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of British Columbia

Home and Community Care Services

Meeting Needs and Preparing for the Future

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The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
Victoria, British Columbia
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Dear Sir:

I have the honour to transmit herewith to the Legislative Assembly of British Columbia my 2008/2009 Report 7: Home and Community Care Services: Meeting Needs and Preparing for the Future.

John Doyle, MBA, CA
Auditor General of British Columbia

Victoria, British Columbia
October 2008

copy: Mr. E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

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Auditor General's Comments

John Doyle
Auditor General

Home and community care services are provided outside the hospital environment to some of B.C.'s most vulnerable citizens. As the population ages, these services will become even more important.

Currently, the government spends approximately $2 billion dollars for the delivery of these services to over 100,000 clients. Having the right service at the right time and in the right location supports improvements in health outcomes while providing needed respite services for the friends and families who provide voluntary care giving. Home and community care services delivered when required can also reduce the need for higher intensity and more costly services

At this time, we chose to focus on the Ministry of Health Service's role in this system because, as steward, the ministry has an important leadership role to play in preparing the system for the future.

Planning to meet emerging needs in this complex system is not a simple task. We found that efforts have been made but that many of the initiatives underway need to be completed and brought together to support an integrated approach.

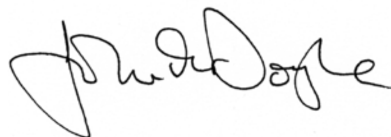
It is also critical that the ministry has high quality information to support the most efficient and effective allocation of resources and to provide relevant and reliable information to the public and key stakeholders on the capacity of the system to deliver required services. Although the ministry has taken steps to improve the level and quality of information used for planning, monitoring and reporting, more work is needed.

The efficient and effective delivery of health services—like home and community care services—has an impact on all citizens. Over the past few years, we have undertaken a number of projects in health and will continue to do so in the future. Not only because of the significant amount of tax dollars that are spent in this sector but also because health care affects every person at one or several points in their lifetime. In looking across these projects some consistent issues are emerging, such as a need to improve public performance reporting and the underlying information infrastructures that support program focus and the delivery of services.

Auditor General's Comments

As we choose our future health audits, we will consider these emerging trends and may focus on health governance areas such as information technology, resource allocation and accountability in an effort to understand how these fundamental building blocks of this complex and important sector support and complement work undertaken by professional health care providers.

I would like to thank the Ministry of Health Services staff for their cooperation and professionalism in the course of this work. The response demonstrates their commitment to continually improve system planning and service delivery—this report is a nudge in the right direction.



John Doyle, MBA, CA
Auditor General of British Columbia

Victoria, British Columbia
October 2008

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Executive Summary

Executive Summary

BC Stats predicts that, between 2006 and 2031, British Columbia's population of seniors will have increased dramatically. In 2006, those over the age of sixty-five accounted for approximately 15% of the total population. By 2031, this proportion is to increase to 24%—about 1.4 million. Such growth poses challenges for the Ministry of Health Services and the health authorities, which are responsible for ensuring that the needs of citizens are met and that the health system is sustainable in the future.

This trend toward an aging population will put particular pressure on home and community care services, where approximately 70% of current users are seniors.

Home and community care encompasses a range of health care and support services for residents—seniors and others—who have acute, chronic, palliative or rehabilitative health care needs. These services range from support for daily activities (such as dressing and meal preparation) to professional health interventions (such as home care nursing and end-of-life services), all of which are offered in client homes, the community and in health care facilities across the province. Many clients rely on these services to support their independence and well-being.

The Ministry of Health Services currently allocates about $2 billion annually to five regional health authorities to deliver home and community care services to more than 100,000 clients. As the steward of the health system, however, the ministry has the lead role in setting the strategic direction for the home and community care system, planning service delivery in coordination with the health authorities, and monitoring and reporting on the performance of this aspect of health care.

Audit purpose and scope

We examined whether the Ministry of Health Services is carrying out its stewardship role effectively to help ensure the home and community care system has the capacity to meet the needs of British Columbia's residents now and in the future. Specifically, we expected the ministry to:

- set a clear direction through vision, strategy, legislation and policy for home and community care services;
- have management information systems in place to support data collection and analysis for home and community care;

- have the processes and information needed to plan for services; and
- provide accountability information to the public on the performance of the home and community care system.

The audit focused on the activities of the Ministry of Health Services for 2007/08 (up to March 2008). We completed our analysis of evidence by May 2008 and released the first draft report to the ministry on August 1, 2008 in part to ensure that no significant changes had occurred since the end of our evidence gathering. We did not audit the activities of the health authorities or BC Housing.

The audit was carried out in accordance with the standards for assurance engagements established by the Canadian Institute of Chartered Accountants.

Audit conclusion

The Ministry of Health Services is not adequately fulfilling its stewardship role in helping to ensure that the home and community care system has the capacity to meet the needs of the population. Although the ministry has taken some action, timely completion of these steps is required to prepare the system for the future.

The first steps are for the ministry to finish developing a new strategic direction for the home and community care system, take a stronger leadership role in improving information systems, and more effectively incorporate information on population health trends, system costs and accessibility of services in planning for system capacity. As well, to better demonstrate its transparency and accountability, the ministry needs to enhance the performance information it provides to the public.

Key findings and recommendations

The ministry is in the process of developing a new strategic direction for home and community care

A critical role for the ministry is setting the strategic direction for its various health care programs. We therefore expected the ministry to have articulated a clear vision and strategic direction for home and community care, defined appropriate services through

legislation and policy, and defined the roles and responsibilities of the primary stakeholders.

We found that the current vision and direction for the home and community care system were set in 2001. The vision and direction were reconfirmed in 2004 via a consultation process. The current vision is inclusive of most home and community care services, with the exception of end-of-life services. In addition, the strategic direction is focussed on the development of residential care, assisted living and supportive housing units but does not encompass critical services offered in clients homes and in the community. The ministry's home and community care program branch is now updating the vision and strategic direction through consultation with the health authorities but has not completed this process. We recommend that the ministry set a clear timeframe and update its vision and strategic direction.

The ministry has also established policy and legislation for most programs and services, however, some policy updates are required so we recommend a clear timeline be set and this be completed. Not all residential care facilities are covered under the umbrella of one licensing act - creating differences in the oversight and treatment of similar facilities across the province. Roles and responsibilities of key stakeholders are in most cases clearly defined, and the ministry has established a council system to coordinate activities with the health authorities.

The ministry's management information systems do not meet the needs of home and community care

For planning of home and community care to be effective, timely and relevant information about present and future capacity is required. We expected the ministry to have identified what information it needs; to be working with the health authorities to ensure systems are in place to provide the required information; and to have processes in place to maintain data quality.

We found that, while the ministry has clearly defined its information needs and reporting requirements, the management information system used to collect and report information from the health authorities is not meeting the ministry's needs.

In 2005, the five regional health authorities agreed to transition from the existing management information system and establish their own client information systems to meet the revised and more comprehensive reporting requirements. However, only one of the five health authorities has done so. As a result, the ministry's access to information on home and community care is at risk and it does not have the information it needs to plan and monitor the system effectively. Furthermore, the ministry has not set and communicated clear timelines to the health authorities for the replacement of the existing system.

The ministry, in conjunction with the health authorities, is in the process of developing a more comprehensive information management and technology plan that is expected to identify and set priorities for the upgrade and/or replacement of systems. We agree with this direction and recommend that it completes this process.

Processes for ensuring data quality is maintained are also in place, but the ministry could improve how it documents these processes, roles and responsibilities.

The ministry has not finalized a comprehensive planning framework for health services including home and community care

Seniors and adults with chronic or short-term illnesses require appropriate services in a suitable setting. Providing the right services at the right time and in the right amount requires careful, coordinated planning. The ministry must work with the health authorities to ensure that the right types of services, the right number of appropriately equipped units or beds, and an adequate supply of qualified care-givers and health care professionals are all in place to meet the needs of the aging population and others who use the system. Given the complexity of the home and community care system, this is not a simple task.

None-the-less, we expected the ministry to have a planning framework that coordinates the health authorities' processes and integrates capital, human resource and information technology planning with program planning. We also expected the ministry to have relevant and timely information on the capacity of the system, as well as a process for evaluating and forecasting system needs and demands. Using this information and these processes, the ministry

would, we expected, have developed a multi-year capacity plan that estimates required services and resources.

We found that the ministry is in the process of developing a comprehensive planning framework for all health services, and as a result did not have an up-to-date capacity plan specific to the home and community care program. The ministry has taken steps to develop a process that coordinates the planning efforts of the health authorities and across resource areas such as capital and human resource planning, but more needs to be done to complete this framework. The home and community care program branch has undertaken system planning but these efforts were not finished or integrated with the ministry-wide planning processes at the time of our audit. Therefore, we recommend that the ministry ensure that this integration occurs.

We also found that the ministry needs to enhance the information it uses in planning and evaluating services. For example, the ministry has a significant amount of data on service utilization (outputs) but, overall, the capacity indicators used to monitor the system are not comprehensive enough to identify critical system pressures or issues across all core services. The ministry has developed two models for forecasting future service needs; however, the analysis of future demand can be refined by incorporating current, reliable information on population health trends and system costs. In addition, the ministry has undertaken research or developed partnerships to undertake research to better understand the system; however, an ongoing cycle of research and evaluation coordinated with the health authorities would support a more structured and planned approach and reduce the risk of duplication. We therefore make a number of recommendations to diversify and expand the information used in planning and monitoring services.

Public performance reports do not provide adequate accountability information

As steward of the home and community care system, the ministry is obligated to report on how the needs of the more than 100,000 citizens it serves are being met and how the $2 billion of health care funds for this purpose are being spent. As well, the health authorities should account publicly for their performance. We therefore expected the ministry to have mechanisms in place for reporting key performance information to the public.

We found that the ministry is providing limited information to the public about home and community care programs. For example, information on the progress of the province's 5,000-bed initiative is in the ministry's service plans. But, overall, accountability information is lacking and not giving a complete picture of home and community care performance. As the ministry improves the information it has on home and community care and as health authority reporting expands, we would expect that the level and quality of performance information made available to the public to also improve.

We recommend that the ministry develop performance measures that provide a more comprehensive picture of how the home and community care system is performing and report publicly the critical few measures that best demonstrate this performance. We also recommend that the ministry require health authorities to report publicly both service plans and annual reports.

Response from Ministry of Health Services

General Comments

The Ministry of Health Service is pleased to receive and respond to the review of home and community care services conducted by the Office of the Auditor General, entitled Home and Community Care: Meeting Needs and Preparing for the Future.

Planning and oversight of community based care services is a complex task, involving government, health care providers, community groups and, most importantly, the clients we serve. The Ministry of Health Services is continually seeking to improve our ability to respond to the needs of the population, and ensure that health care services in all settings are provided in a flexible, integrated fashion that reflects high standards for quality, safety and effectiveness.

The recommendations provided by the Office of the Auditor General in this review are well considered and provide confirmation that we are moving in the right direction. We are pleased to report that we are well underway in implementing the recommendations contained in the report, and will ensure that our progress in this regard is regularly monitored and reported on.

This review identifies four key components of the Ministry's stewardship role for the home and community care sector, with the timeframe of the audit fieldwork providing a 'snapshot' view of progress. Since that time, work has continued in each of these important areas and progress will be reported regularly.

1. Strategic Direction and Vision for Home and Community Care

As with all aspects of healthcare delivery in the province, home and community care has seen unprecedented changes over the past eight years. To support continued innovation and integration of care and support services, the Ministry has undertaken a number of initiatives which will come together to inform a refreshed vision for care in community settings:

Analysis of clients and service utilization patterns for HCC services has been completed to provide a better understanding of the consistency of service demand, and the characteristics of the clients we serve.

Complex systems modelling work has begun which will inform planning beyond demographic projections, and reflect the implications of transitions through the care system, as clients move between services and community resources.

Health Innovation Funding is supporting more than 25 pilot projects for integrated health networks and similar promising practises which point the way for new collaborations between physicians and the care team in the community.

All of these initiatives provide important new thinking, which will be reflected in a new strategic direction for home and community care.

2. Management Information Systems

British Columbia has had an excellent information system in place for home and community care since the 1970's, providing some of the most comprehensive information in Canada. The current system has reached the end of its useful life, and work has been underway for several years to update our systems, while retaining the continuity and integrity of information currently available.

In collaboration with the health authorities, Home and Community Care Minimum Reporting Requirements have been developed. Two health authorities have begun submission of these elements, and the remaining three are in development of systems to align with the new system before the discontinuance of the legacy system in late 2009.

Standardized assessment tools have been implemented in home care and residential settings over the past five years. The InterRAI HC and InterRAI 2.0 minimum data set instruments bring BC into alignment with the rest of Canada in ensuring that clinicians are provided with evidence informed tools to support care planning.

Our goal is to ensure that improvements in information are provided through streamlined tools that reduce duplication, inform better care, provide better decision making for local coordination, and better system planning.

Response from Ministry of Health Services

The province is working with the Canadian Institute for Health Information to join other provinces in implementing the national Home Care Reporting System and Continuing Care Reporting System — ensuring our information is of the highest quality, maximizing the usefulness of the data for all levels of health planning, and allowing BC to evaluate our performance against the rest of the country.

3. Health System Planning

The Office of the Auditor General has recommended a more integrated approach to planning, which connects the strategic direction of community based services with capital planning, information systems planning and budgets.

A new planning approach is being put into effect in October 2008 using a balanced scorecard framework to ensure alignment between resource capacity, system processes and desired system outcomes.

4. Public Accountability

While information has been collected and readily shared regarding home and community care services for many years, these have been focused on service volumes and clients served by the system. As the review points out, there is a need for regular reporting on system capacity, accessibility, effectiveness and safety. The Ministry of Health Services is in development of a comprehensive performance measurement framework for the provincial health system, including home and community care.

In addition, the Ministry cooperates with academics and health authorities in commissioning research and evaluation studies across the health sector, including home and community care. We are committed to continuing support to work which provides continued advances in practice, and provides valuable input on the effectiveness of the services we deliver.

In conclusion, we concur with the findings and recommendations of the Auditor General's report, and are committed to ongoing improvement in our role as steward for home and community care services in British Columbia.

Response from Ministry of Health Services

Ministry of Health Services
Home and Community Care: Meeting Needs and Preparing for the Future
Detailed Action Plan for Implementing the Recommendations

OAG Finding: The ministry is in the process of developing a new strategic direction for home and community care.

	Actions Taken To Date	Status (see note)	Actions Planned (Include Time Frame)
Recommendations: We recommend that the Ministry of Health Services: ■ set a clear timeline for completing the process and update its vision and strategic direction for home and community care; and ■ set a clear timeline and update key policies for home and community care services.	Initial consultations and analysis work has already been completed, and drafting of the strategic directions document has begun.	**P**	HCC Strategic Directions document will be completed by March 2009.
	Several chapters of the HCC Policy Manual have been revised and distributed, three chapters remain to be completed.	**P**	Updating of Chapters 2, 6 and 8 of the HCC Policy Manual will be completed by March 2009

Note: Status of Implementation

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action addresses OAG finding
NA – No substantial action has been taken to address this recommendation

Response from Ministry of Health Services

OAG Finding: The ministry's management information systems do not meet the needs of home and community care

	Actions Taken To Date	Status (see note)	Actions Planned (Include Time Frame)
Recommendations: We recommend that the Ministry of Health Services: ■ work with the health authorities to finalise comprehensive information system planning that identifies key priorities, timelines and expectations for replacement of the existing home and community care system; ■ improve the documentation of roles, responsibilities and processes for data quality.	■ Ministry of Health Services is working with health authorities to develop an Integrated Health Sector IM/IT Plan, which will include consideration of IM/IT alignment to support the HA and Ministry Home and Community Care needs.	P	Under development.
	■ Plans under development to address the issue of health authorities implementing independent information systems to replace the existing provincial Continuing Care Information Management System. ■ Responsibility for home and community care information management systems and their content is being devolved to the health authorities.	P	IBM discontinuing support of PL1 in September of 2009 Interior Health Authority already moved off Continuing Care Information Management System. Vancouver Coastal Health Authority expected to be fully operational for two of its three Health Service Delivery Areas on its own information system fall by 2008. Other health authorities are proceeding with or will need to develop migration strategies for replacement systems. No time frames available.
	■ Establishment of Minimum Reporting Requirements through inter-jurisdictional consultation (MoHS and Health Authorities) to ensure MoHS has information required for monitoring purposes.	I	Completed
	■ Initiatives are under way ensure interRAI assessment information is available for MoHS monitoring and analysis.	P	Project Plan / Business Requirements completion December 2008 Negotiations with Canadian Institute for Health Information for data collection and quality control are under way.

Note: Status of Implementation

I – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action addresses OAG finding
NA – No substantial action has been taken to address this recommendation

Response from Ministry of Health Services

OAG Finding: The ministry has not finalized a comprehensive planning framework for health services including home and community care

	Actions Taken To Date	Status (see note)	Actions Planned (Include Time Frame)
Recommendation: We recommend that the Ministry of Health Services: ■ ensure the integration of planning both across programs and with capital, information technology and human resource planning; ■ diversify and expand its planning and analytical tools by: ■ developing capacity indicators for all home and community care services (such as waitlists, where appropriate); ■ incorporating information on system costs and population needs into program planning and analysis; and ■ developing a coordinated cycle of research and evaluation with the health authorities.	■ The Health System Planning Division in the Ministry has been created to develop, implement and support a system-wide approach to strategic planning in the health system.	P	■ The Division is leading the integrated planning process across the health system beginning with the 2009/10 fiscal year.
	■ A new planning approach is being put into effect in October 2008 that uses a balanced scorecard framework to ensure alignment between resource capacity, system processes and desired system outcomes	P	
	■ An annual coordinated planning cycle has been developed to align current and developing strategies and enable achievement of plans.	P	

Note: Status of Implementation

I – Recommendation has been fully or substantially implemented

P – Recommendation has been partially implemented

AA – Alternative action has been undertaken, general intent of alternative action addresses OAG finding

NA – No substantial action has been taken to address this recommendation

Response from Ministry of Health Services

OAG Finding: Public performance reports do not provide adequate accountability information

	Actions Taken To Date	Status (see note)	Actions Planned (Include Time Frame)
Recommendation: We recommend the Ministry of Health Services: ■ develop performance measures that provide a more comprehensive picture of how the home and community care program is performing and report publicly, the critical few measures that best demonstrate this performance; and ■ require health authorities to publicly report both service plans and annual reports.	■ A comprehensive performance measurement framework for the health system is under development, which will include the home and community care sector. Measures will includes those for capacity, accessibility, efficiency, effectiveness, and safety.	P	■ The new comprehensive performance measurement framework will enable ministry and health authority executive and managers to monitor home and community care services on a broad and ongoing basis. Critical high level measures will be identified that are particularly valuable for aiding strategic decision making by health system executive. Program managers and policy makers will also have access to a broad spectrum of data and detailed analysis from reports on the framework performance measures. ■ Regular reporting on the framework measures will improve knowledge of how the system is performing and will facilitate decision-making based on best available evidence.
	■ Health System Planning Division, in conjunction with Health Authorities Division is developing a projection model of health service need across health sectors. The model incorporates health status and population as the fundamental building block and will be integrated with planning for required system capacity, health human resources, and resource allocation.	P	■ Preliminary version of the model to be complete and used for the full 2010/11 planning cycle commencing fall 2008.
	■ Health Authority Division and Health System Planning Division cooperate with academics and health authorities in commissioning research and evaluation studies across the health sector, including home and community care. Both academic and contracted research work is funded on an annual basis to produce high quality, independent research and evaluation on programs across the health sector.	Ongoing	■ The Ministry will continue to fund independent research and evaluation for programs across the continuum of care as well as its regular performance monitoring.

Note: Status of Implementation

I – Recommendation has been fully or substantially implemented

P – Recommendation has been partially implemented

AA – Alternative action has been undertaken, general intent of alternative action addresses OAG finding

NA – No substantial action has been taken to address this recommendation

Detailed Report

Background

Home and community care in the face of an aging population

As the Ministry of Health Services defines it, home and community care covers a diverse range of health care and support services for eligible residents who have acute, chronic, palliative or rehabilitative health care needs. Home and community care clients receive services from a variety of organizations in a variety of settings. A mix of private for-profit organizations, not-for-profit organizations and health authorities deliver the services under the provincial program (Exhibit 1). For a more detailed description of these services, see Appendix A.

By far the greatest users of home and community care services are seniors (those over the age of 65).

With significant increases expected in the number of seniors who will be living in British Columbia over the next two decades, the Ministry of Health Services and the health authorities face great challenges in ensuring that the needs of the province's residents are met and that the health care system is sustainable. This demographic trend will put particular pressure on the capacity of home and community care services (see below).

The Aging Population Wave

In 2005/06, of the 105,000 people using home and community care services in British Columbia, roughly 70% were seniors.[1] Given the dramatic demographic changes now underway, the number of home and community care clients is expected to go way up. Between 1999 and 2019, the province's population of older adults is forecast to increase much more markedly than any other age segment, making up 17% of the total population. By 2031, seniors are expected to account for 24% of the province's population—about 1.4 million.[2] It is not only the shear number of seniors that will impact health care, but the health status of this group that will have an effect.

For the most part, higher levels of health care interventions occur after 80 years of age as age-specific health problems arise. By 2011, for example, an estimated 55,000 people will have dementia in British Columbia—an increase of 22% in just seven years. Historically, 8% of all Canadians over age 65, and 34.5% of people over age 85, have some kind of dementia.[3]

Sources:

1 Ministry of Health Services Data

2 Statistics Canada, "Health Reports: Seniors Health Care Use" in the Daily February 7, 2006

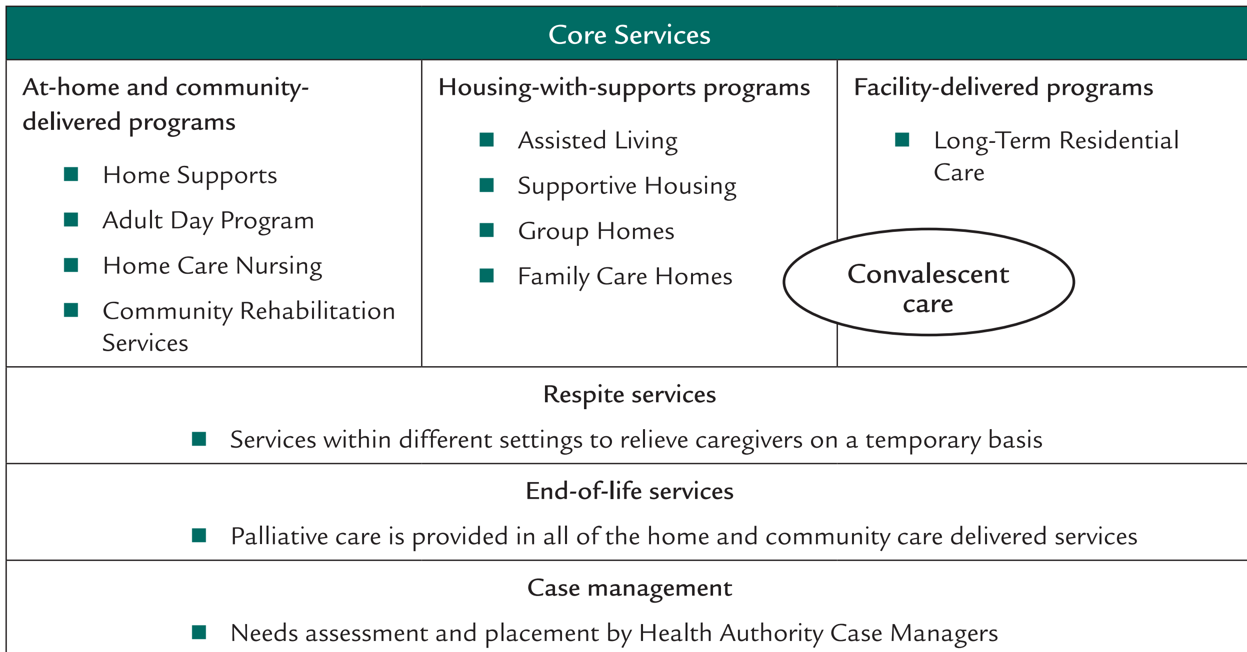
3 Canadian Medical Association, Canadian Study of Health and Aging: Study Methods and Prevalence of Dementia. Canadian Medical Association Journal (CMAJ) –1994, March 15; 150(6): 899-913

Background

The ministry currently provides about $2 billion annually to the health authorities for delivery of home and community care services to more than 100,000 clients. The majority of those clients are frail seniors, many with long-term health care needs. While $2 billion is a significant amount, not providing adequate services levels would have even greater financial consequences, and affect health outcomes for individuals. Effective home and community care services delivered when required can help prevent the need for higher intensity acute care and emergency services—services that quickly become a far more costly commitment. Effective home and community care services also help keep the health care system flexible, which will become increasingly valuable as the population ages.

Exhibit 1

Core home and community care services in British Columbia



Background

How services are delivered

Responsibility for home and community care

The Ministry of Health Services is the steward of the health system in British Columbia. It is therefore responsible for providing the overall strategic direction to key service delivery partners—such as the one provincial and five regional health authorities—and to health professionals, who directly deliver the majority of health services in the province.

For the home and community care system, the ministry is specifically responsible for: setting the strategic direction; planning, in conjunction with the health authorities and other key partners; and monitoring to ensure the system is sustainable and can meet the needs of the population. In this role, the ministry defines the services to be delivered, develops legislation and policy to support that delivery, and works to ensure a minimal level consistency in the services delivered across the province.

- **Home and Community Care and Performance Accountability Branch**

This branch, in the Health Authorities Division of the ministry, has primary responsibility for coordinating home and community care services with the health authorities. The branch develops and maintains policy and the legislative framework to provide direction to the health authorities, undertakes province-wide policy and planning activities, and works internally and externally to monitor and address issues related to the delivery of publicly subsidized home and community care services.

The following three divisions within the Ministry of Health Services support system-wide health planning:

- **The Health Services Planning Division**

This division is responsible for supporting government in setting the strategic direction, objectives and initiatives to provide a sustainable and high quality publicly funded health system. The division leads and supports the Ministry of Health Services and the health authorities to establish clear strategic objectives that are aligned with government's priorities. The division is to work in collaboration with key health care stakeholders to better align services with the government's direction. Among other functions, the division undertakes capital planning as well as health system analysis to support an evidence-based approach to health system planning.

- **The Health Human Resource Planning Division**

This division is responsible for province-wide health human resource planning and is responsible for supporting health human resource planning within the ministry and across the health authorities. The division's role is to also work in collaboration with other partners to increase the supply of health human resources in British Columbia.

- **The Health Sector Information Technology and Information Management Division**

This division is responsible for supporting the planning and management of information technology and management within the ministry. The division leads and supports the alignment of ministry goals and objectives with those of the health authorities.

Updated information regarding the Government's reorganization in June 2008

As of June 2008, the Ministry of Health was renamed the Ministry of Health Services, although most programs relative to our audit were retained within this new ministry. The Office of the Assisted Living Registrar and the Community Care Facilities Branch were moved to the newly formed Ministry of Healthy Living and Sport.

- **Office of the Assisted Living Registrar**

The Registrar has legislative authority to: investigate and ensure the resolution of health and safety complaints regarding assisted-living residences; implement and administer a register of assisted-living residences in the province; and establish and regularly review health and safety standards for the operation of assisted-living residences. The Registrar has jurisdiction over both publicly subsidized and privately paid assisted living residences.

- **Community Care Facilities Branch**

This branch, in the Health Protection Division of the Ministry of Healthy Living and Sport, is responsible for the development and implementation of legislation, policy and guidelines to protect the health and safety of people being cared for in licensed facilities. Residential care facilities fall under the umbrella of community care facilities that the licensing program oversees. The inspection and monitoring of licensed facilities is administered by the health authorities.

Background

Delivery of services

- **British Columbia Housing Management Commission (BC Housing)**

BC Housing was created in 1967 under the Housing Act to fulfill the government's commitment to develop, manage and administer subsidized housing. This organization partnered with the Ministry of Health Services to build assisted living and supportive housing units to meet the government's targets for new builds by 2008. BC Housing works in partnership with the private for-profit and non-profit sectors, the health authorities, other levels of government and community groups. Once built, operational funding for these projects comes from a number of partners, including the provincial and federal governments, tenant rent revenue, and revenue generated from land leases and other sources.

- **Regional health authorities**

The five regional health authorities directly deliver programs and contract with private for-profit and non-profit agencies to provide services. The authorities are responsible for: delivering programs that are consistent with home and community care policies and standards; ensuring operational policies and procedures are in place; planning and monitoring services at a regional level; and reporting to the ministry on their performance.

- **Private operators**

In addition to the health authorities, a number of private operators deliver residential care, assisted living and other services to British Columbia residents who pay directly for the services. These operators are not publicly subsidized and the users of the services pay the full costs.

Exhibit 2 shows an overview of the roles and responsibilities in home and community care.

In 2002, when the six health authorities were established and a new governance model for health was introduced, the ministry confirmed its role as steward of the system and legally defined the health authorities' obligations to plan, deliver, monitor, and report on health services. Part of the authorities' responsibilities include providing public and population health programs, services for persons with mental health or substance use disorders, and acute care as well as home and community care.

The ministry entered into Performance Agreements with the health authorities in 2002 to help ensure its expectations for service delivery were met. These agreements have since been replaced with Government Letters of Expectations. The 2007/08 Letters of Expectations are agreements of the accountabilities and roles and responsibilities between the provincial government and each of the six health authorities. These documents lay out the high-level performance expectations and strategic priorities of government and are meant to form the basis for health authority service planning and reporting. The service planning cycle, accompanied by the Government Letters of Expectations, provides the key mechanism by which the health authorities' strategic direction is aligned with the ministry's direction.

The ministry has also established the Deputy Minister's Leadership Council, made up of the health authorities' CEOs and ministry executives. The council provides a forum to resolve issues or concerns arising between the ministry and the health authorities.

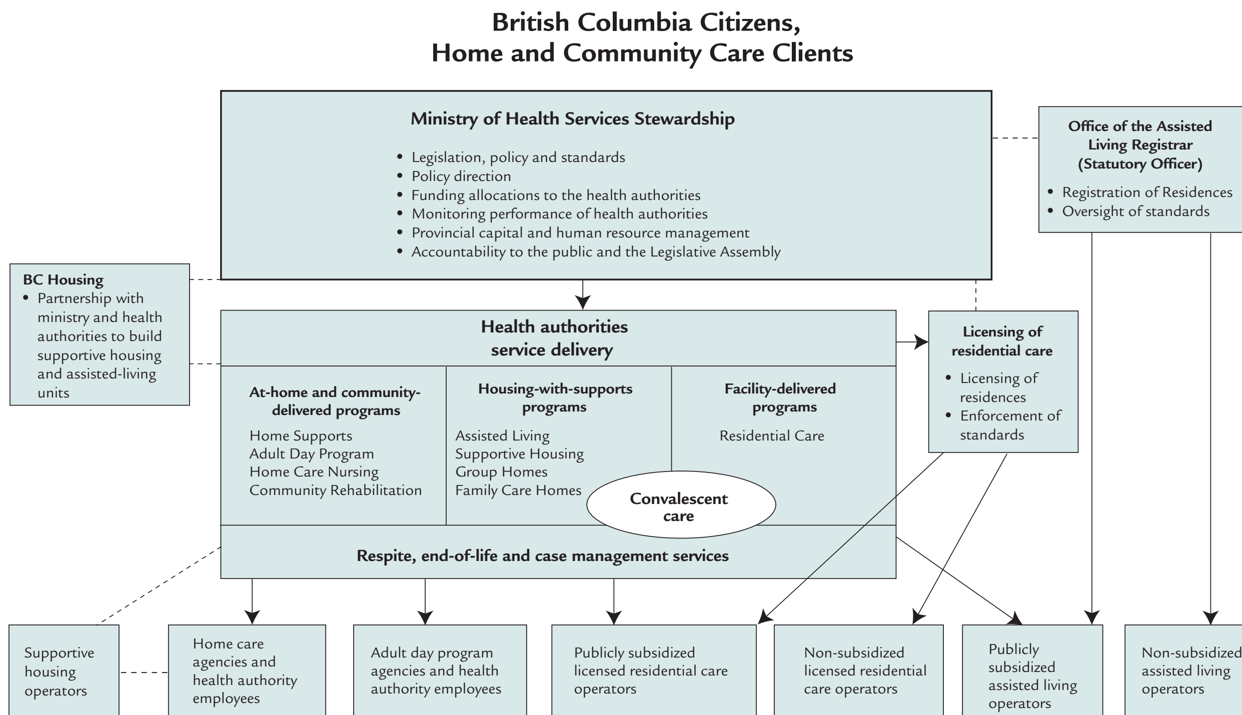
The link between the program level for home and community care and the Deputy Minister's Leadership Council is the Health Operations Committee. The purpose of this committee is to "review health authority operational opportunities, issues and challenges, as well as government and system priorities, evaluate their impact and provide advice and leadership on addressing these matters." The committee is chaired by the Assistant Deputy Minister of the Health Authorities Division. Other members include the Vice-President of Operations/Chief Operating Officers (or equivalent from each health authority), the Executive Directors from the Health Authorities Division and one representative from other ministry divisions as required. The committee chair is a standing member of the leadership council.

At a program level, the link between the ministry and the health authorities is the Provincial Home and Community Care Council. This council includes representatives from each of the five regional health authorities as well as the Executive Director and Director of Home and Community Care in the Health Authorities Division. The purpose of the council is to "provide intelligence, strategic advice and recommendations on the development, implementation and evaluation of provincial home and community care planning, legislation, policy, standards and programs."

The council has a number of subcommittees that are responsible for coordinating initiatives at the program level.

Exhibit 2

Roles and responsibilities in the home and community care system



Background

Funding and Service Volumes

The health authorities receive funding from the Ministry of Health Services to deliver a multitude of services. The authorities develop their budget from the allocation provided and in part based on ministry's priorities as outlined in the Government Letters of Expectation. Within some home and community care services, clients pay a portion of the costs. In addition, private and not-for-profit agencies provide services on a fee-for-service basis, with the full costs being paid by the user. Exhibit 3 shows the expenditures of the health authorities for the delivery of publicly subsidized home and community care services.

Exhibit 4 shows the approximate number of clients who received services within the home and community care system from 2003/04 through to 2007/08.

Exhibit 3

Home and community care gross expenditures ($ millions)

	2004/05 (Actual)	2005/06 (Actual)	2006/07 (Actual)	2007/08 (Actual)
Total HCC Community services (exc. AL)	500.4	559.0	609.6	646.8
Total assisted living (AL)	16.7	26.7	45.2	58.7
Total HCC Residential	1208.9	1,273.1	1,351.5	1423.8
Total	**1,725.9**	**1,858.9**	**2,006.2**	**2,129.3**

Source: Ministry of Health Services, Regional Grants Branch (June 2008)

Exhibit 4

Client Counts, 2003/04–2007/08 (partial year for 2007/08)

Services	2003/04 [b]	2004/05	2005/06	2006/07 [a]	2007/08 (to Oct. 2007[a])
Direct care community rehabilitation	27,491	28,875	31,179	27,032	15,410
Direct care home nursing	37,410	37,017	37,982	28,744	15,906
Home support (excluding CSIL)	32,046	30,323	30,040	26,344	22,016
Choice in Supports for Independent Living (CSIL)	650	681	712	575	558
Adult day care	5,838	6,321	6,241	4,855	3,457
Assisted living	705	1,619	2,146	2,722	2,887
Residential care	34,109	33,512	33,492	27,629	23,891
Total client counts [a, b]	**103,276**	**102,085**	**105,088**	**N/A**	**N/A**

[a] Data for 2006/07 and 2007/08 excludes Interior Health Authority and total client counts are not available.

[b] The Home and Community Client count for the years 2003/04 to 2004/05 is based on a unique count of clients who received any type of home and community service during the fiscal year. However, the 2005/06 provincial client count is not unique because of the separate inclusion of Interior Health Authority data. The authority's 2005/06 data and provincial level data are derived from multiple sources because of the lack of client-level Minimum Reporting Requirements data from Interior Health.

Source: Ministry of Health Services, Health Service Division

Audit expectations

We examined whether the Ministry of Health Services is carrying out its stewardship role effectively to help ensure the home and community care system has the capacity to meet the needs of British Columbia's residents now and in the future. Specifically, we expected the ministry to:

- set a clear direction through vision, strategy, legislation and policy for home and community care services;
- have management information systems in place to support data collection and analysis for home and community care;
- have the processes and information needed to plan for services; and
- provide accountability information to the public on the performance of the home and community care system.

The ministry is in the process of setting a new strategic direction for home and community care

A chief part of the ministry's stewardship role is to set clear direction. Without a defined and communicated direction for home and community care, those who deliver the services may not meet the expectations of the ministry.

Setting direction includes:

- articulating a clear vision and strategic direction;
- defining appropriate services through legislation and policy; and
- clearly defining roles and responsibilities.

These actions help to focus efforts, support consistency in the delivery of services and provide a framework for the planning, delivery and reporting of key home and community care programs and services. Clearly defining services allows the ministry to track system usage in a consistent manner—a critical part of estimating and monitoring the capacity of the system.

We concluded that the ministry needs to complete the development of the new vision and overall strategic direction for the program. Although legislation and policy cover the majority of services, policy and a key piece of legislation need to be updated to provide current and consistent direction for the delivery of services. The ministry has defined roles and responsibilities and developed mechanisms to work collaboratively with the health authorities. It is through these processes that program planning is taking place.

The vision and strategic direction need to be updated

Vision for Home and Community Care

"Individuals will have the support and health services they need to live fully and independently or interdependently as valued members of their community. British Columbia's continuing care services system will respect, recognize and support clients and their caregivers and service providers."

Source: Ministry of Health, Strategic Directions for Continuing Care Renewal, 2001

In 2001, a vision and strategic direction were established and communicated through the Strategic Directions for Continuing Care Renewal plan. This direction continues to guide the ministry's home and community care program. In 2004, through a consultation process, the vision and strategic direction were reconfirmed. At the time of our audit, various initiatives were communicated through the ministry's service plan and Government's Letters of Expectation. The key priority was the 5,000-bed project—meeting the target of 5,000 net new residential, assisted living and supportive housing units by December 2008.

The ministry is in the process of setting a new strategic direction for home and community care

A problem with the vision and strategic direction, in our view, is that it does not include end-of-life services. A separate framework was developed for these. In addition, the key priority focuses only on units and not on the many services delivered at home and in the community.

The ministry is working through the Provincial Home and Community Care Council to establish a new vision, mission and strategic direction for these services. This process is not yet complete.

We recommend that the Ministry of Health Services set a clear timeline for completing the process and update its vision and strategic direction for home and community care.

Legislation or policy is in place to cover most key services

Most home and community care services are covered by two key pieces of legislation, the Continuing Care Act and the Community Care and Assisted Living Act.

The Continuing Care Act and accompanying regulations give the Ministry of Health Services power to administer continuing care services. The Act broadly defines continuing care (also known as home and community care) services. And the regulations, which prescribe the programs deemed to be continuing care under the Act, cover the core services except for home care nursing and community rehabilitation (which are not specifically mentioned in the Act, but not precluded from being administered).

The Community Care and Assisted Living Act defines the powers of the Director of Licensing, the Medical Health Officer and the Assisted Living Registrar with respect to the licensing or registration and oversight of most residential care and all assisted living residences. Similarly, the Hospital Act covers the licensing of residential care facilities designated as private hospitals.

Bringing all residential care facilities under one licensing Act would harmonize the treatment, licensing and oversight of these facilities. Harmonization will occur if section 12 of the Community Care and Assisted Living Act is brought into force.

The ministry is in the process of setting a new strategic direction for home and community care

Ongoing Discussion – Is there a need to define end-of-life services through policy?

End-of-life services, such as hospice and palliative care services are not specifically defined by current legislation or ministry policy. However, they are covered by legislation and policy as these services fall within the core home and community care programs. The ministry has told us that they are currently working on clinical standards and guidelines for these services, as well as developing policy around the costs to clients in using palliative care services; however, they are not specifically defining the services through policy. From their perspective the current framework is adequate. In addition, they have flagged palliative care patients in their data collection system to identify the number of home and community care clients receiving these services. However, for some stakeholders a lack of a distinctive province-wide definition embedded in policy is a concern. Those working in this field believe that end of life services are distinctive services that should not be generically defined under the umbrella of core home and community care programs. The argument is that definitions are needed to clearly identify the full range of services, support the measurement of services and ensure some level of equity in terms of access and costs of these services to clients.

While the ministry has developed policy to define most services, (see sidebar) the policies need updating and consolidation to make direction for service delivery clear. The ministry is currently working on this with health authorities through the Provincial Home and Community Care Council.

The home and community care policy manual covers the majority of services offered under the umbrella of home and community care. A separate policy manual exists for home care nursing and community rehabilitation. As well, the home and community care program has issued guidelines and policy directives that are not embedded in the current manual. Variations like these create a patchwork of direction.

Some key policies are also out of date. Most notably, there is no policy around the mandated client assessment tools; the system of classification outlined in the manual has not been in use since 2005; and case management policy does not reflect current practice.

We recommend that the Ministry of Health Services set a clear timeline and update key policies for home and community care services.

Roles and responsibilities are clearly defined in most cases

Roles and responsibilities for home and community care are well defined between the ministry and the five regional health authorities through legislation and the accountability framework.

The Health Authorities Division (where the home and community care program is located) is the primary link between the ministry and the health authorities. The division's roles and responsibilities are outlined in its operational plan (2007/08) and a program management framework (2007/08).

The ministry is in the process of setting a new strategic direction for home and community care

For the most part, the roles within the division are clear, but overlap of responsibility in the monitoring of health services creates some problems. This function is shared between program staff and those who monitor the health authorities' commitments as set out in Government Letters of Expectation. This overlap can create challenges, such as miscommunication or issues not being addressed. Ministry staff indicated that this is a recognized concern and work is underway to resolve this issue.

For the home and community care program, the ministry has developed ways to work collaboratively with health authority managers on program-related issues. Issues are discussed and resolved at the Provincial Home and Community Care Council and its subcommittees. Roles and responsibilities are outlined in the terms of reference of the council and its subcommittees. As well, the committees have developed detailed work plans.

The ministry's management information systems do not meet the needs of home and community care

Effective planning relies on timely and relevant information from a variety of sources about existing capacity and for forecasting needs. We expected the ministry to:

- have set out its information needs and requirements;
- be working with the health authorities to ensure systems are in place to provide the required information; and
- have data quality processes in place.

We concluded that the ministry's management information systems for home and community care are not providing the information required by the ministry for effective planning and analysis. The ministry has defined its information needs, but the existing system does not meet these requirements. Although useful information is being produced by the system, adapting it to meet expectations is increasingly difficult. This means that the ministry's access to information on home and community care is at risk, yet the ministry has not worked with the health authorities to establish firm timelines for replacing the existing system. As a result, the ministry continues to be hampered by a lack of comprehensive information for planning and analysis. The ministry has data quality processes in place for home and community care, however, documentation of the processes, roles and responsibilities for this function was not adequate.

The information systems in place for home and community care do not fully support the ministry's requirements

The ministry has defined its information needs by developing, in consultation with the health authorities, Minimum Reporting Requirements. These define the type, level, quality and reporting expectations of the health authorities. The data elements set out in these requirements represent an improvement in the data available for planning. Once the health authorities are able to report against all of these requirements, the ministry will have more detailed information and will be better able to understand the health status of clients within the system and to forecast demand.

The ministry's management information systems do not meet the needs of home and community care

> **inter*RAI* Assessment Tools**
>
> The inter*RAI* assessment tools were developed by an international non-profit agency. The Canadian Institute for Health Information (CIHI) is, as part of the work to develop National Indicators and Reporting for Home Care, supporting the use of the tools across Canada. These tools have the potential to provide consistent client group classification, resource utilization groups, profiles of cognitive, social and physical functioning, and other demographic information of the home and community care system users. The ministry has mandated two of the 11 available tools. The RAI-HC is for case managed clients at home, in the community and in assisted living residences and the MDS Version 2.0 is for residential care clients.

The ministry has also mandated the use of two client assessment tools for case-managed clients within the home and community care system (see sidebar). These tools offer an opportunity to collect consistent information on client profiles that can be used to classify clients into groups. The information can also be used to better understand the health care needs of system users, as well as to develop outcome indicators to monitor the system's performance. At the time of our audit, however, this information was not yet available.

The RAI-HC tool has been implemented in the health authorities, but information is not yet available to the ministry. The residential care tool (MDS Version 2.0) is expected to be fully implemented by 2009. Both tools, once fully implemented, will cover the majority of clients using home and community care services.

The Continuing Care Information Management System (CCIMS) has been the main data collection system for home and community care since the late 1970s. An online system originally developed as a payment processing system, it continues to be used as a means of tracking service use. The health authorities enter data into the CCIMS, which is then extracted to a data warehouse and used by the ministry for service monitoring and planning. Although some additional elements identified in the Minimum Reporting Requirements have been added to the CCIMS, gaps still remain between the information available and the requirements as set by the ministry. The CCIMS currently provides useful information on service use, but it is not providing the level and type of information expected by the ministry for planning and reporting.

Furthermore, data extraction is not timely and the system lacks flexibility to meet changes in services delivered. The ministry anticipates that changes to the system will become increasingly difficult and/or costly as technical support for the system is reduced.

The ministry's management information systems do not meet the needs of home and community care

The ministry has not taken a strong leadership role in ensuring the ongoing development of management information system capacity

In 2005, the ministry identified the need to move from the CCIMS to a new client information system. The CCIMS was not meeting the needs of either the health authorities or the ministry. At the time, the ministry did not mandate a new provincial-wide system for home and community care because the health authorities asked for the flexibility to develop their own systems. So instead, in collaboration with the health authorities, the ministry developed the minimum reporting requirements with an expectation that the health authorities would develop their own information systems to meet these requirements. The ministry agreed to maintain the CCIMS pending the move of the health authorities to their own systems.

To date, Interior Health is the only health authority to develop its own client information system and move off the CCIMS. However, the transition for Interior Health was problematic. In 2005, it implemented its replacement system but did not continue a parallel run on the CCIMS. As a result, the ministry had very limited data from Interior Health on home and community care for 2006/07 and 2007/08. At the time of our audit, the ministry was just beginning to receive the requested data for those years.

Learning from that experience, the ministry indicates it will now require a parallel run from the CCIMS when health authorities transition to their own systems. However, there are no requirements for the health authorities to submit transition plans or to otherwise demonstrate their progress in developing systems to meet the Minimum Reporting Requirements. The ministry has also not stated by what date it expects the health authorities to be in full compliance with the reporting requirements or set a clear deadline for the transition away from the CCIMS.

The ministry, in conjunction with the health authorities, is currently developing a more comprehensive information management and technology plan that is expected to address this issue.

The ministry's management information systems do not meet the needs of home and community care

We recommend that the Ministry of Health Services work with the health authorities to finalise comprehensive information system planning that identifies key priorities, timelines and expectations for replacement of the existing home and community care system.

Documentation of data quality processes is not adequate

The ministry, the health authorities and others who provide technical support to the data systems have a collective responsibility for ensuring that good quality data is gathered. We expected the ministry to have developed common data definitions, as well as ways to check for critical errors in data.[1]

We found that the ministry has developed common data definitions and has established manual controls to check system outputs. Within the ministry, responsibility for checking data quality is shared between program and information technology staff. However, these key roles and responsibilities are not fully documented in one area. In addition, procedures are carried out and understood, but are not centrally documented. In our view, better documentation would provide clarity and consistency of practice and reduce the risk that staff turnover may negatively impact procedures.

We recommend that the Ministry of Health Services improve the documentation of roles, responsibilities and processes for data quality.

[1] **Note:** Our audit focussed on the ministry's business processes only. We did not test or review system controls at the health authority or ministry level or review business processes at the health authority level. Therefore, we cannot provide assurance that the data is or is not reliable, accurate or complete.

The ministry has not finalized a comprehensive planning framework for health services including home and community care

Seniors and adults with chronic or short-term illnesses require appropriate services in a suitable setting. Helping to ensure that the right services are available at the right time and in the right amount is a challenging and complex process that depends upon a number of stakeholders and requires sophisticated planning and analysis. The ministry must work with the health authorities and others to ensure that there is the right type of services, the right amount of appropriately equipped units/beds in place and an adequate supply of qualified caregivers and health care professionals to meet the needs of the aging population and other who uses the system.

We expected the ministry to have a framework that coordinates the planning of the health authorities and integrates capital, human resource and information technology planning with program planning. We expected this process to have resulted in a plan that estimates the capital, human and other resources required. To support this planning we also expected the ministry to have relevant and timely information on the current capacity of the system, and a process for evaluating and forecasting system needs and demands.

We concluded that a comprehensive planning framework is not in place for home and community care and that, as a result, an up-to-date plan for the system has not been established. The ministry has taken some important steps to develop an effective planning process and to enhance the information available for planning. Still, more needs to be done to complete the framework and ensure relevant and timely information is analyzed to determine if current capacity is meeting needs and to estimate future needs.

Development of an integrated planning framework for health services that includes home and community care is under way

We expected that the ministry would have a planning framework in place that coordinates the efforts of the health authorities, includes timeframes and milestones for the completion of efforts, and integrates key elements such as capital, human resource and information technology planning.

We did not find this. The home and community care program continues to operate under the strategic direction set in 2001, with specific initiatives directed through high-level ministry service planning and accountability processes. As we noted earlier, the

main aim of the program was meeting the 5,000-bed target by December 2008. This is a significant capital project, focussed on housing with supports and residential care programs. Human resource initiatives were also directed at meeting the needs created by this target.

The ministry recognizes that health services' planning has not been well integrated and needs improvement. Programs have tended to plan in isolation of one another, and system-wide integration of capital, human resource and information technology planning has not occurred. In response, the ministry has created a new planning division and is implementing a planning framework. The ministry is focussed on developing a more population-based approach and is working to have better information on population health needs.

At the time of our audit, the home and community care program (through the Provincial Home and Community Care Council) was also embarking on a new planning process. The outcome of this effort is expected to be a strategic directions document that will inform operational planning at the provincial and health authority level and provide the basis of a performance measurement framework for the program.

Merging the efforts of the home and community care program with overall ministry planning is critical if there is to be an effective and integrated planning framework for home and community care. We did not find these efforts were complete.

We recommend that the Ministry of Health Services ensure the integration of planning both across sectors and with capital, information technology and human resource planning.

The ministry needs to enhance the information it uses for the planning and analysis of the system

We expected the ministry to be using relevant, up-to-date information to determine whether the capacity of the home and community care system is meeting present expectations and whether future demand for service is known.

We found that the ministry's approach to analyzing system capacity is not comprehensive enough to enable it to determine whether the right services are in the right place and in the right

amount. The ministry has developed two models that forecast expected need for services and has undertaken research into the system. These are positive steps, but planning and analysis would be improved if the ministry had better information on system costs, waitlists and other capacity measures and also incorporated information on population health trends.

Evaluating the current status of home and community care services

The first step in planning for any program is to understand the current situation. Gaps and system pressures must be identified to determine how they might affect the future. We found that the ministry has some information that allows it to monitor current capacity in the home and community care system. For example:

- The ministry has a large amount of historical data on the utilization of home and community care services, and it monitors this data to identify trends and project future demand for services. (The limited information available from the Interior Health Authority from 2006/07 to 2007/08 is a concern, however, as noted earlier.)
- As part of the 5,000-bed project, the ministry is monitoring the number of units newly built, closed and refurbished for publicly subsidized residential care, assisted living and supportive housing by each health authority.
- The ministry has developed proxy measures and indicators to monitor the system's capacity.

However, the ministry still needs more information to be able to determine if the right mix of services, in the appropriate amounts are being provided across the province. Its proxy measures and indicators, for instance, do not provide a comprehensive picture of where waitlists and bottlenecks may be in the system — nor do they allow the ministry to identify unmet need in the community at large. They are limited in the services that are covered. Exhibit 5 outlines the capacity measures currently used and how key services are monitored by the ministry.

The ministry has not finalized a comprehensive planning framework for health services including home and community care

Exhibit 5

Measures of capacity

	Measure	Services Covered	Comments
1	Percentage of HCC clients admitted to a residential care facility within 30days of approval for services	Residential Care, Family Care Homes	— an indicator of the accessibility of residential care beds by region and of gaps to support future planning for residential care services.
2	Number of days a client resides within residential care	Residential Care	— an approximation of the “frailty” of those entering residential care.
3	Client rates by age: an age-standardized client count rate per 1,000 population (clients aged 65-74, 75-84, 85+) Service Volumes: the number of units, hours and visits per 1,000 population (clients aged 65-74, 75-84, 85+)	Residential Care, Assisted Living, Adult Day Programs, Home Support/ Choice in Supports for Independent Living and Direct Care (home nursing and rehabilitation services combined)	— a way to track general trends in the use of services. These indicators allow for a comparison of these rates and volumes across the health authorities by age and region over time. This can help the ministry determine if service use for home care, for example, has increased or decreased.
4	Number of alternative care days	Proxy measure for all services (see comments)	— an indicator of whether hospital services are being used as substitution for other services. However, the data available does not allow the ministry to specify which services people are substituting acute care services for and so is not specific enough to rely on to measure true demand for home and community care services.
5	Percentage of natural deaths occurring in settings outside of hospital A) Cancer B) Non-cancer	End-of-life services	— not a specific measure for home and community care, but provides an indicator of whether there is a higher proportion of people who die at home, hospice and/or residential care facilities. It does not provide any information on whether the home and community care system is meeting the needs of people who are at the end of life.

Source: Compiled by the Office of the Auditor General

The ministry has not finalized a comprehensive planning framework for health services including home and community care

Waitlist information can highlight critical pressure points within a system. But as Exhibit 5 shows, the ministry monitors waitlist information only for residential care services. In our view, expanding waitlist information to include waiting times for other key services such as assisted living and adult day programs would allow the ministry to better monitor the system's capacity.

That said, waitlist information is not always an appropriate measure. For at-home services, such as home care support, the current policy does not allow services to be withheld because of resource constraints. In these circumstances, there is a risk that services are offered but in a decreased amount. This makes it difficult for the ministry to determine if service levels are sufficient or equitable across regions. For example, there may be cases where a client in one region has 7 hours of home support a week while another with similar needs is only provided with 3.5 hours due to resource constraints. Developing a quality measure for these services may provide a better indicator than waitlists of whether the services are meeting needs.

The ministry also does some monitoring of system costs through the financial group within the Health Authorities Division. However, the financial information is not at the same level of detail as the service utilization information set out in the Minimum Reporting Requirements. We think that standardizing the service categories with those in the reporting requirements would provide a greater level of detail to help the ministry better understand the cost-effectiveness of services.

Research and evaluation projects undertaken by the Ministry of Health Services to better understand home and community care needs and services:

- developed an innovations inventory that identifies innovations by the regional health authorities in home and community care, tracks the effectiveness of these innovations and allows for a sharing of these practices across the province;
- worked with the Canadian Centre for Health Services and Policy Research to research trends in the use of services offered at home and in the community, which provides information on whether trends in home care services are meeting the ministry's expectations;
- developed a partnership with the Michael Smith Foundation to support and coordinate research into senior's issues in home and community care;
- worked through the Provincial Home and Community Care Council and its subcommittees to gather and share practitioner knowledge across the province; and
- responded to specific concerns by requesting Internal Audit and Advisory Services to review the Assisted Living program.

The ministry has not finalized a comprehensive planning framework for health services including home and community care

Projects undertaken by the ministry to analyze and research the current system provide useful information for planning (see sidebar). Nevertheless, an ongoing cycle of research and evaluation coordinated with the health authorities would provide a more structured and planned approach and avoid duplication of effort.

The inter*RAI* data, when available, will give the ministry information on the health status of clients in home and community care, as well as provide a source of information to develop outcome indicators. Overall, however, the ministry needs to incorporate more information on the population at large, such as rates of chronic diseases, to support system planning and to determine if the right services are available to meet needs.

Forecasting needs

The ministry has undertaken the development of two models [2] to predict future needs:

Baseline model – The baseline model is similar to models used in the past: it projects future demand for services based on 2005/06 service utilization data and projected population growth by age. It assumes that the same type of services will be available in the future and that the demand for these services by differing age categories will remain constant. Ministry staff note that this model provides a greater level of detail than past models because it provides information at the level of the local health area to support both ministry and health authority regionalized planning.

System dynamics model – The ministry has partnered with a research institute (IRMACS) at Simon Fraser University to develop a model that can be used to predict how home and community care will be affected by population trends over the next 10-20 years. Of particular interest is how increased life expectancy and age of the population will impact these services. This model differs from past models (like the

[2] **Note:** We did not conduct a detailed review of these models. We examined them only for their usefulness in planning and considered the inputs and processes used in developing them. We cannot provide assurance that they will or will not produce accurate results.

baseline model) that were simple straight-line calculations of service utilization multiplied by population growth. It also considers the non-publicly subsidized sector and it is more in line with the future direction for planning that will take into account other variables such as health status.

The system dynamics model is seen as an ongoing engagement where improvements can be made over time. At the time of our audit, the data from the inter*RAI* assessment tools was not available to develop the client groups for the model. Other demographic variables, such as gender and marital status, are not yet incorporated into the model either, but could be used in the future to refine its projections.

The ministry is comparing the outputs of the two models to identify any significant differences in the projections. In our view, including population health trends such as rates of chronic disease and dementia in the population would help further refine the models.

We recommend that the Ministry of Health Services diversify and expand its planning and analytical tools by:

- ***developing capacity indicators for all home and community care programs and services (such as waitlist information, where appropriate);***
- ***incorporating information on system costs and population needs into program planning and analysis; and***
- ***developing a coordinated cycle of research and evaluation with the health authorities.***

Public performance reports do not provide adequate accountability information

BC's Reporting Principles

In October 2003, three parties in British Columbia – government, legislators and the Auditor General – reached agreement on a set of performance reporting principles for the British Columbia public sector. This agreement allows those who prepare public performance plans and reports, those who use them and those who assess them to do so from a common basis, with agreement on the fundamentals of meaningful performance reporting.

Accountability and the Health Authorities

The definition in the Budget Transparency and Accountability Act of "government organization" does not cover school districts, universities, colleges and health authorities. These organizations therefore are not required under the Act to publish service plans and annual reports. However, this sector makes a critical contribution to the quality of life of communities across the province and receives a significant amount of funding from government. *cont'd*

Given the significant health dollars the ministry spends for home and community care programs, the public is entitled to know how well the needs of the programs' clients are being met with the monies spent. Appropriate and sufficient information made available to the public and legislators on the performance of the ministry in this regard enhances government's accountability. We expected the ministry, as steward, to put in place the mechanisms through which key performance information is reported to the public including:

- an accountability framework that supports transparency in planning and reporting for home and community care across the health system; and
- adequate performance reporting to the public and legislators.

We found that the ministry has created an accountability framework to coordinate planning and reporting with the health authorities. This framework will be enhanced when health authorities publish annual reports — reports that compare their actual results with their expected results as outlined in their annual three-year service plans. Meanwhile, the quality and level of the performance information the ministry is reporting does not adequately provide a comprehensive picture of the program's performance.

In keeping with the requirements of the Budget Transparency and Accountability Act, the ministry has prepared and made available to the public three-year service plans that set out priorities, strategies, targets and measures for the health system. As well, the ministry issues an annual service plan report that compares expected results to actual results.

The accountability framework for the health authorities for 2007/08 is set out in the Health Authority Act, the Government Letters of Expectations and Health Authority Service Plan Guidelines developed by the ministry. Performance requirements are also set out in more detail in the Health System's Performance Framework, but only three of the health authorities had signed this for 2007/08. In that year, all the health authorities were required by the ministry to produce and make public a service plan consistent with the Government Letters of Expectations and BC Reporting Principles (see sidebar). The authorities were not required to

Public performance reports do not provide adequate accountability information

> Therefore, in the view of the Office of the Auditor General, they should be similarly subject to accountability for their planned and actual performance as are the ministries and Crown agencies of government.
>
> Source: Auditor General of British Columbia 2008/09 Report 2: Strengthening Accountability in British Columbia

produce or publish annual service plan reports. At the time of our fieldwork, health authority reporting requirements for 2008/09 were not finalized.

Exhibit 6 outlines the measures and performance information related to home and community care published by the ministry in its 2006/07 and 2007/08 annual reports and 2007/08 and 2008/09 three-year service plans. Currently, the measures do not provide information on home support or community-based services, which are important aspects of the system. In addition, the number of measures reported on the system has decreased over the past two years with only one in the current year's plan. As the information available on the home and community care system improves, we expect the ministry to provide a more comprehensive picture of the system's performance to the public and legislators.

Exhibit 6

Ministry public measures for home and community care (2006/07 to 2008/09)

	Measure	Services Covered	2006/07 Annual Report	2007/08 Service Plan	2007/08 Annual Report	2008/09 Service Plan
1	Percentage of care facility residents with influenza immunization	Residential Care	Target and actual	Target	Target and actual	–
2	Percentage of clients admitted to residential care within 30 days	Residential Care	Target and actual	–	–	–
3	Percentage of natural deaths occurring in settings outside hospital	End-of-life services	Target and actual	Target	Target and actual reported	–
4	5,000 net new residential care, supportive housing and assisted-living units by December 2008. *See note	Residential Care, Assisted Living, Supportive Housing	Target for completion and net new and replacement units to date	Target for completion of project December 2008	Target for completion and net new and replacement units to date.	Target for completion of project December 2008

Source: Ministry of Health 2007/08–2010/11 Service Plans and 2006/07 and 2007/09 Annual Service Plan Reports

***Note:** In the Annual Reports and the Ministry Service Plan, the 5,000-bed project is a key strategy. In the annual reports the ministry reports the number of net new beds built by the year end, as well as the total number of new and replacement units built between June 2001 and March 2008. However, these do not include targets for the builds per year or break down the number of units by each of the program areas (i.e. residential care, supportive housing and assisted living). This would provide a more transparent and informative picture of the progress of this project.

Public performance reports do not provide adequate accountability information

We recommend the Ministry of Health Services:

- ***develop performance measures that provide a more comprehensive picture of how the home and community care system is performing and report publicly the critical few measures that best demonstrate this performance; and***
- ***require health authorities to report publicly both service plans and annual reports.***

Appendices

A: Definitions of Home and Community Care Programs

At-home and community-delivered programs

Home Supports Programs—These services are delivered directly to a person in his or her home and cover personal assistance services such as bathing, dressing, grooming and light household tasks. These services assist clients with health-related disabilities to continue living in their own homes when personal and family resources are not sufficient to meet the individuals' need for care.

- Choice in Supports for Independent Living (CSIL) is a "self-managed model of care." Clients receive funds directly for the purchase of home support services. They assume full responsibility for the management, coordination and financial accountability of their services, including hiring, training, scheduling and supervising home support workers. For more information see http://www.healthservices.gov.bc.ca/hcc/csil.html.

Adult Day Programs—These programs provide supportive group activities that assist clients with daily activities and give individuals an opportunity to be more involved in their community. The services may include bathing programs, administering of medications, therapeutic recreation and social activities, caregiver education and support, meals and transportation.

Home Care Nursing and Community Rehabilitation Programs—Home care nursing and community rehabilitation are professional services, delivered to clients in the community by registered nurses and rehabilitation therapists. Nursing care is available on a non-emergency basis. Rehabilitation therapists provide assessment and treatment to ensure a client's home is suitably arranged for their needs and safety.

Housing with support programs

Assisted Living Programs—This program is delivered in residences with apartment-style accommodations registered under the Office of the Assisted Living Registrar. These residences offer a range of personal care and hospitality services such as meals, laundry, housekeeping and social activities and include a 24-hour emergency

response system. Residents within Assisted Living can live independently but require assistance with daily living activities.

Supportive Housing—These units provide apartment-type accommodation with hospitality service, similar to those offered in the Assisted Living Program. This program is not delivered under the umbrella of services that is the responsibility of the Ministry of Health Services, but it is an important aspect of the home and community care system and is a part of the Ministry of Health Services's 5,000-bed initiative. Like persons living at home, residents within supportive housing may receive home support through a home support agency or directly from health authority staff. They may also receive nursing and rehabilitation services directly from health authority staff.

Facility-delivered programs

Residential Care Facilities—The facilities provide 24-hour professional nursing care and supervision in a protective, supportive environment. Care is provided for the most vulnerable British Columbians, and may include seniors with Alzheimer's disease or other types of dementia or who have complex clinical care needs or severe behavioural problems that require professional nursing care.

Group Homes—Adults with health-related disabilities can live independently in their community in publicly funded group homes. Group homes usually accommodate four to six residents on a short- or long-term basis and can provide skills training, peer support and counselling.

Family Care Homes—These are single-family residences that offer clients a home-like atmosphere, meals, housekeeping services and assistance with daily living activities, such as bathing, grooming and dressing. Family care homes are for seniors and people with health-related disabilities who: may require a more individualized approach to their care than is available in a residential care facility; have an immediate need for residential care and are unable to find other suitable alternatives; find the care environment at a residential care facility is not compatible with their religious, ethnic or cultural background or lifestyle; or need short-term assistance upon leaving hospital but are not ready to return to living in their own home.

Appendix A

Cross-cutting Services and Programs

Convalescent care means functional restoration and reactivation services provided in a facility to a person who is clinically stable, has a defined treatment plan and is no longer in need of the full diagnostic and therapeutic capabilities of an acute care hospital. He or she does, however, still require clinical and medical services to restore function to make the transition from acute care to home. These clients have slower functional restoration than other levels of care and lower tolerance for therapy, in addition to the functional complexity of multiple health conditions.

End-of-life care is supportive and compassionate care meant to improve the quality of life of people in the end stages of a terminal illness or preparing for death (see sidebar). It is provided wherever the client is living, whether in his or her home or in hospital, hospice, an assisted living residence or a residential care facility.

End-of-Life and Palliative Care Definitions

"End-of-life care" is the term used for the range of clinical and support services appropriate for dying people and their families. The goal of end-of-life care is the same regardless of the setting—to ensure the best possible quality of life for dying people and their families.

Palliative Care
"Palliative care" means the specialized care of people who are dying—care aimed at alleviating suffering (physical, emotional, psychosocial or spiritual) rather than curing. The term "palliative care" is generally used in association with people who have an active, progressive and advanced disease, with little or no prospect of cure.

Hospice Palliative Care
"Hospice palliative care" is a philosophy of care that stresses the relief of suffering and improvement of the quality of living and dying. It helps patients and families to:

- address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears;
- prepare for and manage self-determined life closure and the dying process; and
- cope with loss and grief during illness and bereavement.

Source: Ministry of Health, End of Life Framework 2006

Hospice Services—A hospice is a residential, home-like setting where supportive and professional care services are provided to those who are in the end stages of a terminal illness or preparing for death.

Hospice is available for people who are unable to remain at home or prefer to spend their remaining time with others and do not require hospital care. A palliative care client may also move to a hospice on a short-term basis to provide respite to family caregivers.

Caregiver Relief/Respite Services—Many people receiving home and community care services are assisted by non-professional caregivers, often a friend or family member. Respite care can give the caregiver temporary relief from the demands of caring for a friend or family member. Respite may take the form of a service in the client's home. Alternatively, the client may be admitted, on a short-term basis, to a residential care facility, hospice or other community care setting.

Case Management Services—Case managers work within the five regional authorities and are responsible for assessing the needs of individuals and managing their placement within facility or assisted-living settings and/or arranging for appropriate at-home and/or community interventions.

Appendix B

B: Home and Community Care Redesign 1998–2007/08

Year	Action
1998	Ministry of Health Services launched a review of what was then named Continuing Care Services.
1999	In October, the steering committee leading the Continuing Care Services review produced a document entitled *Community for Life- Review of Continuing Care Services in British Columbia*. This report provided a high-level view of the 1998 system, its conditions, future expectations and a framework for change. The framework included recommendations for key policy directions: ■ implement the means of ensuring sustainability ■ embed services in a caring community ■ provide integrated and flexible service delivery ■ maintain and improve quality
2000	Responding to the 1999 report, the Ministry of Health Services released its vision for continuing care renewal in December, Strategic Directions for Continuing Care Renewal. The document highlights five policy directions: ■ improved access and responsiveness ■ improved appropriateness ■ improved client outcomes ■ improved participation ■ improved system management
2001	In addition to the renewal initiative, the Liberal government's New Era document in 2001 announced a commitment to work with non-profit societies to build and operate an additional 5,000 new intermediate and extended care beds by 2006, expand home care and palliative care services, and provide better home support and home care services. As part of the effort to redesign home and community care, the ministry expanded alternatives to institutional care. It also changed access criteria for residential care under the assumption that many people residing in these facilities did not need the level of supervision and support provided in these settings.
2002	Reforms undertaken by the ministry led to the development of assisted living and changes to facility-based care. Assisted living offers a more independent apartment-style setting for those who can effectively direct their own care. This leaves residential care for those with complex care needs who require 24-hour professional support.
2004	The government enacted the Community Care and Assisted Living Act to provide a regulatory framework for these services.
2002/03-2004/05	Over the past few years, some long-term care units have been decommissioned, others have been converted to Assisted Living and new facilities have been constructed. In the 2002/03–2004/05 Performance Agreements, the ministry called for regional authorities to increase the percentage of high-needs clients receiving services at home. In conjunction with these changes, the ministry introduced changes to the assessment process and system for identifying service needs.
2005	The Ministry of Health Services introduced a set of standardized assessment instruments for people needing services within home care.
2007/08	In its service plan, the Ministry of Health Services re-stated its target for the construction of new units or beds: to "partner with BC Housing and community affiliates to meet the target of 5,000 new residential care, assisted living and supportive housing with care spaces by December 2008."