care beds. Between 1990/91 and

[7] So named because of the province's efforts to create regional structures (community health councils and regional health boards) beginning in the early 1990s.

2005/06, the number of operating residential care beds per 1,000 population for those 65 years old and over decreased 13.7% in BC compared to an average 8.5% decrease across Canada over the same time period (Residential Care Facilities: 2005/2006, Statistics Canada, 2007).

- An increase in the number of assisted living facilities (see Figure 7).
- The substitution of registered nurses in residential care facilities with licensed practical nurses.

The changes post 1994, including reductions to home support, home health care, and residential care facilities since 2001 (see Figure 7), have led to significant changes in the delivery of HCC services in BC. The following section describes these services and recent trends.

Current Home & Community Care System

HCC services are provided in the community, through assisted living facilities, or in residential care facilities.

Community Care Services

Home Support provides assistance with the tasks of daily living for people with chronic illnesses, disabilities or progressive medical conditions. Home support workers provide personal assistance with daily activities, such as bathing, dressing, grooming, and light household tasks, that allow patients to stay in their homes for as long as possible. Access to publicly subsidized home support services is based on an assessment by Health Authorities. Eligible patients using publicly funded home support services are charged a daily rate based on their after-tax income. These services may also be purchased privately. About 73% of people receiving home support services pay no fee due to their low incomes (Premier's Council on Aging and Seniors' Issues 2006).

Access to publicly funded home support services has become more limited in BC since the mid-1990s. From 2000/01 to 2004/05, the number of home support patients dropped by 24% and the number of total home support hours dropped by 12% (Cohen, McLaren et al. 2006). This corresponds to a shift in the home support case-mix toward patients with higher needs and services. As services have become more narrowly focused on medical tasks, the public system provides fewer and fewer daily living services such as meal preparation, shopping, housekeeping, and social contact (Cohen, McLaren et al. 2006). Researchers have found that home care patients are more likely to be admitted to residential care and/or use acute care and home support services over time when basic preventive and maintenance services are not provided (Hollander 2001; Hollander M 2001). The impact of reductions in home support services on the health care system is potentially significant, as home support is a form of preventive health care that can delay the need for institutional care.

Choice in Supports for Independent Living (CSIL). CSIL is a self-managed care model that provides an alternative for home support patients who want more flexibility in arranging home support services. Patients approved for CSIL receive funds to purchase their own services, and manage the recruiting, training, scheduling and supervision of community health workers. Individuals who are unable to direct their own care can obtain CSIL funding through a patient support group, which manages services on the patient's behalf. There are provisions for funding of family members as caregivers within the CSIL program.

Caregiver Relief/Respite. Many people receiving home and community care services are assisted by non-professional caregivers, often a family member or friend. Respite care gives the informal caregiver temporary relief from the emotional and physical demands of caring for a friend or family member. Respite may take the form of a service in the patient's home or the patient may be admitted, on a short-term basis, to a residential care facility,

hospice or other community care setting. Caregivers may also take a break while the patient attends an adult day centre or is receiving home support services.

Finally, *Home Health Care* includes the provision of post-acute professional care services such as those delivered by nurses, physiotherapists or occupational therapists in order to help acute and chronic care patients re-adjust to living in the community and support maintenance of function and independence. *Adult Day Centres* can provide bathing programs, personal care, recreational activities, meals and transportation. *Family Care Homes* are single family residences with accommodation for up to two patients.

Informal Caregivers. Informal caregivers have been charged with caring for aging relatives for generations. It is estimated that 80% of care for the elderly comes from families and other informal caregivers. The growing demand for home and community care services amongst seniors, coupled with decreasing access for these services, will put additional pressure on informal caregivers. The tasks of informal caregivers are numerous and broad, including assisting with the activities of daily living (e.g. housekeeping, meal preparation), providing personal care (e.g. bathing, eating), and assuring emotional, psychological, and spiritual support. To deliver upon these tasks, informal caregivers contribute substantive resources, time and money (Henderson K 2002). In 1999, the economic value provided by informal caregivers was estimated to save the Canadian healthcare system over $5 billion per year, and their contributions were considered equivalent to the work of over 275,000 full-time health care employees (Fast J 1999; Fast J 2001).

Assisted Living

Assisted living is a care setting that combines publicly subsidized apartments with support services for frail seniors and people with disabilities who can no longer live at home, yet do not require the 24-hour professional care and supervision provided in residential care facilities. Patients pay an inclusive fee for which they receive room, board, meals, weekly laundry and housekeeping and only one or two prescribed personal care services to assist with the activities of daily living. Additional services are paid for out of pocket by the residents or their families. Nursing care is not provided but there is a 24-hour emergency response system in place.

In 2002, under the Community Care and Assisted Living Act, a Provincial Assisted Living Registrar was established to oversee the health and safety of assisted living occupants. All assisted living residences must be registered, and through a complaint driven process, the Registrar can mediate or, if necessary, suspend or cancel an operator's registration.

Residential Care

Residential care in BC is provided in *Residential Care Facilities (RCFs).* RCFs provide nursing care and supervision for people with complex health care needs who can no longer live independently in their own homes or in another setting. Patients in RCFs cannot remain in their homes due to their need for medication supervision, 24-hour surveillance, assisted meal service, professional nursing care and/or supervision. In British Columbia, RCFs must be licensed under the Community Care and Assisted Living Act which sets out minimum legal standards for health and safety, building requirements, staffing, food service, medication administration, and resident care. RCFs charge daily fees based on the patient's after-tax income. Publicly subsidized residential care can be provided by both for-profit and not-for-profit providers.

Figure 7: Home & Community Care Services and Trends in British Columbia

Service	Description	Trends in Supply and Funding	
Home support	Personal assistance with daily activities, such as bathing, dressing, grooming and light household tasks.	↓	Home support services now provides fewer daily living services such as meal preparation, shopping, housekeeping, and social contact to patients with higher needs. Between 2000/01 and 2006/07 (Ministry of Health data from CERTS 2008-0040): ▪ The number of home support clients decreased by 12% (38,720 to 33,995) ▪ The number of home support hours of care provided increased 1.8% (8,192,988 to 8,344,456)
Choice in Supports for Independent Living (CSIL)	Patients receive funds, either directly or through a patient support group, to purchase and manage their own home support services.	↑	From 2000/01 to 2005/06, funding increased 49% from $22.9m to $34.2m (BC Ministry of Health, 2006). Between 2000/01 - 2005/06: ▪ Number of CSIL patients increased 46% (from 489 to 712). ▪ Hours of service increased 49% (from 914,680 to 1,366,625). ▪ Despite nearly 50% growth in patients and hours of service over these five years, the CSIL program continues to represent 2% of the home support system. ▪ CSIL patients tend to be younger (average age = 47) and more independent than patients in conventional home care programs (average age = 74). ▪ The most common functional diagnoses amongst CSIL patients are quadriplegia and paraplegia whereas physical frailty is more common amongst conventional home care patients (VIHA, 2006).
Home Health Care	Professional health services delivered in the home such as nursing care, physiotherapy, and occupational therapy.	↓	▪ In 2003/04, BC's per capita spending on home care was $82 which was below the national average of $91. BC also had one of the lowest utilization rates for home care in Canada with about 20 home care users per 1,000 population (Public-Sector Expenditures and Utilization of Home Care Services in Canada: Exploring the Data, CIHI, 2007). Between 2001/02 and 2206/07: ▪ The number of home care nursing clients increased by 7.6% (Ministry of Health data from CERTS 2008-0040). ▪ The population of elderly age 65 and older increased 15%; those 75 and older increased 20% (BC STATS, P.E.O.P.L.E. Run 06/12. (December 2006) 1971 - 2006 Statistics Canada estimates. 2007 - 2031 BC Stats forecast)
Adult Day Centres	Supportive group programs for seniors and adults with disabilities living at home. May include bathing programs, personal care, social activities, meals, and transportation.	↑	▪ Between 2001/02 and 2006/07 the number of ADP clients increased 18%, from 5,900 to 6,973 and the number of service days (Ministry of Health data from CERTS 2008-0040).
Caregiver Relief/ Respite	Temporary relief to informal caregivers either in the patient's home, or the patient may be admitted temporarily to a facility.	?	Data are not publicly available for the number of respite beds in residential care facilities. Tracking respite that is provided in the patient's home, facilities, and day centres is difficult. Caregiver needs are not assessed, nor are their health outcomes measured.

Figure 7: Home & Community Care Services and Trends in British Columbia

Service	Description	Trends in Supply and Funding	
Assisted Living Units	Publicly subsidized apartments with support services for frail seniors and people with disabilities. Housing, meals, laundry, housekeeping, and some personal care services are provided. . Nursing care is not provided but there is a 24-hour emergency response system in place.	↑	▪ Since 2004, over 5,000 units have been built or converted in BC. In January 2008, there were 151 registered assisted living residences in BC with a total of 5074 units. 27 sites are currently in development (Office of Assisted Living Registrar, 2008).
Residential Care Facilities	24- hour professional nursing care and supervision in a facility.	↓	▪ In 2002, the access criteria for residential care was changed: only patients who are assessed as requiring complex care within 90 days are accepted on a waitlist for residential care, and patients were assigned the first available bed regardless of whether it is in their preferred facility. ▪ Between 2001/02 and 2006/07, the number of residential care beds decreased by 553, from 25,420 to 24,867, below the 30,420 beds that would have been in place in 2006 had the 5,000 bed commitment been honoured by the Provincial Government. In 2005/06: ▪ BC spent the least nationally on residential care on a per-capita basis for those aged 65+ ($1,874). ▪ BC had the lowest number of residential care beds per capita for those aged 65+ in Canada at 36.5.
Family Care Homes	Single family residences that provide supportive accommodation for up to two patients.	?	Government does not have information on family care homes because the majority of family care homes are privately run.

Implications for Service Delivery

The Ministry of Health has depicted the access to HCC services as a smooth process beginning with the Health Authorities, whose case managers conduct an assessment to determine the nature, intensity and duration of services that would best meet patients' needs, and then arrange their services (see Appendix A). If the patient is eligible for services, the case manager works with them, their family, and their physician to prepare a care plan that best meets their needs. The patient is then referred to one or a combination of HCC services. Case managers also work with patients and families to facilitate transition between hospital and home or residential care settings.

In reality, the system-wide changes described above have made accessing appropriate HCC services a difficult and timely process. The insufficient capacity of HCC services, the restrictive eligibility for HCC services, and the narrow scope of some HCC services being provided all contribute to this access problem.

The following three charts depict more common paths that patients follow when accessing residential care, assisted living and home support[8]. Although the focus here is on the publicly subsidized HCC system, the private HCC system is also incorporated to illustrate how it has become a more desirable option for patients especially if they cannot receive appropriate subsidized HCC services in a timely manner.

Accessing a Residential Care Facility. Figure 8 illustrates a senior attempting to access publicly subsidized residential care either from home or from the hospital. The potential barriers to timely access are:

- Long waits for a case manager assessment and admission to a publicly subsidized residential care facility.
- Insufficient number of residential care beds. As the number of beds in residential care facilities declines, access to these facilities will become increasingly more limited.

Deterioration in crisis prevention. Given that patients only qualify for residential care services if they have very high complex care needs, many who are ineligible are nonetheless physically and mentally compromised. It is not uncommon for patients in the community to experience a deterioration in their condition to the extent that support cannot be provided at home or elsewhere, be admitted to the hospital, and wait for a residential care bed.

Accessing an Assisted Living Facility. Figure 9 illustrates a senior's efforts in accessing publicly subsidized assisted living. The potential barriers to timely access are:

- Long waits for a case manager assessment and admission into an assisted living facility. Given the prolonged wait times for subsidized assisted living beds, many patients are accessing private assisted living facilities where wait times will be shorter due to a greater bed supply and the scope of care provided is greater.
- Insufficient number of assisted living units. Seniors who do not qualify for residential care will usually remain in their homes or be referred to other community-based HCC services like assisted living or home care. Access to assisted living can be prolonged since supply has not matched increasing demand.

Accessing Home Support Services. Figure 10 illustrates a senior attempting to access publicly subsidized home support services. The potential barriers to access include:

- Long waits for a case manager assessment. Since services cannot be provided until the patient is

[8] In Figures 8–10, the GP is shown to be the primary referral for HCC services. However, patient referrals to HCC services also originate from other providers (hospital liaison, mental health), community services, families, neighbors, or the patient themselves.

assessed, long waits here effectively deny care to patients.

- Insufficient care is provided to patients who are frail with greater complex care needs. Home support does not include assistance with meal preparation, shopping, housework, or driving. Without assistance in these areas, the patient's condition may worsen until a crisis occurs and they are admitted to the ER. Alternatively, patients may receive private home care if their publicly subsidized hours are inadequate and/or inflexible.

Figure 8: Senior Accessing Residential Care

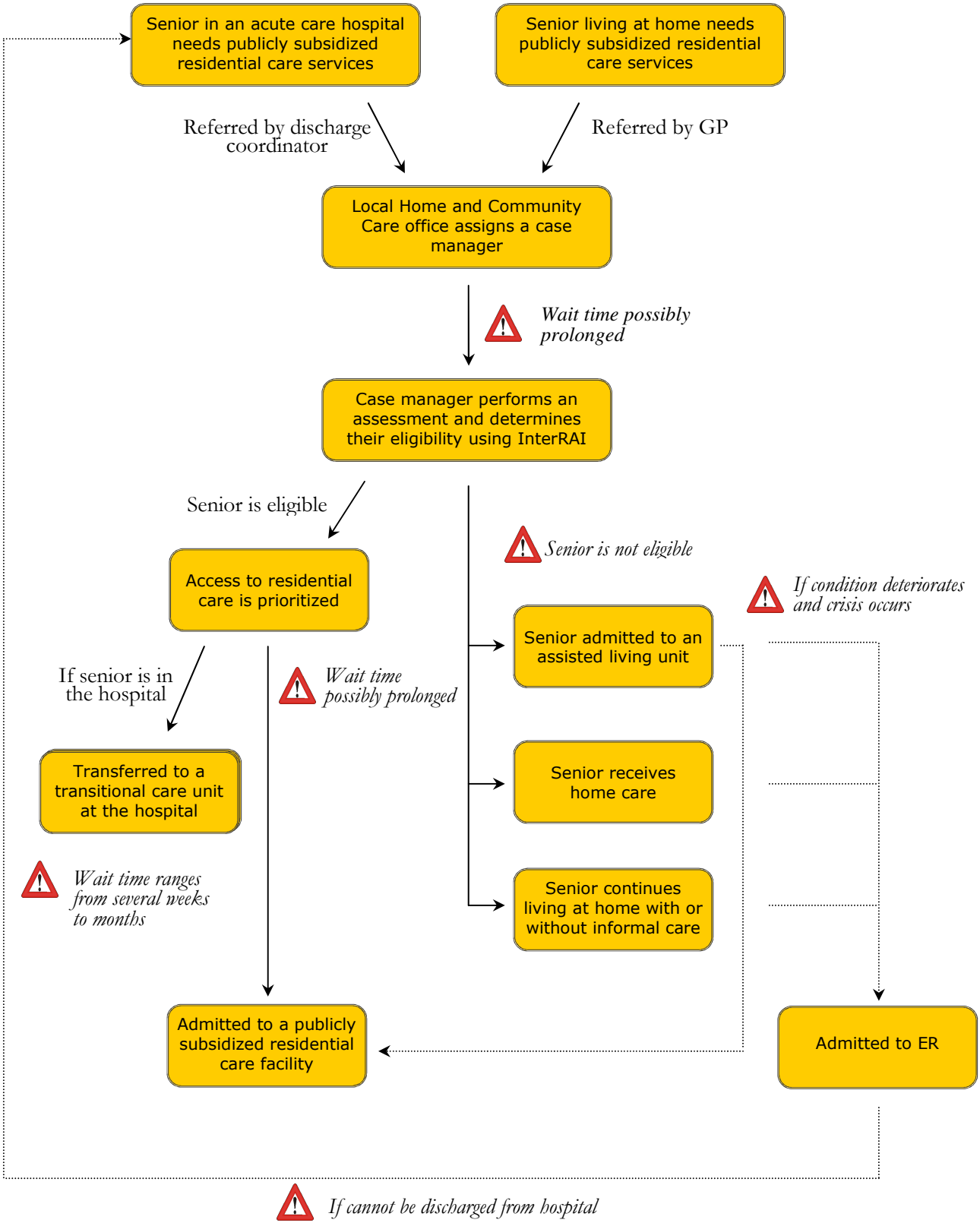


Figure 9: Senior Accessing Assisted Living

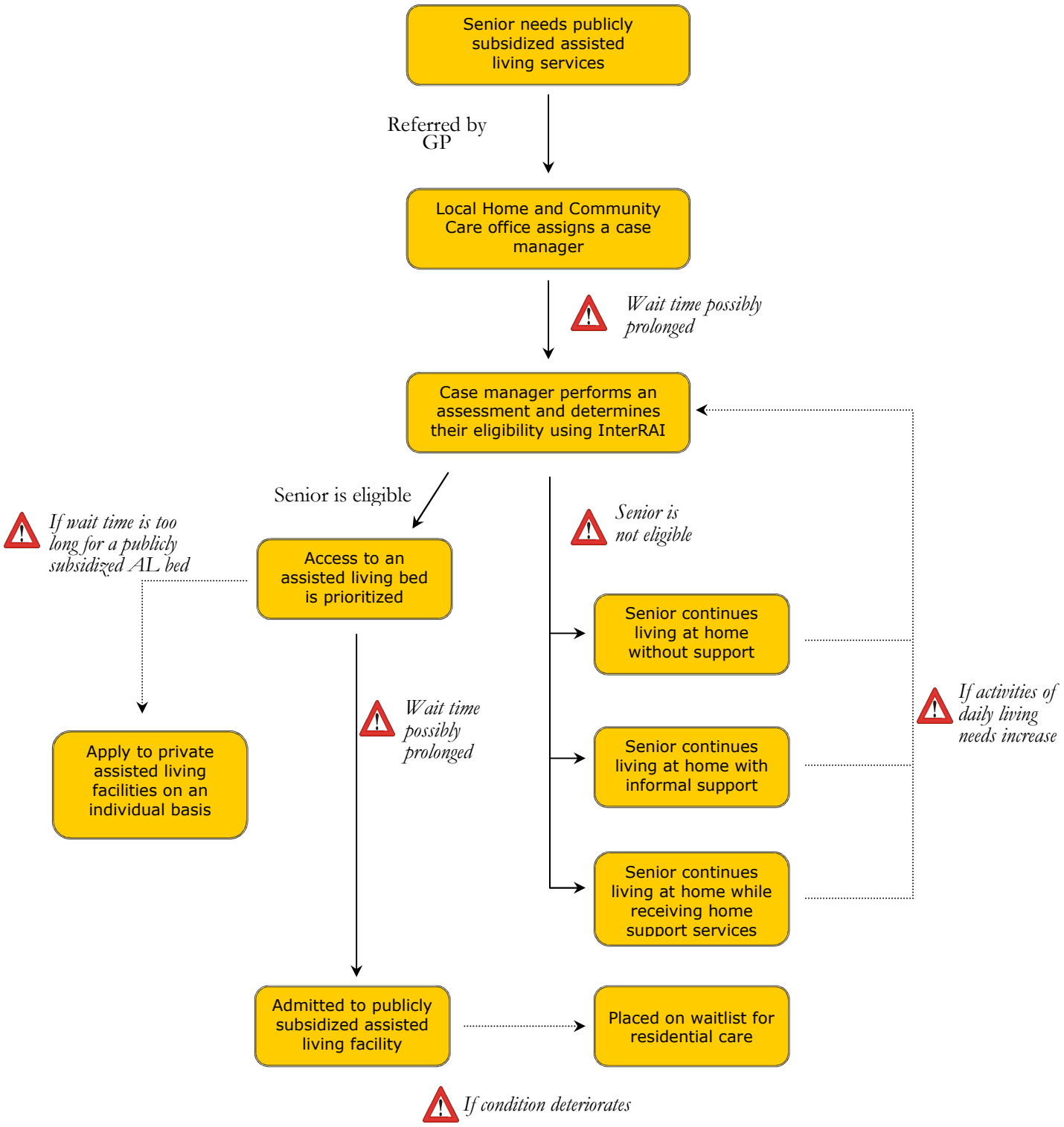
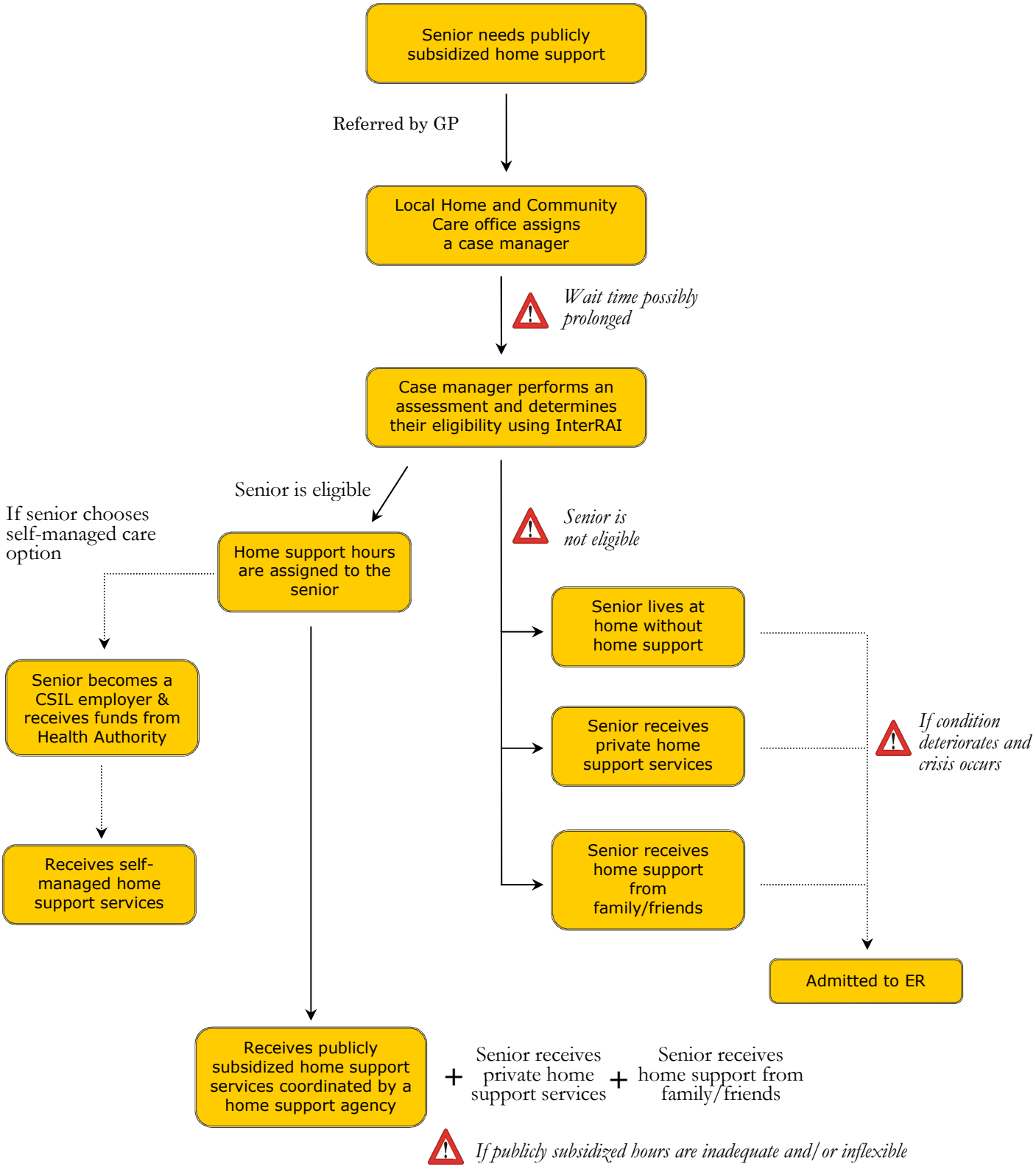


Figure 10: Senior Accessing Home Support



The BC Government's Positions on HCC and Recent Activities

The BC government's vision for HCC centres on shifting services from acute care crisis intervention to preventive services delivered closer to home in order to reduce hospital overcrowding, shorten wait lists for services, improve health status, and control cost increases. The government has stated that, as part of its commitment to ensuring that seniors receive the right care in the most appropriate setting, it is striving to provide more options for independent seniors such as assisted living, home care, and home support (BC Ministry of Health 2005). The updating in 2004 of the Community Care and Assisted Living Act, as well as the appointment of a provincial assisted living Registrar to regulate assisted living residences, make clear the government's desire to shift to more community-based model.

In principle, this shift is appropriate and supported by research: using an integrated system and moving to a community-based model can reduce costs while maintaining or improving the quality of care. However, the experiences internationally and in Canada suggest that doing so successfully depends on meeting certain criteria, some of which are not being met in BC.

The reduction in residential care beds without a concomitant increase in community based care is an illustrative example. Denmark issued a moratorium on the construction of new residential care beds as part of its strategy to shift to a more community-based model of care; however, this was accompanied by a significant increase in home care and home support funding. Today, Denmark is one of the highest spenders on HCC, and care is provided in a tightly integrated system that exhibits the characteristics of an integrated service delivery system. In contrast, the decreased funding for residential care beds in British Columbia has, at least since 2001, been accompanied by a *decrease* in home support funding (although, appropriately, funding for assisted living and home care has increased).

In 2001, the government promised to build 5,000 new not-for-profit long-term residential care beds by 2006, bringing the total number of beds to 30,420. Shortly thereafter, the 5,000 residential care bed target was changed to 1,500 residential care beds and 3,500 independent living beds (primarily assisted living but also some supportive housing). Two years after this deadline, the government announced that it was "on-track to meet its commitment." However, a closer look at the data reveals that the province opened only 3,677 "new beds or units" without specifying either how many of these were new residential care facility beds or whether this figure represented a net increase in the total provincial bed capacity (Vancouver Sun 2008). Under the unlikely assumption that all 3,677 beds were in residential care facilities and that this is a net increase in the available total, the government still falls short of its goal by over 1,300 beds. This is consistent with Ministry of Health data showing that from 2001 to 2007, there had actually been a net *decline* of 553 residential care beds (Ministry of Health CERTS Data 2008-0040).

These concerns about access to care have implications throughout the HCC system, not just in residential care facilities. In 2002, the government introduced its Continuing Care Renewal Plan which included new access criteria for residential care that limited admission to residential care to people who required the most complex care (Cohen M 2005). The vast majority (90%) of patients entering BC's residential care facilities in 2002/2003 were categorized as requiring the highest level of support, illustrating the significant needs of most residential care patients (Crawford C 2003). As the number of beds in residential care facilities declines, access to these facilities will become increasingly more limited. Patients will, in turn, have to rely on a decreasing share of home care and home support services, likely until a crisis arrives and they are cared for in an emergency room, the

costs of which well exceed those of more preventive care.

This argument is not to deny those positive aspects of the current system which include establishing publicly-subsidized assisted living and supportive housing as a care option, implementing a new standardized home care assessment instrument, and using case managers as a single entry point to HCC. The importance of the case manager role was discussed in the international chapter. In BC, physicians credit what integration there is in the HCC system to case managers, describing them in once instance as "doing an excellent job of integrating services for patients." Supporting and strengthening the case manager role should be central to reform of the HCC system in BC. To the extent that BC can emulate successfully integrated, community-based HCC systems elsewhere, it can improve quality and reduce costs. An expanded range of HCC services should be viewed as a vital element of an integrated system to support older people to stay at home in a cost-effective manner.

IV. BCMA Physician Members and Home and Community Care Case Manager Survey Results

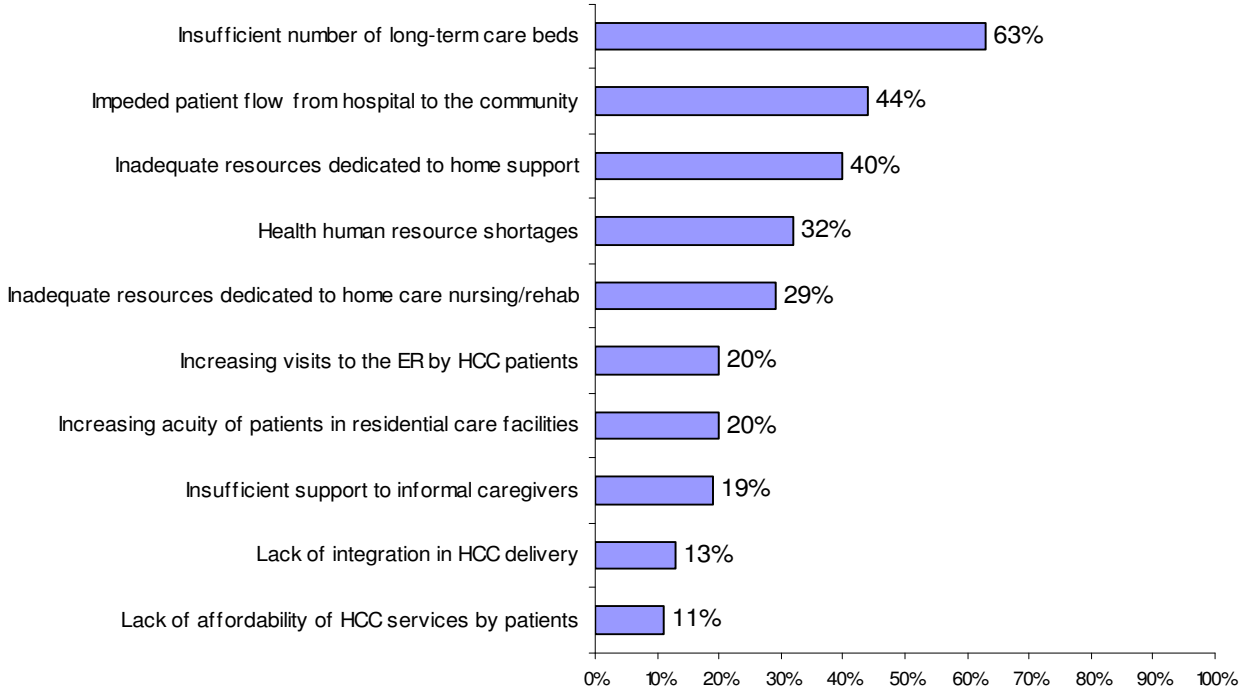
The BCMA conducted two studies to understand BCMA members' views on home and community care issues. The first was an e-mailed survey to a sample of the entire BCMA membership. This was followed by a more focused set of in-depth telephone interviews of selected physicians. An online survey of HCC case managers was also conducted to understand their views on home and community care issues and case management. The following section will discuss the main findings from these studies and the implications for our policy recommendations. Details on the methodology and results of the studies can be found in Appendix B.

Summary of Findings

There were several common themes that emerged from the membership survey data, physician telephone interviews, and the case manager survey data:

- The findings suggest a system in decline, largely because of deteriorating access to services. When asked about changes in access to, supply of, and quality of the HCC system over the past five years, physician and case manager survey respondents consistently stated that things have become worse. The most commonly cited challenge facing the HCC system was the insufficient number of residential care beds (see Figure 11). The lack of adequate home support was also cited as a top challenge by physicians and case managers. Physician interview and case manager respondents anticipated continued decline due to the increasing number of patients requiring HCC services, a shift towards less appropriate providers, decreasing access to services, and increasing patient complexity.

Figure 11
Top Challenges Facing BC's HCC System



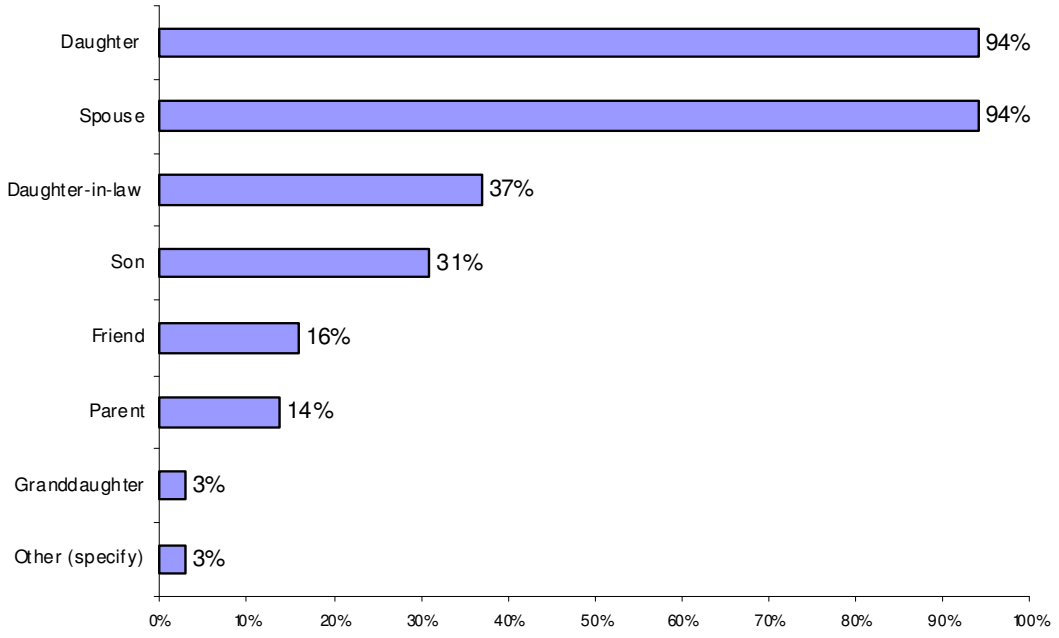
Survey question: "In your opinion, what are the top three challenges facing BC's HCC system?" n = 313.

- The HCC system demands that physicians provide excessive amounts of indirect care. While some of this is inherent to the practice of this type of medicine (e.g., counselling family members) much is an artefact of the current organization of HCC services (e.g., forms and paperwork) and could be reduced. Interview respondents suggested that additional funding to the HCC system be used to reduce the burden of indirect care work.
- Physicians are less concerned about the quality of care provided by formal caregivers *per se* than they are about how pressures on the HCC system (e.g., growing population of elderly, limited access to services) will affect their ability to continue to provide high quality care. Some, including case managers, expressed concern that staff training has not increased in conjunction with patients' increasingly complex needs, and that staffing cuts have led to high patient-to-staff ratios.
- A major barrier to maintaining or improving the state of the HCC system is the fragmentation of services. A key challenge cited by three-quarters of physician respondents was having HCC patients needing a higher level of care than was currently offered. Physicians were also significantly concerned over impeded patient flow from the hospital to the community. Where the system is integrated, physicians credit the work of case managers. This notwithstanding, most physician interview respondents saw the lack of service integration and communication between care providers as the biggest barrier to improving the HCC system.
- Case manager respondents consistently state that their high caseloads and the shortage of case managers have contributed to longer waits for HCC services and a shift from in-depth case management to crisis management. They suggest streamlining their administrative work,

increasing the supply of case managers, reducing their caseloads, and allowing more service flexibility to help improve HCC case management in BC.

- The plight of informal caregivers requires serious attention. Should access to formal HCC services continue to decline, the burden on informal caregivers, who are primarily unpaid and female (Figure 12), will grow substantially. Eighty-three percent of physician survey respondents agreed that the complexity of patients cared for by informal caregivers has grown over the past five years, and physician interview respondents recommended indirect payments to informal caregivers as one policy solution. Case manager respondents consistently rated the quality and access of respite services to have declined the most over the past five years.

Figure 12
Informal Caregivers



Survey question: "Who are the three most frequent informal caregivers of Home and Community Care patients that you encounter?" n = 296. Multiple response question; % adds to more than 100%.

V. Recommendations

Building on the research reviewed here, as well as the surveys of its physician members and case managers, the BCMA offers 15 policy recommendations. Following our analogy of rebuilding the home and continuing system to create a continuum of care out of the existing islands of services, our recommendations fall into three categories:

- *Building bridges:* creating the linkages that support a continuum of care;
- *Developing the islands:* ensuring that the services offered meet current and future demand; and
- *Funding for the future:* making available the financial resources to realize these objectives.

Building Bridges

Linking together the various home and community care services requires appropriate leadership to guide the creation of a truly integrated service delivery system, a central role for integrated case management, and the timely flow of information. An overarching objective in the development of such a system should be to ensure dignity and respect for patients' wishes and to guarantee timely access to HCC services for patients.

1. To ensure that the Provincial Government has in place the leadership structure necessary to ensure a sustainable, integrated home and community care system, the BCMA endorses the 2006 recommendation of the Premier's Council that the Premier appoint a Minister of State Responsible for Aging.

2. The Ministry of Health and other appropriate government ministries should support the creation of an integrated service delivery system for home and community care services. At a minimum, such integration requires:
    a. increased emphasis on integrated case management, and
    b. increasing the number of case managers in each region and reducing average case loads.

3. To improve the flow, usefulness, and public accessibility of information across the home and community care system, the Ministry of Health:
    a. must increase accountability by measuring and publicly reporting system capacity (e.g., bed rates per 1,000 population, wait times) and outcome (e.g., morbidity and mortality rates, recidivism) data across the home and community care system, and
    b. should facilitate the flow of patient clinical information among those providing care in the community.

4. Upon entry into the home and community care system, physicians should, as early as possible, document patients' wishes for end-of-life care. This information should be made available to other providers within the home and community care system wherever appropriate.

5. The Ministry of Health and Health Authorities should promote flexible, practical, and patient-centric policies for placement in institutionally-based care settings. Patients should be cared for as close as possible to their family and community support networks. Rigid application of the first available bed policy should be discouraged. In addition, Health Authorities should publicly commit to providing patients with their desired care when practical and medically appropriate.

6. Wait time benchmarks for accessing home and community care services should be implemented. For a case manager assessment,

the maximum allowable wait time should be one month from the time of GP request. For placement in the appropriate care setting, the maximum allowable wait time should be one month from the time of case manager assessment.

Developing the Islands of Care

To ensure that the home and community care system can meet the current and future needs of the population, some services must be expanded and the recent decrease in residential care beds must be reversed. In addition, the number of physicians providing such care must be increased, and additional supports for informal caregivers, who will assume increasing responsibilities over the coming years, must be provided. The gap between the demand for home and community care and skilled providers is growing, especially with the high number of skilled health professionals nearing retirement age. Finally, reducing the administrative burden on physicians delivering HCC care would help ease the already substantial indirect care component associated with HCC patients.

7. In 2001, the Provincial Government committed to create 5,000 new residential care beds by 2006, but in fact the number decreased by 1,464. The Government must honour its original promise, and these beds must be:
   c. a net increase in actual beds relative to the number of beds available in 2001, and
   d. above and beyond any increases to the number of assisted living units or other types of HCC services.

8. The Provincial Government must immediately increase funding to home health care and home support programs, at a minimum, to the national average in order to both increase the number of users and expand the range of services offered. Particular emphasis should be placed on restoring the homemaker role and extending eligibility requirements to include a broader range of patients, in order to ensure proper monitoring of patients' health status and provide preventive care before a crisis occurs.

9. The Provincial Government and Health Authorities should make available educational opportunities and support programs for informal caregivers.

10. The Provincial Government must work with the BCMA to address the physician shortage in home and community care by improving training opportunities and continuing support for physician incentive payments[9].

11. The Ministry of Health should form a task force, with membership including the medical profession, to streamline home and community care forms and eliminate duplication. The task force should make recommendations to the Ministry of Health by June 30, 2009.

Funding for the Future

Ensuring the sustainability of the home and community care system requires re-examining previous assumptions and expanding the opportunities for both public and private sources of funding.

12. The Federal Government should increase support for informal caregivers by expanding respite care and indirect compensation to informal caregivers.

13. Health Authorities should explore opportunities such as alternative funding models to increase integration and collaboration among physicians, nurses, and case managers when planning and delivering care.

[9] In 2006, a Facility Patient Conference Fee and a Community Patient Conference Fee were made available to better support GPs in working with patients, other health care providers, and patient family members in the review and ongoing management of patients in a facility, and for creation of a coordinated clinical action plan or the care of community-based patients with more complex needs, respectively. As of April 2008, GP visits to long-term care facilities increased by 44% (fee code 13114 & 00114) and 64% (fee code 00115).

14. The Federal Government should allow the creation of personal, tax-advantaged funds to meet future home and community care needs.

15. BC's Premier, along with other Canadian First Ministers, should jointly seek an enhancement of the comprehensiveness principle of the Canada Health Act to include home care and home and community care services. Similarly, the Provincial Government should expand the Medicare Protection Act and any all other legislation that addresses community health services.

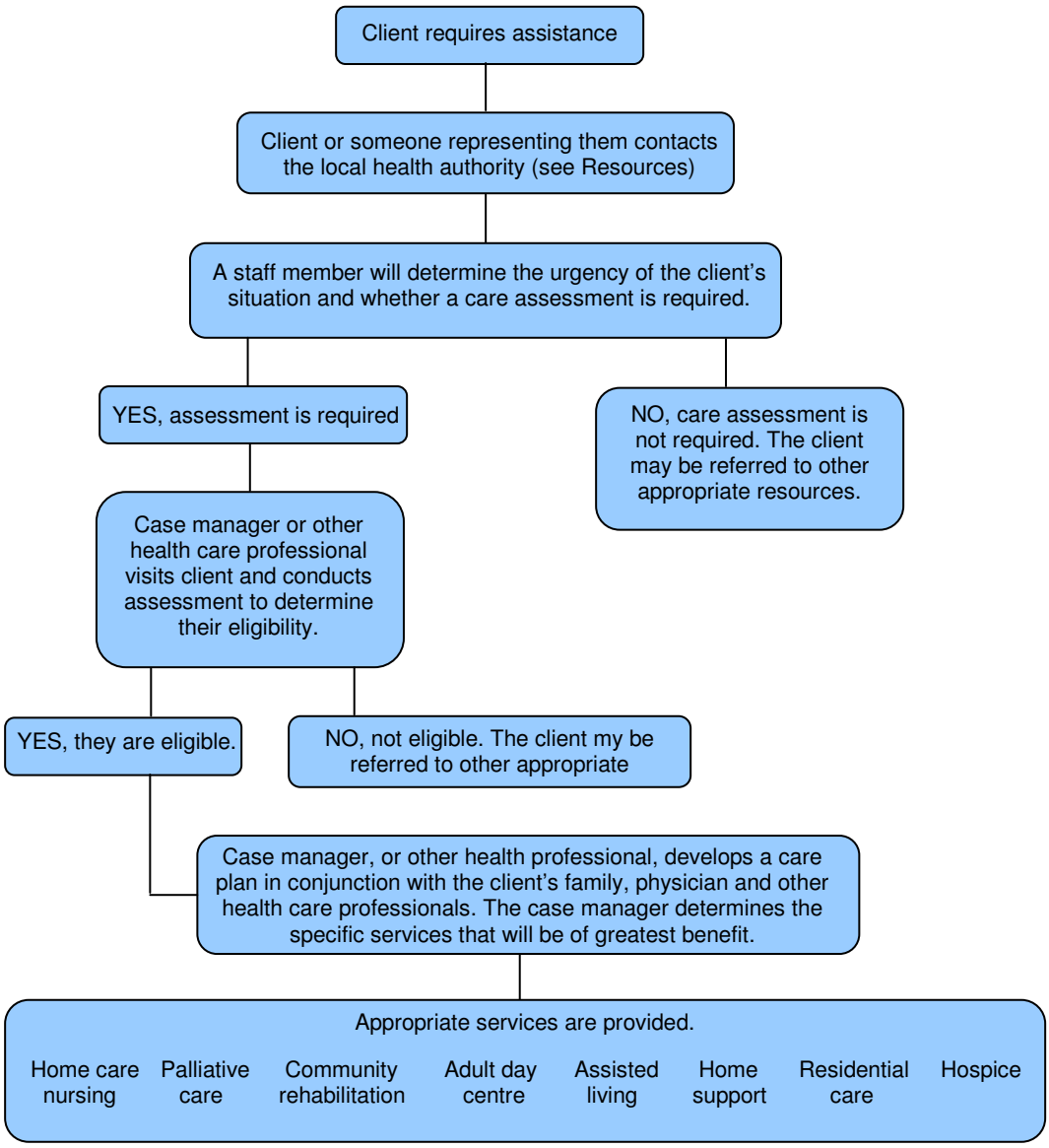
Conclusion

British Columbia's home and community care system is in a state of decline. While the reduction in residential care beds would not necessarily have been wrong if also accompanied by an increase in community-based care, provincial data show a simultaneous *decrease* in home care and home support services – the very services that evidence suggests are the most cost effective and best able to promote *aging in place*. To use our earlier analogy, we've taken down the bridges linking our islands of services and forfeited the opportunity to develop a true continuum of care. Patients' desire to remain autonomous for as long as possible has not been met. The net effect of these reductions, combined with growing case loads for case managers and the substitution of registered nurses with less appropriate LPNs in residential care facilities, will leave the province with a home and community care system unable to meet future demands. According to physicians and case managers, the reductions have already decreased patients' access to necessary services. Our ability to identify and respond to the needs of the frail elderly, and thereby avoid or delay their entry into institutionally-based care, has all but vanished. While dire predictions about the effects of an aging population and the collapse of the home and community care system are not inevitable, they become more likely every day that necessary reforms are delayed.

There are, nonetheless, reasons to hope. The Provincial Government has done the right thing in several areas. Recent increases in the number of assisted living units suggest an understanding of the importance of community-based care. The ongoing use of case managers and integrated case management – a hallmark of an integrated service delivery system – remains one of the most important bridges allowing patients to transition across the continuum of services. The ability of administrators to allocate services with exceptionally tight budgets indicates important management capacity. Fee increases for physicians providing home and community care send an important message to doctors that their time and efforts are valued. Importantly, positive and productive collaborative efforts between the Ministry of Health and the BCMA in the areas of primary care and chronic disease management show that both organizations can work together to implement meaningful, system-wide changes. Together, physicians and the government have already built bridges. We need only to leverage that success to re-build the home and community care system.

The solutions to the current and, even greater, future challenges facing the home and community care system require neither revolutionary approaches nor radical interventions. But they do require the political will for reform and an ongoing commitment to implement change. Integrated service delivery systems that facilitate *aging in place* through community-based services have operated elsewhere with demonstrable improvements in quality and access to care. With such experiences providing the blueprints for action, we can build the bridges and develop the islands to link our services into a continuum of care. It only requires that we first have the desire to do so.

Appendix A
Accessing Home and Community Care Services in British Columbia



Source: BC Ministry of Health, 2007.

Appendix B
BCMA Surveys: Methodology and Results

E-mailed Survey

Methodology

E-mail invitations were sent to 3,500 BCMA physicians. This included a sub-group of 36 geriatricians, plus 3,464 randomly selected physicians. In addition, nine members completed the survey via a link on the BCMA website. Between October 16 and December 2, 2007, 313 individuals completed the survey.

Because response rates were lower than expected and several questions had very high "don't know" response proportions, we offered a shorter version of the survey mid-way through data collection (on October 30, 2007). All web-link versions from the BCMA website used the revised (shorter) survey.

The results in this report include the questions that were on both surveys, and the ones that were included only in the revised version. The survey included questions to elicit views on a range of HCC issues: demographic information (e.g., practice location, age); challenges in the HCC system; physician management of HCC patients (e.g., number of patients using HCC services); access to, supply of, and quality of HCC services; informal caregivers, health human resources; and physician compensation.

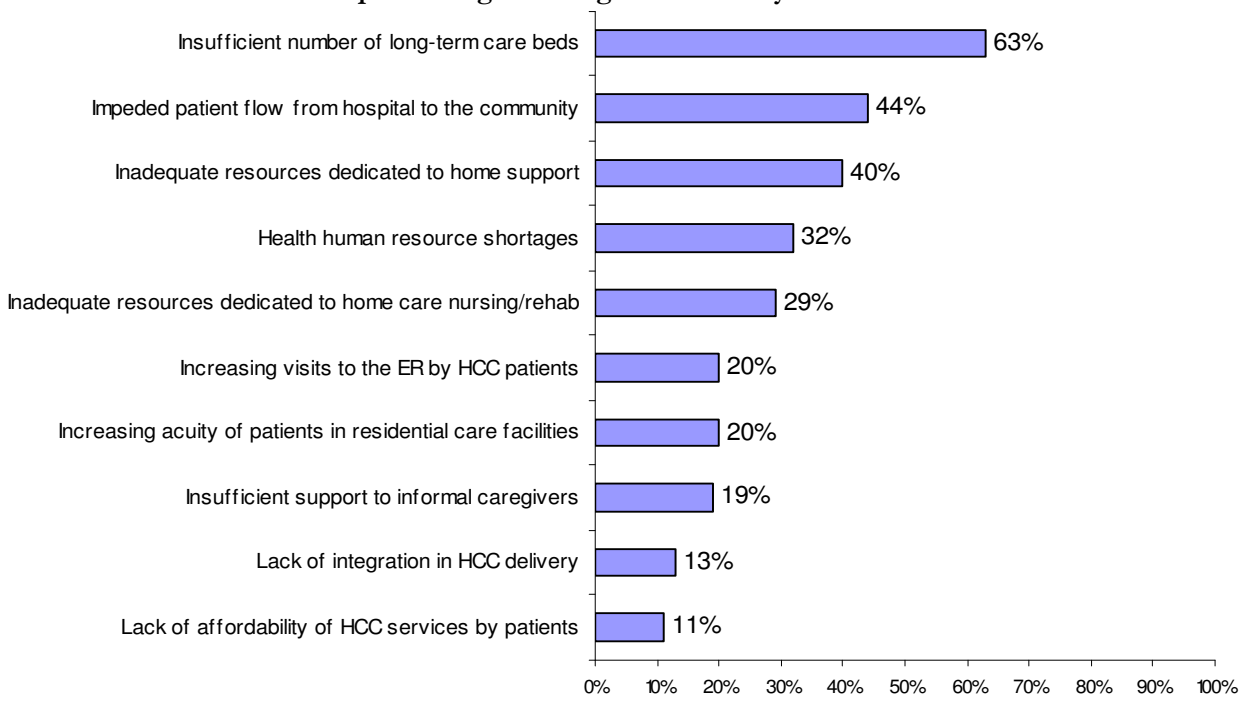
The survey respondents did not differ significantly from the BCMA membership in terms of average age, rural/urban practice location, or gender. However, there were more GPs in the sample, likely because of the topic.

	Original (longer)	Revised (shorter)	Total
Partially completed	116 (40%)	102 (41%)	218
Completed survey	174 (60%)	139 (60%)	313

Challenges in the HCC system

When asked to select the top three challenges in the HCC system, the most common response, and the only one cited by a majority of respondents, was the insufficient number of long-term care beds (63%). This was followed by impeded patient flow from the hospital to the community (44%) and inadequate resources dedicated to home support (40%). Figure 11 shows how other topics fared.

Figure 11
Top Challenges Facing BC's HCC System



Survey question: "In your opinion, what are the top three challenges facing BC's HCC system?" n = 313.

Physician Management of HCC Patients

On average, participants said that 15 of their patients, representing an average of 5% of their patients, were dependent on HCC for daily living. Respondents spent, on average, 35 hours per week providing direct care to patients, with an additional 10 hours per week providing indirect care (e.g., completing paper work, interacting with family members). However, physicians spent proportionately much more time providing indirect care to their HCC patients: one hour for every two hours of direct care provided.

When asked to comment on the change in proportion of HCC patients in their practice, three out of five (60%) said that the number of HCC patients had increased over the past five years. Nonetheless, a majority of respondents offered home visits (56%) and nursing home visits (59%) for their HCC patients. Nearly three-quarters (74%) declared that they had patients who required a higher level of HCC care than they were currently receiving. However, only 40% were willing to accept more HCC patients. Some notable exceptions included rural physicians and those physicians with a higher-than-average proportion of HCC patients. Both groups were significantly more likely than others to accept new HCC patients.

Access to, Supply of, and Quality of HCC Services

Difficulty in accessing HCC services was a common theme that emerged from respondents' answers to the survey. More than 90% said that services should be available in less than one month, but only half of participants agreed that this actually happened. And although physicians generally saw access to HCC service providers as acceptable –

two-thirds (67%) said access was average or good – 54% of participants said that the time to access HCC services has worsened over the past five years. Concerns about access may have been related to concerns about supply. While most (58%) of participants said that the supply of HCC services was average or good, half (50%) said that the supply of HCC services had worsened in the past five years. Participants also noted that HCC service assessments take about as long as getting access to the services.

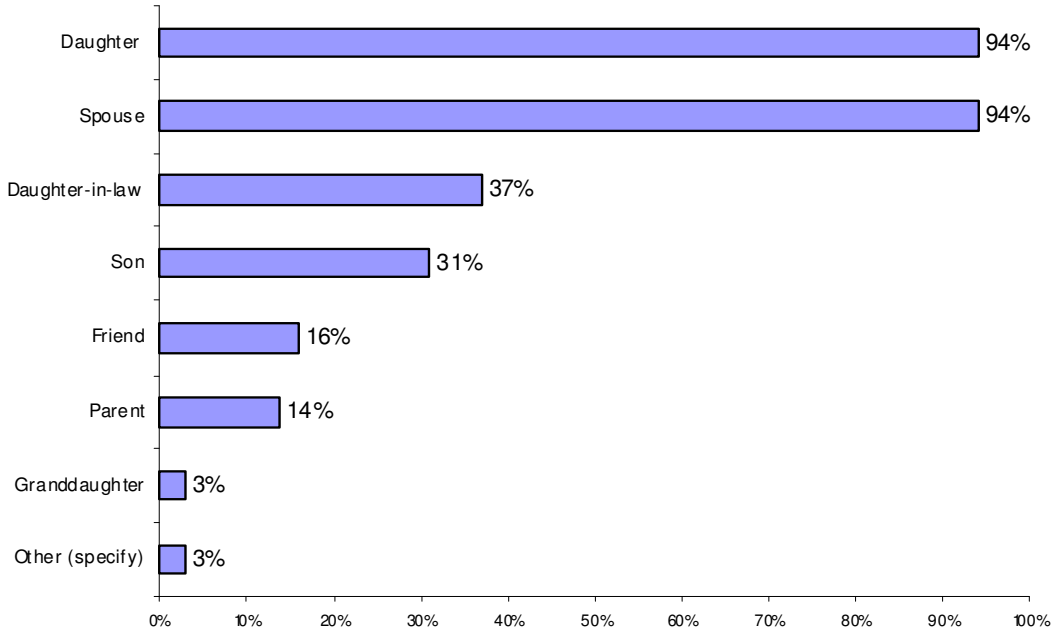
Finally, when asked about the quality of HCC services, a strong majority (87%) of participants said the quality of HCC services was average or good.

Participants views of how the quality of HCC services had changed over the last five years varied significantly. While the majority thought the quality had stayed the same or improved (54%), more than a quarter (29%) thought the quality had worsened.

Informal Caregivers

The situation of informal caregivers, as perceived by physicians, illustrates clearly the unpaid burden placed on women. When asked to name the three most frequent informal caregivers of HCC patients, the most common were daughter (94%), spouse (94%), and daughter-in-law (37%). Figure 12 shows the breakdown of responses.

Figure 12
Informal Caregivers



Survey question: "Who are the three most frequent informal caregivers of Home and Community Care patients that you encounter?" n = 296. Multiple response question; % adds to more than 100%.

Perhaps equally disturbing has been the increased complexity of these patients: four out of five respondents said that the complexity of patients for which informal caregivers offer support has increased over the past five years. Potential policy solutions to improve this situation included greater home support services (94%), expanding respite services (86%), more funding to purchase caregiver services (83%), and greater indirect payments to informal caregivers (69%).

Physician Compensation

When asked if they would be willing to provide on-call services to residential care facilities if compensated, almost two out of five participants (38%) said they would. Forty-three percent said no, and the remaining 19% responded "don't know."

Telephone Interviews

Methodology

Telephone interviews were conducted in November and December 2007 with 16 physicians: six GPs, six Geriatricians, and four Medical Directors of long-term care facilities. These physicians, who lived in various areas around BC, were selected because of their experience with Home and Community Care in the province.

The telephone interview questionnaire included 14 questions covering HCC issues similar to those in the e-mailed survey: challenges in the HCC system; physician management of HCC patients; access to, supply of, and quality of HCC services; and funding issues and policy recommendations for improving the system.

Most Important Issues in the HCC System

Participants had differing opinions about the most important issues facing the HCC system. The primary concerns included:

- Continuity of care. Many participants saw the lack of service integration and communication between care providers as the biggest barrier to improving HCC.
- Organization and structure. The lack of structure and role delineation can result in inconsistent care for patients, as well as demoralization and stress for care providers.
- Human resources challenges.
  - Not enough health care providers to meet current needs, let alone increased needs in the future. This could be alleviated with financial incentives for working in HCC.
  - Inadequate training – Both formal and informal caregivers would benefit from training on how to care for elderly patients.
- Pressure on the HCC system caused by reduced in-patient care, growing numbers of seniors, and increasing case complexity.
- Excessive amounts of indirect care. This could be improved with better communication systems and tools.
- A lack of residential care beds and funding for the HCC system overall.

Physician Management of HCC Patients

All interview participants administered care to HCC patients regularly. The proportion of their patients using HCC services ranged from 10% to 100%, typically depending on the participant's line of work (GP, Geriatric specialist, or Medical Director).

Most participants said that the number of patients requiring HCC services has increased over the past 10 years, and that it will continue to increase in the future. The increase in HCC patients stems from several sources:

- Population aging – The demographic shift toward an older population increases the need to have patients cared for in the community.

- Cost of beds – HCC services should be increased to keep patients out of acute care settings (because there are not enough acute care beds). Doing so reduces the cost of caring for patients.

Access to, Supply of, and Quality of HCC Services

Opinions about patients' access to HCC services varied noticeably. While some thought access was good, most thought it was inadequate. Several participants noted that increasing access to HCC services would significantly impact the number of long-term and acute care beds needed. Others mentioned that increasing access to physiotherapy and occupational therapy could help keep patients in the community for longer by giving the means to remain mobile. Some participants felt that the HCC system could benefit greatly from assisted living homes – something to bridge the gap between residential care and community care.

Perhaps most disconcerting was that regardless of whether participants thought access was currently good or not, they expected access to services to decrease in the future. There were various reasons for this forecast, including:

- Increasing demand for services is not matched by supply (i.e., not enough people working in the HCC system).
- There are fewer long-term and acute care beds to care for patients, forcing them to live in the community.

With respect to the supply of HCC services, most participants felt that there was some type of HCC provider lacking in their practice community. Often it was that service was lacking in all areas, but some specific areas were mentioned on several occasions, including case management, home care nursing, and home support.

Participants generally held the view that the quality of HCC service providers was not a problem. Most viewed service providers as well-trained and hard-working care providers. While the quality of services was viewed positively, there was some concern that the quality of care providers has been decreasing, and may continue to decrease. One driver of this trend has been the replacement of better-trained care providers with less well-trained care providers. For example, nurses have been replaced with LPNs, and many nurses have not been replaced at all. The low salary of many care jobs is a barrier to hiring and attracting staff.

While care providers were viewed positively, the increasing need for HCC services has reduced the quality of care that patients receive. That is, the care providers are doing a very good job but there are not enough of them to provide patients with the care they need. Participants also felt that the lack of consistency in care providers (i.e., different staff each day) reduced the quality of care that patients receive.

HCC System Fragmentation

Most participants agreed that the HCC system was fragmented, and that continuity and integration should be improved. The fragmentation was often seen as a result of not integrating physicians into the HCC system properly. Those who felt the system was not fragmented credited case managers with doing an excellent job of integrating services for patients. Some suggested ways of integrating services included:

- Developing communications networks, potentially including internet communications for care teams.
- Creating dedicated liaisons to communicate between HCC nurses and physicians, and to communicate between physicians.
- Moving to a smaller patient management model, where physicians deal with residential care facilities rather than the HA, and where physicians lead a team of care providers.

- Ensuring that patients have dedicated care providers so that relationships between patients and care providers can be established.

Best Applications for HCC Funding

When asked where additional resources for the HCC system should be spent, respondents provided several suggestions. About half of participants thought that additional payment for providing geriatric care was the best use of HCC funding, although almost all would be happy to receive increased payment. There was generally a feeling that caring for geriatric patients was not a well-paying line of work, so many physicians do not do it. However, participants said that payment for services should be time-based, not task-based, and that the work expectations for the payment need to be made explicit. Finally, several participants suggested that funds should be used to pay for physicians who deal only with HCC and residential care patients. Having such physicians in the community could make discharging patients from acute care easier, as there would be someone in the community to care for the patients.

When asked whether fees for indirect care were appealing, most participants said they would be. Most participants saw the indirect care, particularly paperwork, as an excessively time-consuming task, although a minority thought indirect care work was a necessary and important part of dealing with HCC patients. Their views on what components should be remunerated differed:

- Some thought everything from phone calls to forms should be covered, while others were more limited in the items that should be covered.
- While the fees for physicians' indirect care was appealing, several participants suggested that using the funds to reduce indirect care work would be better.
- Duplicate paperwork could be reduced (e.g., through electronic medical records), and doctors should focus on using their expertise.
- Improved communication between case managers and physicians could also reduce the amount of indirect care work physicians need to engage in.

Participants recognized the work that informal caregivers do as a very important part of the care that HCC patients receive. They identified numerous supports that could improve their quality of life and reduce their burnout, such as flexible respite services and the provision of training on how to deal with care-related issues, and how to work effectively with other care providers.

Indirect payment to informal providers was seen as an acceptable incentive, particularly for caregivers who were losing income because of the care they provided. In contrast, direct payment for informal caregivers was generally not seen as an effective or viable option. This was viewed as a problematic compensation because it might reduce the intrinsic motivation to provide care for loved ones. The payment might send the wrong message about caregiving, and the administration of such a system would be overwhelming.

Recommendations for Improving the HCC System

In summary, telephone interview respondents identified sources of growing pressure on the HCC system, including human resource challenges, a growing population of the elderly, and a lack of residential care beds. Respondents' suggestions for improving HCC services focused on improving the continuity of care offered and increasing access to services. For example, respondents recommended that policymakers search for a better way to obtain HCC services before patients have a crisis event. This could include using a team of care providers to provide home-service in the event of a crisis. Also recommended was a specific service to evaluate and manage geriatric cases and patients with dementia. Improved training for both formal

providers (to deal with the changing needs of patients, including the mentally ill and culturally diverse) and informal providers was also suggested.

Home and Community Care Case Manager Survey Results

The BCMA conducted an online survey of HCC case managers to understand their views on home and community care issues and case management. The following section describes the methodology and the results of the survey, and concludes with implications for our policy recommendations.

Methodology

The survey was developed using SurveyMonkey, an online surveying tool. The survey was based on questions contained in our membership HCC survey and covered areas such as demographic information, HCC case management, access and quality issues, and challenges in the HCC system. Unlike the electronic survey of physicians, however, the case manager survey included many open-ended questions and was designed to elicit in-depth responses appropriate for this kind of qualitative analysis.

Potential survey participants were identified by the HCC project group members and HCC case managers. E-mail invitations were sent out to 16 case managers over a two week period at the end January 2008. Participants were asked to forward the survey to other case managers if possible. In total, 17 complete responses were received from both rural and urban regions in BC. Most participants work as full-time HCC case managers while a few work in a blended role that included case management.

Challenges in the HCC System

Participants had varying opinions when identifying the top challenges facing the HCC system. Their primary concerns included:

- Inadequate home support resources;
- Health human resource shortages;
- Increased ER visits by HCC patients;
- Inadequate home care nursing/community rehabilitation resources;
- Shortage of case managers;
- Increased acuity of patients in the community without appropriate and sufficient support; and
- Insufficient number of long-term care beds.

From our membership survey, the participants identified two common priority challenges with BC physicians: inadequate home support resources and insufficient number of long-term care beds.

Access to, and Quality of, HCC Services

The majority of participants stated that the wait time for a case manager assessment has increased over the past five years. Reasons for the increase included:

- Increased complexity of patients' medical needs resulting in case managers spending more time with current patients and managing their needs;
- Increased patient caseloads;
- Increased complexity of new referrals;
- Shortages of case managers; and,
- Completion of the minimum data set (MDS) assessments is time-consuming and overwhelming.

In general, participants stated that access to HCC services has worsened over the past five years, especially for respite services. According to our membership survey, BC physicians also held the same view. According to the participants, the main reasons for the decline in access are:

- Inadequate resources to respond to the growing needs of HCC patients (e.g., respite beds, residential care beds and assisted living units);
- Heavy case manager caseloads; and,

- Shortage of qualified staff to respond to the increasingly complex needs of HCC patients (e.g., community care aides, home care nurses, case managers).

Participants expressed concern that the quality of some HCC services has deteriorated over the past five years such as residential care, home support and respite services. In comparison, physicians' views varied quite a bit – while the majority thought the quality had stayed the same or improved (54%), more than a quarter thought the quality had worsened (29%). According to the case manager participants, the key reasons for the decline in quality of some of the HCC services are:

- Cutbacks in home support which leaves patients at risk in their homes without basic supportive services (e.g., cleaning, homemaking);
- Increased workloads on case managers and providers which result in less follow-up care and face-to-face time with patients;
- Staffing cuts which have lead to high patient and staff ratios and substandard care;
- Staff training has not adjusted to patients' needs becoming more complex and heavy; and,
- Lack of continuity, education, and supervision of home support workers which can be detrimental to cognitively impaired seniors and stressed-out caregivers.

Recommendations on Improving the HCC System

There was a general consensus among case manager participants that the key ways to improving HCC case management in BC are to address the shortage of case managers; streamline the administrative work associated with InterRAI assessments; and allow more service flexibility. When participants were asked how InterRAI patient assessments could be streamlined, their suggestions included:

- Shortening InterRAI assessments to include only necessary information;
- Providing additional clerical support to input data, especially for intake and discharge assessments;
- Increasing the supply of case managers and reducing their caseloads;
- Creating an electronic, accessible, timely InterRAI assessment tool that can be shared with other providers and case managers to avoid duplication; and,
- Making InterRAI assessments more readable to providers and administrators.

When participants were asked what issues they would like to have emphasized in the BCMA report, there was a consistent belief that keeping patients at home for as long as possible both reflects patient preferences and is a more cost-effective option than providing residential and hospital care. Participants recommended several methods for achieving this:

- Dedicating additional resources to home support, community care nursing, respite and supportive housing for patients who cannot be managed in a typical residential care facility or assisted living unit;
- Re-establishing home-makers and life-skill workers under home support and increase home support hours;
- Reducing paperwork and bureaucratic requirements that are taking valuable time away from providers interacting with patients;
- Moving away from crisis management to effective in-depth case management by increasing the supply of case managers and reducing their excessive caseloads;
- Increasing staff, especially community care aides, community care nurses, and mental health workers;
- Addressing the difficulty of having too few HCC patients seen by physicians or receiving home visits by physicians;

- Allowing more flexibility in service provision to patients living in the community;
- Increase training for staff (e.g., dementia care);
- Establishing a more central organization that can monitor the quality of HCC care provided and ensure equitable access to HCC services; and
- Promoting a team approach to care in the community.

Appendix C
Glossary

ACTIVITIES OF DAILY LIVING: Activities (e.g., bathing, dressing, toileting and transferring) that are part of normal daily life.

AGING IN PLACE: Refers to one's ability to stay living independently in one's home. This may require modification of the home and/or additional support from family, friends or professionals.

ALTERNATE LEVEL OF CARE: Hospital beds occupied by people waiting for placement in residential care, or to return home with the appropriate home health or rehabilitation supports. These individuals do not require acute hospital services but are unable to leave the hospital until the residential and home health services they require are available.

ASSISTED LIVING: A form of housing for largely independent seniors who require daily personal support. Assisted living does not include care provided by Registered Nurses and is not designed for people with significant physical or mental needs. In publicly subsidized assisted living, residents pay an inclusive fee for which they receive room, board, meals, weekly laundry, cleaning and only one or two prescribed personal care services to assist with activities of daily living (e.g., assistance with mobility, medication management, bathing). A 24-hour emergency response system is provided. Additional services can be paid out-of-pocket by the resident or their families.

CAREGIVER RESPITE: Temporary relief to informal caregivers provided either in the patient's home, or the patient may be admitted temporarily to a facility.

HOME AND COMMUNITY CARE (HCC): The range of services for dependent people who require help with day-to-day living and life-skills over an extended period of time. While the elderly make up the majority of HCC patients, it also includes younger populations with disabilities, addictions, and mental health problems. Hospice and palliative care patients have been excluded from this report due to their unique needs.

HOME HEALTH CARE: Professional health services provided to individuals in their own homes. It includes home care nursing (post-acute, chronic, and palliative) and rehabilitation services. These services may also be purchased privately.

HOME SUPPORT: Non-professional personal care services provided by Community Health Workers to assist people to remain in their own homes. Publicly subsidized home support includes personal assistance (bathing, grooming, dressing). Additional services may also be purchased privately.

INDIRECT CARE: Time spent providing services other than direct patient care. Indirect care includes, for example, filling out forms, communicating with other providers to manage patient care, or spending time providing support to a patient's family members.

INTEGRATED CASE MANAGEMENT: Case managers arrange and coordinate health and/or social services for people in an integrated manner that involves support and coordination from other care providers (e.g., geriatricians, GPs, social workers, nurses, rehabilitation therapists). Aspects of integrated case management include longitudinal care coordination, ability to link patient information between providers, and service flexibility.

INTERRAI: The clinical assessment tool that is used by case managers when conducting Home and Community Care client assessments. The data are collected using the Resident Assessment Instrument

(RAI) Minimum Data Set developed by InterRAI, an international, non-profit consortium of researchers. This instrument contains over 500 data elements documenting the clinical and functional characteristics of residents, including measures of cognitive function, psychosocial well-being, health conditions, treatments/procedures, physical function, disease diagnosis, and activity patterns.

INTEGRATED SERVICE DELIVERY SYSTEM: A network of health care providers and organizations that provide or arrange for a coordinated continuum of services to a defined population.

RESIDENTIAL CARE: Previously referred to as long-term care, residential care includes intermediate care, extended care, complex care, multi-level care and nursing homes. Residential care is for individuals who require 24-hour nursing supervision. Only people with complex care needs are being admitted to residential care. (Complex care includes only those residents who were previously classified at intermediate care level 3 and extended care.) In publicly funded residential care, residents pay daily fees based on their income.

SUPPORTIVE HOUSING: Housing facilities in which clients need to be completely independent in mobility and are able to live independently. Services offered are usually one daily hot meal, light housekeeping, weekly linen service and a 24-hour response system. There are no care attendants or nursing services.

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